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The power of diagnosis

EDITORIAL

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The new diagnosis of gender incongruence is a recognition of the right of transgender persons to decide for themselves who they want to be.

Our understanding of gender and gender identity is changing, in Norway and internationally. The disappearance of the 'gender identity disorders' diagnostic group, which includes 'transsexualism' and 'other gender identity disorders', from the ICD-11 diagnostic manual that is currently being published must be viewed as an expression of this. A diagnosis of 'gender incongruence' is being introduced in its place, encompassing those who define themselves neither as a man nor a woman and thus have a non-binary gender identity. The change in diagnosis is the result of a protracted battle by a socially marginalised and stigmatised group, but also of contemporary changes in understandings of gender identities (1, 2).

Diagnoses are not innocent (3). They divide the sick from the healthy – and define the limits of normality, how society sees it at any particular time. Thus, witchcraft, drapetomania (the tendency of slaves to flee captivity) and homosexuality have been perceived as diseases at various times. Diagnoses are contested: they may cause tension between patient and doctor, among doctors or among professions – for example, by dictating who should take

responsibility for different diseases (4). They shape the patient's life history and self-perception, and guide research and economic prioritisations (3). They are therefore important for patient advocacy organisations, which use them to fight for recognition, funding and other forms of support (5). The history of the diagnosis of gender variants provides a good example of diagnosis' function in medicine.

For more than a century, western medicine has labelled gender identities and expressions of gender that have differed from (and thereby threatened) society's perception of what is normal, including sexual inversion (1870), metamorphosis sexualis paranoica (1886), transvestism (1910), eonism (1928) and transsexualism (1966), for example. In the diagnostic manuals, gender variants have been categorised as sexual deviancy, psychosexual disorders and gender identity disorders. These diagnoses have served to further stigmatise transgender people, leading many activists to believe they should be abolished, in the same way homosexuality was removed from ICD in 1990. For transgender people, however, medicine has also enabled identities, lives and bodies. Since the story of Georg Jørgensen – who became Christine Jørgensen in Copenhagen in 1952 as a result of gender confirmation treatment – gained worldwide fame, patients have sought help from doctors in making their bodies more consistent with their gender identity. The working group in ICD-11– with support from many activists – has therefore decided that it is essential to retain a diagnosis, not least because diagnoses are connected to rights, such as health services and welfare benefits (6).

Why is the diagnostic change so important? Firstly, the new diagnosis recognises that gender identities are fluid. Concepts such as 'anatomical sex and 'opposite sex' have been removed. The diagnosis of transsexualism in ICD-10 (F-64.0), which is now being abandoned, was mainly directed at those who feel that they are 'born in the wrong body', in other words, have defined themselves as either male or female. Until now, only patients with this diagnosis have been offered gender confirmation treatment at Oslo University Hospital Rikshospitalet. The new diagnosis of gender incongruence is defined as an incongruence between one's gender identity and primary or secondary sexual characteristics, accompanied by a strong desire to remove or change some or all of these. The diagnosis lays the foundation for more people with various gender identities to have access to gender confirmation treatment. Lack of access to health services – due to personal finances, restrictive policy or lack of knowledge among healthcare personnel – has led to high-risk self-medication (6, 7). The fact that transgender persons in Norway are seeking out private health services for gender confirmation treatment may be seen in light of our excessively restrictive treatment practice (8).

Secondly, the new diagnosis in ICD-11 has been moved from the chapter on mental disorders and placed in a new chapter for sexual health that explicitly integrates medical and psychological perspectives. The World Health Organization's (WHO) working group does not define gender incongruence as a psychiatric diagnosis (6). A main reason for placing the diagnosis in a new chapter was that, in many countries, psychiatrists have served as gatekeepers in a comprehensive, cumbersome system that has complicated access to health services (6). In contrast to ICD-10, there is no requirement in ICD-11 for all

transgender people to desire full gender confirmation treatment: some may perhaps only want a prescription for a wig, some wish for hormone treatment, some want to remove facial hair, others want to remove their breasts, and yet others will want 'full' gender confirmation treatment by means of hormones and surgery.

Transgender people constitute a heterogeneous population, and we need prospective treatment studies, including for medical treatment of the broader group of patients who fall within the new diagnostic criteria for gender incongruence (2). Until that research is completed, it is nonetheless time for a health service that, above all, does not harm those who have come to them for care.

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