Gender Incongruence as a Condition Relating to Sexual Health: The Mental Health ‘Problem’ and ‘Proper’ Medical Treatment

**Introduction**

In the 11th version of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) there has been a significant change in the placement of gender identity conditions. What is currently termed in the ICD-10 as ‘Gender Identity Disorder’, or ‘Transsexualism’ in adolescents and adults and ‘Gender Identity Disorder of Childhood’ in pre-pubertal children[[1]](#footnote-1), will be re-named as ‘Gender Incongruence’ of either childhood or adolescence and adulthood.[[2]](#footnote-2) These conditions will also be moved from the category of ‘Mental, Behavioural or Neurodevelopmental Disorders’ to the category of ‘Conditions Relating to Sexual Health’.[[3]](#footnote-3) This reclassification results from years of debate by the WHO working group, which comprises of some of the most experienced healthcare professionals and researchers internationally within the field of transgender health. [[4]](#footnote-4) A significant reason for the change in the nomenclature is that the term ‘gender incongruence’ is widely regarded as being less pathologising or pejorative than existing terms. The reason for the removal of the condition from the list of mental disorders is, obviously, to correct the view that gender diverse people are mentally disordered or sick.[[5]](#footnote-5)

In this paper we suggest that there are a number of potential ethical and clinical problems with classifying gender incongruence as a condition relating to sexual health. One problem is that sexual health conditions are often assumed to have psychofunctional aetiology, so the rejected psychiatric classification may reemerge regardless of reclassification. The second problem is that reclassifying gender incongruence as a condition relating to sexual health could lead to a misguided understanding of gender identity as an issue that is necessarily or inherently related to one’s sexuality and subsequently to an imprudent focus on genital incongruence. This could reinforce the mistaken view that being gender diverse necessarily involves suffering from genital dysphoria. In addition, that appropriate medical treatment for gender incongruence necessarily involves correcting medically and surgically the ‘mismatch’ between one’s genital morphology and their gender identity. Whilst this is true in some cases, not all gender diverse people need or desire genital surgery. The new classification may therefore potentially have important and undesirable medical and legal consequences, particularly for gender diverse people who do not have genital dysphoria and do not wish to undergo full gender-affirming surgery.[[6]](#footnote-6) Without a clear collocation within the ICD, the eligibility of this population for any medical treatment may be at risk. There are potentially legal consequences too. In some jurisdictions, legal gender change is only allowed to those who have full gender-affirming surgery. Some of the existing laws on gender change (for example the Italian Law 164/82 1982[[7]](#footnote-7)) have been constructed as requiring complete genital surgery (therefore, effectively, sterilization) as a condition for legal gender change. As widely known, this has been criticized by the Council of Europe as a violation of a fundamental human right to identity and bodily integrity[[8]](#footnote-8), and to some extent rectified[[9]](#footnote-9). There is a potential risk that the classification of gender incongruence as a disorder related to sexuality may inadvertently continue to reinforce a binary view of gender, and consequentially affect people’s right to affirm their identity at law without submitting to unnecessary medical procedures.

We do not suggest here the new ICD-11 will cause an upsurge of unnecessary surgeries for those who do not need it. We instead suggest that understanding gender incongruence as something relating to one’s sexuality and thus becoming ultimately integral to a person’s sexual health may shape the perception of what is proper medical treatment. To explain how this may happen we will consider the case of intersex conditions and specifically so-called ‘genital-normalising’ surgery. We do not want to compare intersex with gender variance, yet there is a lesson to be learnt from the way clinical nomenclature may shape the understanding of human diversity and health and disease, and therefore influence the provision of medical care, specifically genital surgery.

**Defining Gender Incongruence**

In the next section we will look in greater detail at why gender incongruence has been reconceptualized in the ICD-11 and explain why the new classification can give raise to our concerns. Before we present our arguments, it is necessary to understand the definitions of gender incongruence within the ICD-11 and further clinical nomenclature associated beyond the ICD-11.

Gender incongruence is defined as being *‘characterized by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex’*.[[10]](#footnote-10) Specifically in childhood the definition includes

*‘a strong dislike on the child’s part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender’[[11]](#footnote-11)*

Whereas within the definition of Gender Incongruence of Adolescence and Adulthood the incongruence is explained as often leading to

*‘a desire to ‘transition’, in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender’. [[12]](#footnote-12)*

Of significance is that the term gender incongruence is not universally applied across clinical guidelines and other diagnostic classification systems. Instead of ‘gender incongruence’ the World Professional Association of Transgender Health (WPATH) Standards of Care use the term ‘gender dysphoria’, coherently with the US Diagnostic and Statistical Manual of Mental Disorders (DSM-V).[[13]](#footnote-13) Gender dysphoria is described as being characterized by distress caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth.[[14]](#footnote-14) Within the WPATH Standards of Care, gender variance is recognised as encompassing both gender non-conformity and gender dysphoria. Whilst gender non-conformity is acknowledged in the Standards of Care as normal human diversity, it is the distress associated with gender dysphoria that identifies the need for access to specialist psychological care or medical treatment, specifically when it may be alleviated with medical intervention and body modifications.[[15]](#footnote-15) The ICD also recognises that gender variant behaviour and preferences alone are not a basis for assigning the diagnosis of gender incongruence.[[16]](#footnote-16) Moreover, gender incongruence does not necessarily imply gender dysphoria. In other words, gender diversity can occur in different forms and degrees, and not all those who have gender incongruence, as defined in the ICD, necessarily must experience gender dysphoria within the updated ICD definition.

**Disordering Gender Identity**

Our first concern relates to the issue of whether the reclassification will address the aim to shift away from a psychiatric diagnosis. Atypical gender identity (variably named as gender identity disorder, transsexualism, gender-variance, gender dysphoria and now gender incongruence) has been traditionally regarded as mental disorder and defined through the discipline of psychiatry.[[17]](#footnote-17) There have been two major reasons for this: the first is that there is no identified physical cause to it; the second is that many people who are gender diverse also suffer from concomitant psychological distress, such as anxiety and depression. [[18]](#footnote-18) However, it has been noted that psychological distress is often a result of social ostracism and hostility, discrimination and abuse, and not primarily a result of being gender diverse per se.[[19]](#footnote-19) Gender diverse people generally suffer less in supportive environments and societies.[[20]](#footnote-20) When considering the relationship between gender incongruence and psychological distress, Meyer-Bahlburg argues that gender can develop in many different ways; it is social hostility towards this development that causes psychological harm.[[21]](#footnote-21) Furthermore, Winter *et al* point out that transgender people have been traditionally perceived in many socio-cultural contexts as having a form of sexual deviance, particularly with the historical nomenclature of transsexualism.[[22]](#footnote-22) This has resulted, and still does result in gender diverse people being the target of indignation, discrimination, abuse and violence.[[23]](#footnote-23) All of these are primary causes of psychological ill health, not gender diversity.

The psychiatric classification may then obscure the real roots of the psychological distress suffered by gender diverse people. Moreover, the psychiatric classification has been heavily criticized by the Council of Europe[[24]](#footnote-24) and by clinical and academic commentators concerned about the detrimental impact of a psychiatric aetiology. For example, Lev argues that classifying gender diversity as psychopathology is one example of how medicine pathologises ordinary human diversity.[[25]](#footnote-25) Failing to recognise the spectrum of gender identities and classifying some gender identities as pathological is stigmatizing and discriminatory.[[26]](#footnote-26)

If one accepts that gender does not necessarily develops in a binary ‘male/female’ way, and that gender diversity is a normal and natural part of what it is to be human, one may have trouble seeing what ‘proper’ medical treatment may be for gender diversity, as there is no ‘disorder’ to treat. Recognition of different genders, which appears inspired by respect of human diversity, may easily turn into a peremptory denial of people’s needs and their claim to medical help. Therefore, we can understand the purpose and value in the efforts made by the WHO working group in finding a classification for gender diversity that may temper the stigma and psychopathologisation of the condition, without affecting negatively access to medical treatment.

One alternative option considered by the WHO working group was to include gender diversity among the so-called Z codes, Factors Influencing Health Status and Contact With Health Services within the ICD-11.[[27]](#footnote-27) Winter et al argued that Z codes are able to offer a person access to the resources of medical professionals to address the impact of something that is not classified as an illness or disease on their health.[[28]](#footnote-28) However, the problem for Z code classification is that not all healthcare systems will provide access to treatment for anything under these, for example the Netherlands.[[29]](#footnote-29)

Ultimately there is a pragmatic reason for the inclusion of gender diversity in the ICD and other diagnostic manuals, whereby such inclusion allows and facilitates access to healthcare and the needed gender affirming treatment. Whilst we can see the rationale for a shift away from mental health classification, we need to consider the appropriateness of gender incongruence as a condition relating to sexual health.

**Reclassification as a Condition Relating to Sexual Health**

Following years of debate and reflection, the WHO working group placed gender incongruence within a new chapter entitled Conditions Relating to Sexual Health. The WHO defines ‘sexual health’ as being,

***‘****a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.’[[30]](#footnote-30)*

The new ICD-11 chapter also covers female genital mutilation, violence against women, sexually transmitted infections, contraception and sexual dysfunctions and sexual pain disorders which may have psychological, cultural and relationship causes.[[31]](#footnote-31) Other conditions within the chapter are specifically focussed on sexual dysfunction or sexual pain.[[32]](#footnote-32) Sexual dysfunctions are defined as ‘syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities’[[33]](#footnote-33), including sexual desire, sexual arousal, orgasmic and ejaculatory dysfunctions.[[34]](#footnote-34) Sexual pain disorders are explained as pain experienced during consensual vaginal sexual intercourse that can result in penetrative sex difficulty and/or anxiety[[35]](#footnote-35).

Despite the WHO’s holistic definition of sexual health, which focuses on the wellbeing of a person in all aspects of sexual health, within the new chapter many of the conditions appear to focus on the functional or physiological elements of sexual intercourse. One problem with enlisting gender incongruence in this category is that, as Drescher *et al* pointed out, it risks ‘mischaracterizing gender identity as a sexual issue’*.*[[36]](#footnote-36) Moreover, sexual dysfunctions are often associated with marked personal distress and decreased quality of life.[[37]](#footnote-37) Importantly, they often coexist alongside mental health diagnoses or exist as a result of trauma or abuse,[[38]](#footnote-38) and treatment usually involves psychological therapy.[[39]](#footnote-39) Consequently sexual dysfunctions have in many cases been classified as mental disorders within previous versions of the ICD.[[40]](#footnote-40)

Sexual dysfunction and disorders are thus often intrinsically associated in some way with psychopathology.[[41]](#footnote-41) Therefore moving gender incongruence from the list of mental disorders to the list of conditions relating to sexual health is unlikely to protect gender diverse people from the misguided view that being gender diverse is having a mental disorder. Furthermore, healthcare professionals should be mindful not to assume that because many sexual dysfunctions have psychological origins, or have roots in trauma and adverse life experiences[[42]](#footnote-42), gender incongruence also has.

**The role of psychiatry in gender care**

One consequence of the original classification of gender diversity as a mental disorder was that psychiatrists played a fundamental role in decisions relating to the provision of gender affirming treatment. The mental health professionals had to be satisfied that the dysphoria was not the result of delusion or other underlying mental disorder, and that medical treatment for gender diversity was necessary to alleviate psychological distress. We are not suggesting that this is inherently problematic – however, some have complained that this effectively renders psychiatrists gatekeepers for medical treatment of a condition that is not psychiatric in nature.[[43]](#footnote-43)

The reclassification of gender incongruence in the ICD-11 as a condition relating to sexual health has however not negated the clinical guidelines for specialist psychological care. Beyond general practice and primary care, mental health practitioners continue to be the specialist clinical care provider in the first instance referral for assessment, diagnosis and ongoing psychological care. Access to endocrinological and surgical treatment continues to be through mental health professionals.[[44]](#footnote-44) Mental health assessment remains part of diagnosis in this reclassification. Again we are not suggesting that mental health professionals should not be involved in the diagnosis. We are merely pointing out that the reclassification risks being merely a formal re-shuffling, which may not fully respond to the concerns relating to the psychopathologisation of gender diversity and to the routes of access to medical treatment. As such any reconceptualisation should be viewed in the context of current clinical guidelines and in this case we should acknowledge that the reclassification is aesthetic rather than interventional in so far as addressing the psychopathologisation of gender incongruence.

**Gender or Genital Incongruence?**

Our second concern in this paper is the impact of using the lens of sexual health to classify and frame gender diversity within clinical practice. The term gender incongruence, as we mentioned earlier, was chosen as an alternative to terms that were seen as pejorative or pathologising. Whereas we do not wish necessarily to engage with a debate on the nomenclature of gender incongruence, we should note that the term chosen has also caused concerns, and this has relevance for the purposes of this paper. Moser has argued that the term incongruence reflects binary norms and does not consider those who identify as agender, both genders or as a third gender.[[45]](#footnote-45) Incongruence suggests that some of the phenotypical features of the person are incompatible with their sense of self. This term then evokes an understanding of gender diversity as a mismatch between the external phenotypical appearance and the ‘internal’ gender identity, which is apparent in the definitions of gender incongruence within the revised ICD.

Whereas many gender diverse people may indeed experience a degree of mismatch between some of their external phenotypical features and their sense of self, the reclassification may seem to imply two things: one is that gender incongruence is the incompatibility between sense of gender/self and genitals; the other is that sexual health and function is the central problem of gender diverse people. Perhaps in the same way that being ‘disordered’ is pejorative, we suggest that so may be the central focus on sexual health. Crucially the new chapter may subsequently imply that genital surgery specifically should be viewed as being integral to the sexual health of gender diverse people. This certainly has the advantage of potentially facilitating access to gender-affirming genital surgery for those who wish to apply for it. However, many gender diverse people do not experience distress around their genital morphology, may never seek genital surgery and may not be dissatisfied with their sexual function.

The framework of the revised ICD could then be viewed as inadvertently binary. It may reinforce the view that there are men, born as males, women, born as females, as well as the rhetoric of transgender people as ‘males/females trapped in the wrong body’; it may also reinforce the idea that transition (as in genital surgery) is the treatment of choice. The population of all those who are bi-gender, agender, or who identify clearly as women or men without applying for genital surgery may not find clear collocation under the new ICD classification. This population may become vulnerable to a number of adverse misconceptions: because they defy the classification they risk being ineligible for any medical treatment under the new ICD. This is a risk that we urge the WHO working group to consider and that should be dispelled with accurate additional guidance.

Another problem is the impact of reclassification upon gender diverse people who may in some jurisdictions have problems in accessing legal gender change. Already, even in the most liberal jurisdictions and in the UK under the Gender Recognition Act 2004[[46]](#footnote-46), people have to embrace a binary gender identity and demonstrate the desire to live permanently and fully as in the other gender in order to obtain a gender change. In other countries, as mentioned earlier, people may have difficulties in accessing legal gender change unless they also undergo full genital surgery. The ICD classification may cause confusion and even a backlash in the legal understanding of gender identity as requiring a ‘congruent’ genital morphology.

**Potential clinical risks: What can we learn from DSD?**

We have suggested that considering gender incongruence as a condition relating to sexual health may have serious consequences in the way that ‘appropriate’ treatment is construed. There is a lesson here to be learnt from the (in)famous case of intersex (termed clinically as Disorders of Sex Development (DSD)). We do not want to compare gender diversity with DSD but consider what we ought to learn from the way nosology and nomenclatures have influenced the construction of ‘proper medical treatment’. In order to demonstrate this, it is important to give an overview of DSD and clinical intervention before turning to the potential lessons that could be learnt.

When the 2006 International Consensus Statement on Management of Intersex Disorders was published, it recommended that the term intersex be replaced with Disorders of Sex Development.[[47]](#footnote-47) DSD classification encompasses conditions in which the development of chromosomal, hormonal and external and/or gonadal sex characteristics are atypical.[[48]](#footnote-48) DSD are classified within the ICD-11 according to their clinical pathology and aetiology, for example as developmental anomalies and malformative disorders of sex development.[[49]](#footnote-49)

The term DSD has given rise to objections and controversies.[[50]](#footnote-50) As mentioned in the introduction, ‘naming’ a condition ‘a disorder’ or ‘an illness’ has various normative consequences. In the case of DSD the nomenclature and classification has given further legitimacy to surgical and endocrinological (controversial or outright unethical) procedures. As widely known, genital surgery and subsequent lifelong medical treatment have been routinely provided to young children with a DSD. These treatments not only alter the genital conformation; they also represent a decision about a child’s gender. Many of these children, later on, as adults, report feeling ‘disabled’ by the surgery obtained, both in respect of their identity and sexual health, and forced to live a life of medical treatment and confusion around their gender.[[51]](#footnote-51)

Whilst the term DSD refers to the anatomical, physiological and genetic features of the conditions, there was recognition in the 2006 consensus statement that such nomenclature must not only consider these characteristics, but also be accompanied by a conceptual shift towards consideration of a person’s long-term quality of life, and that this exists beyond sex characteristics.[[52]](#footnote-52) However, as Reiss acutely notes, the allegedly ‘medical’ term ‘Disorders of sex development’ obscures the political and social issues surrounding intersex, and reinforces a degrading conception of people’s sex characteristics as something to be concealed and corrected.[[53]](#footnote-53) [[54]](#footnote-54) In other words, nosology and classification shape an understanding of what proper medical treatment is (and must be, regardless of what the individual concerned may wish for themselves).[[55]](#footnote-55) [[56]](#footnote-56)

It may appear that in comparison to being ‘disordered’ and often ‘requiring’ surgical intervention (as is for DSD), those with gender incongruence are seemingly better placed within the ICD-11. In this sense, the new ICD seems to represent a step in the right direction of depathologising human diversity. However, this is where we should consider the potential clinical risks associated with reconceptulising gender incongruence as a condition related to sexual health.

The important parallel between gender incongruence and DSD within the ICD-11 is then that, whether ‘disordered’ or not, there is an emphasis on bodily modification as integral to the treatment of these conditions (and thus as integral to the understanding of what the condition is about). We will consider this in what follows.

**‘Medically appropriate’ surgery**

The ICD-11 recommends genital or gonadal surgery for children as part of the management of some identified DSD, for example congenital adrenal hyperplasia.[[57]](#footnote-57) The World Professional Association for Transgender Health (WPATH) reinforces this, distinguishing gender-alignment surgery for gender incongruence/gender dysphoria and state that

*‘genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient’s wishes’*. [[58]](#footnote-58)

The most recent clinical guidance for managing DSD promotes the use of a broad multi-disciplinary team to diagnose and support parents in assigning a binary sex to an intersex child, with consideration of genital surgery if indicated from the medical investigations.[[59]](#footnote-59) In recent years psychological support has been recognised as essential and beneficial in the management of children with a DSD, but importantly in tandem with and not instead of medical treatment, to support aligned and appropriate sexual characteristics.[[60]](#footnote-60)

Genital morphology that is considered as medically ‘abnormal’ or ‘inappropriate’ is assumed to have a negative and potentially detrimental effect on the child with a DSD as they develop into adolescence and adulthood, despite the lack of evidence to support this.[[61]](#footnote-61) Yet this genital surgery may be carried out partly with the intended benefit of supporting aesthetic and functional future sexual health.[[62]](#footnote-62) However, Lee et al highlight significant sexual dissatisfaction experienced as a result of genital surgery carried out in infancy for those with a DSD, in particular females with congenital adrenal hyperplasia.[[63]](#footnote-63)

In contrast, interventions for pre-pubescent children with gender incongruence are focused on purely psychological management, which is strongly influenced by the high reported recordings of desistence of gender incongruence upon reaching and during puberty.[[64]](#footnote-64) Immediate physical intervention for gender incongruence in adolescence is therefore initially limited to so-called puberty suppression therapy after the onset of puberty, usually using gonadotropin-releasing hormone (GnRH), to temporarily suspend secondary anatomical and physiological sex characteristic development.[[65]](#footnote-65) Partially irreversible cross-sex hormone therapy may be considered from around the age of 16, with surgical intervention limited to chest surgery initially and then genital or gonadal surgery, which is not recommended until a person achieves the age of majority. [[66]](#footnote-66) Where a person who has attained the age of majority is requesting genital-alignment surgery, the surgeon must be convinced that physical characteristics are incongruent with the gender that the patient aligns to and therefore abnormal.[[67]](#footnote-67) Latham describes genital abnormality from the perspective of the surgeon as being ‘gender inappropriate’ and therefore justification for surgery is based on inappropriateness, as opposed to a dysmorphic perception.[[68]](#footnote-68)

Our concern is that classification of gender incongruence as a condition relating to sexual health may result in the emergence of a clinically presumptive negative sexual health prognosis. This presumptive negative sexual health prognosis in gender incongruence could be explained as this; if a person experiences a male or female gender identity, then clinically they should have corresponding genitalia for satisfactory sexual health. This is problematic in many ways.

Firstly, the new classification carries the risk that the presence of ‘congruent’ genitalia is integral to healthy gender identity. We have seen instead that many may develop a healthy gender identity without the need for ‘matching’ genitalia. Secondly, the new classification carries the risk of presenting gender diversity or distress around one’s gender as an issue of sexual health. This is a reductive view of gender identity. Thirdly, whilst some gender diverse individuals may need genital-alignment surgery, many do not. The new classification inadvertently may shape a misguided understanding of what is ‘proper medical treatment’ and of what it is to be ‘really gender diverse’. This may impact negatively on the eligibility for individualized treatment, and on the clinicians’ ability to provide treatment, which may not involve any form of genital surgery or sexual health intervention. Finally, as we noted earlier, in some jurisdictions, gender diverse people can only live in their real gender and have legal recognition on the condition that they do submit to genital surgery. Whereas the Council of Europe and national legislation attempt to correct this clearly unethical practice, inadvertently the ICD-11 may appear to support the old and damaging view of gender diversity as something that must be corrected surgically in the same way for everyone (as in the case of DSD), regardless of their own experience and wishes.

**How Should We Classify Gender Incongruence?**

So far we have argued that classifying gender incongruence as a condition relating to sexual health may not achieve the purpose of dissociating gender diversity from psychopathology; moreover it may suggest that gender incongruence is a form of ‘genital’ incongruence. As one of the authors of this paper has previously argued, there are no epistemological reasons to consider gender diversity as pathology. [[69]](#footnote-69) Therefore, the inclusion in diagnostic manuals is in principle problematic. However, there are pragmatic reasons to retain the diagnosis: one is to facilitate access to medical treatment; another is to oversee medical provision and ensure proper quality of healthcare provision.

One option that has not been considered by the WHO so far may be to entitle a new chapter *‘Conditions Relating to Sex and Gender Identity’*. Referring to gender identity, rather than gender incongruence, would enable access to interventions tailored to the needs of the individual patients. These interventions could range from psychological care, to endocrinological treatment and to surgical treatment. The suggested chaptershould acknowledge that gender identity development is not fully understood, and that it appears to result from complex interactions between psycho-social, hormonal and genetic factors[[70]](#footnote-70). In this way, the diagnosis of gender diversity would not occur within the misguiding binary framework of ‘male/female’ born in the wrong body – and for whom proper medical treatment necessarily involves ‘corrective’ genital surgery. Focusing on gender identity, rather than incongruence, may give due recognition of different gender identities while, at the same time, also acknowledging that in some cases people may need either psychological support to discover and adapt to their real gender, or certain types of medical treatment (not always encompassing surgical intervention, and certainly not always encompassing genital surgery) or both.

What is important is that the new diagnostic manual should clinically set out that gender identity exists far beyond the sphere of sexual health and is not primarily a sexual health problem that can or should be fixed by altering the sexual organs.

We could even suggest that the chapter could encompass variations of sex characteristics. We of course acknowledge that in many cases DSD co-exists with syndromes as part of a more complex physiological aetiology. However, the emphasis within this suggested chapter would be on the variation of sex characteristic(s) and that this should exist in clinical classification separately from any other condition/pathology, in the same way that conditions related to sexual health will do in the ICD-11.[[71]](#footnote-71) This reconfiguration of both sex and gender identity would shift the nomenclature of being disordered, where there is simply a benign sex characteristic variation or gender diversity. Ultimately the reclassification would ensure provision of psychological care and medical intervention or treatment if needed by a person in relation to sex or gender identity. Medical treatment would thus be based upon experienced individual identity and need, rather than presumptive and indeed detrimental prognosis.

**Conclusion**

The removal of gender identity disorder from the list of mental disorders has been met with much support on the basis that those with gender diversity are not regarded primarily as being mentally disordered. However, we have reflected upon the potential ethical and clinical impact of the proposed nomenclature and classification changes. The re-naming of gender identity disorder as gender incongruence is not by itself problematic, and certainly is not as pejorative as gender identity disorder or transexualism. However, in reclassifying gender incongruence within the new chapter of conditions relating to sexual health there will not be a resulting change in the role of specialist mental health practitioners and services. Furthermore, this new chapter may misdirect gender incongruence towards being construed as ‘incongruence’ with natal genital morphology. We know however that many gender diverse people do not experience any incongruence with the phenotypical appearance and characteristics of their genitalia. This risks reinforcing, rather than tempering, the binary framework of male/female and trans as male/female born in the wrong body, which is now increasingly challenged scientifically.

Using the case of intersex conditions or variations of sex characteristics, pathologised as Disorders of Sex Development, we can further argue that focusing on medical anatomical or functional sexual health prognosis fails to consider gender identity in its entirety. Placing gender incongruence among the conditions relating to sexual health may facilitate access to genital-affirming surgery for those who need it, but may inadvertently render it difficult to collocate precisely those who are gender diverse, who need medical help, but not in the form of genital-affirming surgery. The risk may even be that some gender diverse people may feel ‘pushed’ into applying for medically unnecessary surgery in order to obtain any treatment at all, and in order to see their diversity validated and recognized. The management of DSD can teach us a powerful lesson around how a certain conception of ‘normality’ or ‘health’, when ingrained in medical thinking, shapes ideas around ‘medical necessity’ and proper medical treatment, and how hard it is to then reverse that thinking, once it has been established.

Gender diverse people often need medical care. It is known that not receiving proper medical care has serious and adverse consequences when it comes to gender identity; the treatment may encompass psychological care, endocrinological or surgical treatment, and there is not one clear treatment plan that can be applied to everyone. As gender identity develops in unique ways, people will need different types of care, and clinicians working in this field have to be sensitive to the individual circumstances of each individual person. There is a difficult balance to be struck between facilitating access to treatment and care without negatively pathologising human diversity. The WHO has attempted to strike this balance by renaming gender identity disorder as gender incongruence, and by moving it under the conditions relating to sexual health. This is though potentially problematic when we acknowledge that a person’s gender identity is not just narrowly a matter of sexual health.

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