This increase in control might also indicate a more worrying trend—a neglect of attention to establishing trusting relationships with troubled and severely mentally ill individuals. If we lose the emphasis on this core skill from our training and practice, it could be very difficult to re-establish. Therapeutic engagement and continuity of care need to move back up our profession's priorities.

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I declare no competing interests.

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A gender incongruence diagnosis: where to go?

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The Mexican field study report by Rebeca Robles and colleagues[1] in *The Lancet Psychiatry* has addressed an important aspect of the WHO proposals concerning transgender diagnosis in ICD-11; the place of the diagnostic category in the manual. The authors investigated the proposal to remove the categories related to gender identity from the Mental and Behavioural Disorders chapter by examining whether distress and impairment, considered essential characteristics of mental disorders, could be explained by experiences of social rejection and violence rather than being inherent features of transgender identity. The key question asked here is whether there is evidence to support the classification of gender incongruence as a psychiatric condition. The authors report that the distress and dysfunction many participants recalled experiencing in their early adolescence were associated with their recollections of social rejection and violence at that period in their lives, rather than with factors more directly related to their gender incongruence. The authors conclude that this is an argument for moving the trans-related diagnoses to a chapter outside of the Mental and Behavioural Disorders. They argue, along with others,[2] that this move would help to remove the double burden of stigma: having a mental disorder diagnosis and being transgender. The authors' conclusion will be welcomed by many; it meets the demands of clinicians and others who have argued that trans people's gender identities are not psychopathological.[3]


Daniel Sambraus/Science Photo Library

The strength of this field study is that, besides arguments for a reconceptualisation of the categories related to gender identity, it gives us an analysis of the social context wherein these transgender adolescents were reared. In the retrospective structured interviews focusing on participants' recollections of adolescence, the rates of physical abuse (n=157 [63%]), social

rejection (n=191 [76%]) and stigmatisation in the families (n=161 [84%]) and schools or workplace (n=104 [55%]) of these transgender adolescents were extremely high. This indicates environmental conditions that push transgender individuals to the margins of society, into risky environments and towards risky behaviour. Unsurprisingly, 40% of the trans women (but none of the trans men) of the Condesa clinic were HIV positive, although the HIV status of the participants in this trial was not recorded. Another result is psychological distress and dysfunction. Minority stress is a well-documented event in the transgender population, as it is in the LGB population.[4] A prominent UN advocate has put it this way: "Transphobia is a health issue".[5] This study prompts primary caregivers and psychiatrists to be aware of a "slope leading from stigma to sickness"[6] for transgender individuals, and to contribute to their mental health by a gender-affirmative approach.

The authors also conclude that WHO's proposal to reduce the prediagnosis period for Gender Incongruence of Adolescence and Adulthood (from 2 years in ICD-10 to "several months") is clinically more appropriate, because, in this study, although the trans people reported that they had first become aware of their transgender identity and felt that they might need to do something about it at a mean age of 5·7 years (SD 2·5 range 2–17), those who received hormone treatment (n=182 [73%]), did not do so until an average age of 25·0 years (SD 9·1; range 10–54). The authors argue that adding more time before diagnosis would cause added stress, and cannot be justifed.

This field study unfortunately did not address where in ICD (upon removal from Mental and Behavioural Disorders) would be the most appropriate place for the diagnosis. At the time of writing it is provisionally assigned to a new chapter called Conditions Related to Sexual Health.[7] This more medical chapter might attach less stigma to the diagnosis, and open up more opportunities for education (for medical practitioners and the general public) on sexuality and gender issues. In the debate during the WPATH–ICD consensus meeting in 2013 some participants expressed their fear that placement in this chapter would serve to conflate concepts of gender and sex.[8] There was also controversy concerning the name "gender incongruence". Some participants find this name pathologising, as the term incongruence presumes normative thinking around appearance. Another argument against the name is that translation into other languages can be difficult and sometimes carry negative connotations.[8]

In conclusion, this field study provides evidence to support one aspect of the WHO proposals—namely, moving health-related categories related to transgender identity out of the classification of mental disorders in ICD-11. Many questions remain, such as the case for a diagnostic category, the name and diagnostic guidelines that should be used, the place the diagnosis should occupy in the manual, and, above all, the need for a diagnosis for children, for which other field studies are needed.

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GDC was an external reviewer for, and SW was a member of, the WHO Working Group on the Classification of Sexual Disorders and Sexual Rights that generated these proposals. SW and GDC were coresearchers on a survey of WPATH members' attitudes towards the GIC proposal. SW was a member of the GATE Civil Society Experts Group.

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