Controversies

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Diagnostic Neutrality or Sociopolitical Conformity? The Depathologisation of Gender Dysphoria and Gender Incongruence in the DSM and ICD

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Abstract

Here, we explore how the modern classification of Gender Dysphoria (GD) (DSM-5) and Gender Incongruence (GI) (ICD-11) diverges from the evidentiary standards that historically governed psychiatric nosology. While DSM-III initiated a shift toward reliability, construct validity, and theoretical coherence, the redefinition and depathologisation of gender-related diagnoses reflect a markedly different trajectory shaped by advocacy, institutional pressures, and rights-based frameworks rather than empirical advances. Bibliometric trends, policy developments, and medico-legal cases illustrate how academic, clinical, and political domains reciprocally reinforce conceptual models that lack demonstrated reliability or validated aetiology. Parallel reviews, including NICE and the Cass Review, characterise the evidence for medical transition in minors as of very low certainty, raising ethical concerns regarding irreversible interventions administered amid severe knowledge gaps. The paper argues that GD/GI currently function as provisional constructs rather than scientifically established disorders and that maintaining diagnostic integrity requires conflict-independent governance, methodological transparency, and adherence to empirical standards. Ultimately, the case of GD/GI highlights a broader tension within contemporary psychiatry: the challenge of upholding scientific neutrality in an era where diagnostic categories risk being shaped by cultural affirmation rather than validated clinical science.

Introduction

Psychiatry can be understood as the branch of medicine that specialises in identifying, understanding, and treating diseases of the mind. The human mind is comprised entirely of conscious and unconscious experiences that cannot be directly observed, measured, or manipulated. As a result, psychiatric diagnosis is unlike that of all other medical specialties in relying entirely on indirect inferences derived from speech and behaviour. This has led to serious debate over whether psychiatry can properly be understood as a branch of medicine or should be seen as something fundamentally different (for example, (1)).

One of the strongest attacks on psychiatry in the mid-20th Century was that it was less scientifically rigorous than other branches of medicine. In response, the third edition of the most widely used psychiatric diagnostic framework, the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), (2) moved away from vaguely defined psychoanalytic formulations of psychiatric illness towards more reliable but aetiologically agnostic polythetic symptom checklists. (3) However, over the past three decades, psychiatric nosology has shifted away from the focus on reliability and towards di-

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agnostic categories shaped by cultural advocacy, identity politics, and institutional pressure. (4,5)

The reclassification of Gender Dysphoria (GD) in the DSM-5 and the parallel emergence of Gender Incongruence (GI) in the International Classification of Diseases 11 (ICD-11) illustrate how significant sociopolitical biases can affect the diagnostic framework of western psychiatry. This is a modern echo of the formulation of homosexuality as a psychiatric disorder prior to the DSM-III in 1980. (6)

Recent bibliometric analyses show that GD/GI publications surged after the release of DSM-5 in 2013 and ICD-11 in 2018. This surge was more reflective of intense activism and political lobbying than any strong empirical basis for the elimination of pathological forms of gender identity from the two dominant psychiatric diagnostic platforms. (7)

Starting with the DSM-III, a rigorous approach to psychiatric diagnosis prioritised reliability, construct validity, and theoretical coherence. (8) The evolution of GD/GI is anomalous when measured against this standard. Lawrence (2014) observed that the DSM-5 reconceptualized gender distress not as discomfort with one's biological sex, but as the result of a mismatch between sex and the novel and scientifically unsubstantiated category of "assigned gender," a shift introduced for political rather than clinical reasons. (9) This redefinition severed the diagnosis from any scientifically studied biology/psychology and recruited psychiatry as an ally of identity-based advocacy movements. Aria et al. argued that such conceptual changes coincided with the rise of interdisciplinary, post-structural discourses that displaced medical criteria in favour of sociological constructs of gender. (7)

The empirical foundation for gender-affirming treatment of gender distress, however defined, remains limited. Defant (10) highlights systematic reviews, including the Cass Review, (11) which classifies the evidence base for puberty blockers and cross-sex hormones as "very low quality," citing methodological flaws and lack of long-term outcomes. (7) These findings parallel Swedish and UK health authority cautionary statements that emphasize the absence of longitudinal safety data, particularly for minors. Such evidence gaps have direct ethical implications when irreversible interventions are administered in the absence of stable identity formation or psychological maturity.

This diagnostic and therapeutic evolution has occurred within a broader ideological and institutional context. Putatively, clinical organisations which are strongly influenced by social justice advocacy, such as the World Professional Association for Transgender Health (WPATH) (12) have asserted that trans identity is not a mental disorder without providing a theoretical rationale or empirical evidence. The influence of such activism is visible in legal and governmental spheres: for instance, the *Boe v Marshall* (2023) proceedings and testimony before the Australian Human Rights Commission (*Hansard – AHRC – Cody 07.10.25*) document the collision of medical evidence, ideology, and human-rights frameworks. (13,14) Similarly, recent controversies over Queensland's 2025 ban on puberty blockers illustrate how policy alternates between precautionary medical scientific reasoning and activist condemnation, with the Sex Discrimination Commissioner labelling evidence-based moratoria "discriminatory." (15)

Taken together, these developments suggest a reciprocal reinforcement between trans rights activism and institutional medicine. Political advocacy supplies a moral momentum claiming contested political rights such as gender self-identification and gendered access to previously single-sex spaces, while academic and pharmaceutical infrastructures facilitate their practical implementation. This paper will examine this dynamic in detail: Section 2 describes the evolution of trans-related diagnoses and contrasts them with more reliable DSM diagnoses; Section 3 analyses the influence of advocacy, law, and politics; Section 4 interrogates the theoretical assumptions of the WPATH model; Section 5 assesses diagnostic validity and reliability; Section 6 discusses ethical and clinical ramifications; and Section 7 concludes by calling for a reinstatement of evidence-based, ideologically independent psychiatric standards.

Ultimately, the case of GD and GI highlights a critical tension in contemporary psychiatry: between reliability achieved through the rigorous application of empirical science and the imperatives of cultural affirmation.

Historical and Scientific Context

The Evolution of Trans Diagnoses in the DSM

Gender-identity-related classifications in the DSM have shifted markedly over seven decades. Gender-variant experiences were not explicitly classified in the first two editions of the DSM in 1952 and 1968, but were categorised as a form of sexual deviation alongside homosexuality and paedophilia, among others. DSM-III introduced the specific diagnostic category of gender identity disorder (GID). (2) DSM-IV (16) retained GID with criteria empha-

sising persistent discomfort with one's assigned gender and significant distress or impairment. DSM-5 replaced GID with GD, reframing the diagnosis to focus on clinically significant distress associated with incongruence rather than identity per se. (17) Proponents presented this as a destigmatising move; (6) critics noted that the shift reflected modern cultural affirmation and advocacy aims rather than new empirical evidence or theoretical understanding of the causes and mechanisms of transgender experience. In place of the extensive field trials used to demonstrate the reliability of other DSM-5 diagnoses, gender dysphoria is entirely based on the opinion of a small group of clinical advocates. (9) DSM-5-TR retained GD with minor clarifications, but did not address the lack of scientific grounding for the diagnosis. (18)

The International Classification of Diseases (ICD-11) went further along the path of depathologisation, replacing the diagnosis of gender identity as a form of mental disorder with the sexual health category of "gender incongruence." (19) Thus, the treatment of gender related distress in both the DSM-5 and ICD-11 moved away from reliable diagnosis of a well-defined clinical syndrome and toward claims of previously unrecognised human rights grounded in personal identity. This tracks broader sociocultural shifts and the political goals of advocacy groups more than advances in the understanding of human development, phenomenology, or psychopathology. (8,9)

The methodology and epistemology of psychiatric diagnosis

The inclusion of diagnoses in the DSM and ICD typically requires evidence of diagnostic reliability, construct validity, clinical utility, and theoretical coherence. Field trials assess inter-rater reliability; validators include symptom clusters, course, comorbidity patterns, treatment response, and (where available) biological correlates. (8) Working groups and advisory committees iterate proposals before Board approval, with the aim of minimising bias and maximising clinical usefulness. (8,20)

Against this backdrop, the GD/GI trajectory is remarkable. The mechanisms which led to the replacement of gender identity disorders as forms of mental illness by gender dysphoria/gender incongruence as aetiologically unexplained health phenomena appear to have been driven largely or entirely by social and policy considerations. The clinicians who defined gender dysphoria and gender incongruence were explicitly focused on reducing stigma and facilitating access to care rather than establishing robust evidence for the reliable diagnosis of mental or physical illness likely to benefit from well-defined medical/psychiatric treatment. (6,9,17) This atypical pathway underscores the central question of this paper: whether the present classification rests more on sociopolitical settlement than on the conventional evidentiary thresholds used elsewhere in psychiatric nosology.

The Influence of Advocacy and Politics

Political Influences in Diagnostic Development

Advocacy organisations have been explicit about their culturally affirmative goals for the classification and care of gender-related distress and incongruence, however defined. The World Professional Association for Transgender Health (WPATH) called for depathologisation of gender variance (12) and, through successive Standards of Care (SOC7 and SOC8), promoted an affirming model that reinforced the diagnostic shift in the DSM and ICD from gender identity to dysphoria/incongruence. (21,22)

Legal forums have amplified these dynamics. In the U.S., litigation over paediatric interventions (e.g., Boe v. Marshall) has brought expert testimony and guideline authority under scrutiny, conflating clinical standards and rights-based arguments. In the U.K., the Cass Review (11) recommended service reconfiguration and highlighted the very low quality of evidence that medical interventions improve the health or mental health of minors with gender dysphoria. In Australia, recent family-court proceedings illustrate tensions between advocacy, expert independence, and evidentiary standards in medico-legal decision-making. (23)

Systematic reviews of all relevant research in gender medicine, commissioned by U.K. authorities in 2020 as part of the Cass Review, characterised the evidence for puberty blockers and cross-sex hormones in adolescents as of very low certainty due to low-quality design, confounding, selection bias, and short follow-up. (24) Based on these studies, alongside extensive interviews with transgender patients, their families, and other stakeholders, the Cass Review concluded that the evidence base for gender affirming care in minors is weak and recommended a research-led model with stronger safeguards in which puberty blockers are not provided to minors with gender dysphoria outside clinical trials. (11) These developments support the view that classification and clinical standards have been influenced

by policy and advocacy objectives at least as much as by stable empirical consensus.

Suppression of Dissenting Research

While there are exceptions, systematic reviews generally capture only published research. There is evidence that the conclusions about gender affirming care for minors have been systematically biased by researchers who refuse to publish their results when they do not suggest that interventions like puberty blockers, hormones, or surgery improve patient outcomes. For example, a prominent U.S. provider of gender affirming care to minors, Johanna Olson-Kennedy, is reported to have suppressed her own research into puberty blockers because it did not show any improvement in patients' mental well-being. (25)

Given the lack of knowledge about the long-term risks and benefits of gender-affirming care for minors, it is even more concerning that adult gender services in the U.K. flatly refused to cooperate with researchers who wanted to check on the outcomes of child patients after they moved to adult services. (11)

Both court documents and the internal communications of trans rights advocacy groups, which include ostensibly clinical groups like WPATH, suggest that the suppression of research that does not support gender affirming care is a conscious strategy. A strategic plan for trans rights groups prepared by Dentons concluded that the more the public hears about proposed rights like access to single-sex female spaces for biological males who identify as trans women, the less they like them. They recommended avoiding public scrutiny where possible. (26)

In removing their interest in Doe v. Georgia, the U.S. Department of Justice revealed their conclusion that "WPATH restricted the ability of SOC-8's evidence review team to publish the systematic evidence reviews finding scant evidence for transitioning treatments" (p2).

Journalistic investigations and academic critiques have described pressures on evidence-synthesis teams and guideline groups, including attempts to influence framing and publication timing. While the details of such claims must be evaluated case by case, the broader methodological issues are clearer: selective citation, weak comparators, short follow-up, and loss to follow-up limit inference, especially in youth cohorts. (11,24) An evidence environment characterised by low-certainty studies is especially vulnerable to confirmation bias and advocacy capture, increasing the premium on transparent methods and preregistered protocols.

From the perspective of scientific integrity, suppression, or marginalisation of dissenting findings if present would compromise neutrality and risk overweighting values-driven priors in guideline development. Courts have likewise cautioned that expert witnesses must remain independent and avoid advocacy roles that undermine objectivity (e.g., (23)).

Case Study: Michelle Telfer and Re Devin

In (23), the Federal Circuit and Family Court of Australia scrutinised expert testimony related to gender-affirming care provided by Dr Michelle Telfer, first author of the AusPATH treatment guidelines for trans and gender diverse youth used as the standard of care by all public paediatric gender clinics in Australia. The judgment raised concerns about the compatibility of overt advocacy with the requirement for independent, objective expert evidence, and emphasised comprehensive assessment of comorbidities and developmental factors in paediatric presentations.

In his judgment, Judge Strum drew attention to Dr Telfer's failure to honour her duty "to give an objective and unbiased opinion" to the court on the field of gender medicine because of her self-described "advocacy to remove the legal requirement for trans and gender diverse adolescents to obtain Court authorisation to access gender affirming hormone treatment" (para 11).

Whatever one's policy position, the case underscores the need for evidentiary transparency and role clarity when clinical leaders also act as advocates. (23)

The Core Assumption: Transgender Identity and Mental Health

The WPATH Position and its Problems

In 2010, the WPATH Board argued for what it described as the de-psychopathologisation of gender variance and asserted that stigma and discrimination, rather than psychopathology associated with abnormal identity development drive adverse outcomes like elevated rates of suicide in transgender people. (12) The formulation of gender dysphoria in the DSM-5 rests on the similar assumption that the distress and dysfunction associated with gender variances is the result of incongruence between sex and gender, not the result of developmental disturbances

leading to disordered identity. (17,18) Critics contend that, absent clear boundaries and validators, uncritical de-pathologisation risks conflating clinically significant dysphoria with non-clinical identity variation, prevents rigorous differential diagnosis, and suppresses the search for effective forms of psychological treatment. (6,9)

There are three potential problems with the de-pathologisation of gender medicine: 1) the assertion that mental illness plays no role in the development of gender diversity has prevented the study of etiological theories linking gender variance, dysphoria, and impairment; 2) the assertion that gender dysphoria is purely the result of external factors like discrimination and persecution of gender diverse people (for example, the minority stress theory) has prevented the development of psychological treatments of internal factors like dissociation; and 3) there is limited longitudinal data on which to base diagnostic, acute treatment outcome, or long-term prognostic claims. These concerns do not deny the ethical case for dignity and non-discrimination; rather, they argue that normative goals should not substitute for empirical standards in diagnostic construction.

Political Motivations of the DSM-5 Committee

Lawrence argued that the DSM-5 Work Group's shift from GID to GD reflected political and administrative aims (destigmatisation, insurance coverage) as much as clinical science. (9) Published accounts of the development of the gender dysphoria diagnosis for the DSM-5 acknowledge that there were competing pressures to retain a billable diagnosis while reducing stigma. (20) Whatever one's view of those trade-offs, the net result is a diagnosis with no evidence of reliability, a lack of construct validity compared with other DSM constructs, limited evidence of clinical utility, and a complete absence of theoretical coherence. This history justifies renewed scrutiny of whether GD/GI meet acceptable standards for psychiatric diagnosis and whether additional safeguards are warranted, like research registries, outcomes auditing, and clearer role separation between advocacy and guideline authorship.

Diagnostic Integrity and Scientific Standards

Diagnostic legitimacy is based on reliability, validity, and clinical utility, criteria recognised by the rigorous field trials undertaken by the American Psychiatric Association in support of the DSM-5. (8,20) Categories that fail to meet these benchmarks do not belong in evidence-based nosologies. The DSM-5 acknowledges this in its chapter on "Conditions for Further Study", which lists syndromes that have been hypothesised as potentially valid and reliable diagnoses but do not yet have the scientific evidence to be included in the DSM-5 proper. It is notable that there is significantly more research available about the nature and treatment of some of these categories, such as attenuated psychosis syndrome, than there is for gender dysphoria (DSM-5-TR p903). (27)

As Ioannidis (28) observed, poorly powered, value-laden literatures inflate false-positive conclusions; GD research exemplifies this risk. Without preregistration, longitudinal replication, or blinded assessment, claims of intrinsic identity incongruence remain hypothetical.

From a methodological viewpoint, GD/GI function as sociopolitical constructs with clinical corollaries, not validated psychiatric disorders or health conditions. Until replicable biological or psychological correlates are identified, they should be treated as hypotheses undergoing evaluation rather than settled diagnoses. Maintaining them within the DSM in their current form risks compromising psychiatry's evidentiary integrity and eroding public trust in diagnostic neutrality.

Discussion

Ethical and Clinical Implications

The inclusion of GD/GI within major diagnostic manuals before any serious effort at proving their reliability or validity based on the political goal of destigmatisation, presents a profound ethical dilemma. Psychiatric classification is intended to protect patients by anchoring care in empirically verified constructs. (29) As documented by Judge Strum's censure of Dr Michelle Telfer in *Re Devin*, the creation of diagnoses to pursue ideological agendas or achieve political goals erodes clinical neutrality and subordinates the welfare of individual patients to abstract notions of justice. As established by the Cass Review, (11) NICE, (24) and other international studies, the evidence supporting medical transition for minors remains of "very low certainty," with virtually no long-term follow-up. The provision of life-altering interventions with severe side effects including sterility, sexual dysfunction, and osteoporosis, with no well-established benefits challenges the foundational medical principle of *non-maleficence*.

Ethically, clinicians operate within a dual mandate:

to respect autonomy while safeguarding patients from harm. Yet autonomy presupposes informed consent grounded in reliable evidence. (30) When that evidence is weak or contested, consent risks devolving into endorsement of social identity claims rather than medical decision-making. The rapid institutional embrace of affirmation protocols, often without differential diagnostic assessment for comorbidities such as autism, trauma, or mood disorders, (11,31) blurs the line between psychosocial support and experimental medicine.

Risks to Scientific Credibility

A broader risk concerns the credibility of psychiatry as a science. The incorporation of politically contingent diagnoses undermines the epistemic standards that differentiate psychiatry from ideology. As Ioannidis (28) warned, the systemic bias of small, confirmatory literatures produces self-reinforcing dogma. The absence of falsifiable hypotheses in GD/GI research, combined with institutional hostility to dissent (32) creates conditions antithetical to cumulative science. In effect, psychiatry risks repeating the mistakes of earlier politically shaped classifications, where moral or social preferences dictated nosology rather than empirical necessity.

Addressing Counterarguments

Advocates of the current model often invoke harm-reduction and rights-based frameworks, arguing that diagnostic removal would restrict access to care. Yet rights frameworks cannot substitute for evidence; they delineate ethical obligations, not biological truths. De-pathologisation outside of evidentiary reform merely relocates authority from science to politics. A pragmatic reconciliation is possible: psychiatric systems can support individuals experiencing gender distress through evidence-based treatment paradigms such as psychological formulation, trauma-informed therapy, or adaptive coping interventions, without reifying identity incongruence as a disorder. This approach preserves access to compassionate care while restoring diagnostic restraint.

Toward Scientific Governance

Re-establishing integrity in the field of paediatric gender medicine requires structural reform. Future revisions of the DSM and ICD should implement preregistered evidence thresholds, transparent conflict-of-interest disclosures, and an independent audit of advocacy influence. Cross-disciplinary panels including developmental neuroscientists, bioethicists, and epidemiologists could restore methodological rigour. Longitudinal cohort studies with standardized outcome metrics are essential to determine whether medical and surgical affirmation alleviates or compounds distress across developmental stages. (11) Until such data exist, GD and GI should be treated as hypothetical syndromes requiring theoretical clarification and empirical investigation. They may be suitable for inclusion as "Conditions for further study", but they lack any of the characteristics required of reliable and valid medical or psychiatric diagnoses.

Conclusions

The evolution of GD/GI within modern psychiatric classification illustrates a defining challenge for contemporary mental-health science: maintaining diagnostic neutrality in an era of identity politics and moral advocacy. These categories have emerged and persisted not through scientific scrutiny but through sociopolitical consensus. Evidence for their construct validity, reliability, and predictive value remains tenuous, with a research base entirely comprised of short-term, low-quality studies.

The integrity of medicine was built on an ethical foundation focused on patient health, most concisely expressed as the first principle to "first, do no harm." The systematic and unbiased reliance on evidence-based care is the most effective tool by which modern doctors promote patient health and prevent patient harms. Where advocacy or administrative convenience dictates diagnostic inclusion, the profession risks transforming moral preference into medical practice. Until clear aetiological, phenomenological, and therapeutic correlates with persistent patient outcomes are clearly demonstrated in research, GD and GI should be regarded as provisional hypotheses rather than established disorders.

Re-establishing an evidence-based and politically neutral diagnostic framework will require independent research governance, transparency regarding conflicts of interest, and renewed commitment to methodological rigour. The future of psychiatric classification and public trust in it rests on the discipline's willingness to subordinate cultural affirmation to scientific verification.

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