

COMMENTARY: What exactly is gender incongruence?

By Juan Carlos Jorge, PhD

I have always been fascinated with words for as long as I can remember. The exact word is “fascination”, from “[L “fascinatus, pp. of fascinare, to bewitch, charm, <fascinum, a charm ? akin to Gr baskanos, sorcerer].” The DSM-V Workgroup on Sexual and Gender Identity Disorders for the American Psychiatric Association has recently announced their intention to re-classify the diagnostic category “gender identity disorder” (GID; APA 2000) as “gender incongruity”. Incongruous, “adj. [L incongruous] not congruous; specif., a) lacking harmony or agreement; incompatible b) having inconsistent or inharmonious parts, elements, etc. c) not corresponding to what is right, proper, or reasonable, unsuitable; inappropriate”. These are definitions by the world-famous Webster’s Dictionary. But, what exactly is gender incongruence? Unfortunately, I was unable to find the term “incongruence”, or any of its forms, in a medical dictionary (Steedman’s Medical Dictionary, 1990).

In the early 1980’s, an interdisciplinary collaboration between pelvic and plastic surgeons, endocrinologists, urologists, gynecologists, psychologists, psychiatrists and research specialists established what became to be known as the “gender identity movement” (Pauly and Edgerton, 1986). But more than 50 years after the appearance of the term “gender” in the clinical setting, we have yet to uncover the mechanisms and factors that lead to gender identity formation. In fact, current scientific evidence suggests that if there is a developmental program for gender identity formation such program would rely on multiple biological substrates according to chromosomal make-up. The time span of such developmental program and the net contribution of each potential biological substrate across development remain unknown. Clinical wisdom has secured the notion of an “embryology of gender” as a dogma despite scientific evidence of its inadequacy. This has been possible because biomedical experts rely on the logic of human embryology as a set of programmed, sequential, and overlapping events to distinguish between a “healthy” and a “sick” gender. In spite of arguments to the contrary (Zucker 2008), a look into the history on the psychiatric management of sexual variance has revealed that there is nothing “natural” about it (Kirk and Kutchins 1992). The reality is that many gaps in the field do not warrant a biomedical framework to explain and to manage gender.

Nevertheless, the new proposition of re-naming GID as an incongruity validates the argument made by many academicians, sex researchers, physicians, activists, and people of diverse sexualities

since GID debuted as a diagnostic category in the DSM. That is, the new term acknowledges out in the open that the psychiatric management of gender essentially aims to define and to regulate what is right, proper, reasonable, suitable, and appropriate behavior. It remains as a challenge to question this medical rhetoric as it makes every effort to hold onto the monitoring of the livable boundaries of sex and gender with a simple, but dangerous, game of words.

References:

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author; 2000.

Kirk SA, Kutchins, H. The Selling of the DSM: The rhetoric of science in psychiatry. New York: Aldine de Gruyter; 1992.

Pauly IB, Edgerton MT. The gender identity movement: a growing surgical-psychiatric liaison. Arch Sex Behav 1986;15:315-329.

Steedman's Medical Dictionary, 25th edition. Baltimore: Williams and Wilkins;1990.

Zucker KJ. On the "natural history" of gender identity disorder in children. J Am Acad Child Adolesc Psychiatry, 2008;47:12.