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Depathologising gender diversity in childhood in the process of ICD revision and reform

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ABSTRACT
From 2007 on, the World Health Organisation (WHO) has been revising its diagnostic manual, the International Statistical Classification of Diseases and Related Health Problems (ICD), with approval of ICD-11 due in 2018. The ICD revision has prompted debates on diagnostic classifications related to gender diversity and gender development processes, and specifically on the ‘Gender incongruence of childhood’ (GIC) code. These debates have taken place at a time an emergent trans depathologisation movement is becoming increasingly international, and regional and international human rights bodies are recognising gender identity as a source of discrimination. With reference to the history of diagnostic classification of gender diversity in childhood, this paper conducts a literature review of academic, activist and institutional documents related to the current discussion on the merits of retaining or abandoning the GIC code. Within this broader discussion, the paper reviews in more detail recent publications arguing for the abandonment of this diagnostic code drawing upon clinical, bioethical and human rights perspectives. The review indicates that gender diverse children engaged in exploring their gender identity and expression do not benefit from diagnosis. Instead they benefit from support from their families, their schools and from society more broadly.

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Introduction
Over the last decade, there has been a change in the conceptualisation of gender development processes, including gender diversity in childhood, away from being viewed as a mental disorder or illness, and towards being understood as a human right. From 2007 onwards, an international trans depathologisation activism has emerged that draws on the participation of groups, organisations and networks from Africa, Asia, Europe, Latin America, North America and Oceania.

The international trans depathologisation movement demands, among other things, the removal of diagnoses that classify gender transition as mental disorder, access to state-funded trans healthcare, a move towards an informed consent approach to trans healthcare, legal gender recognition without medical requirements, as well as the depathologisation of gender diversity in childhood. For a review of the scope and main demands of this movement see Suess Schwend (2016) and Suess, Espineira, and Crego Walters (2014). These demands are based on an awareness of the links between the diagnostic classification of gender diversity and gender development processes.
as a mental disorder, and dynamics of discrimination, stigmatisation and transphobic violence perpetrated against trans people worldwide (Winter et al., 2009).

The revisions of the International Statistical Classification of Diseases and Related Health Problems (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) have prompted a discussion regarding the diagnostic classification of gender diversity and gender development processes. Some of the arguments against the diagnoses echo those in earlier decades for the declassification of homosexuality as a psychiatric diagnostic category. At the same time, differences between both revision processes can be identified, specifically regarding the role of access to trans healthcare in the current revision process of trans-related diagnostic categories (Suess Schwend, 2016). In the current discussion, debates on the diagnostic classification of gender diversity in childhood can be observed, with a wide range of arguments in favour and against the maintenance of the GIC code in ICD-11.

In the current ICD and DSM versions (ICD-10 and DSM-5), the processes of exploring, expressing and affirming one’s gender when different from the sex assigned at birth are classified as mental disorders. The diagnostic categories have for several decades included pre-pubertal children; 1975 in the case of ICD-9 and 1980 in the case of DSM-III. Currently, gender diversity in pre-pubertal childhood is coded as ‘Gender Dysphoria in Children’ in DSM-5 and as ‘Gender identity disorder of childhood’ in ICD-10. The ICD-11 Beta Draft proposes that the latter be replaced with one called ‘Gender incongruence of childhood (GIC)’, included in the Chapter ‘Conditions related to sexual health’ (Tables 1 and 2).

The ICD-11 proposal for a GIC diagnosis is one of a number of trans-related diagnostic categories in the ICD-11 Beta Draft. A WHO Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH), commissioned with the task of developing proposals for trans-related diagnostic categories (Cochran et al., 2014; Drescher, Cohen-Kettenis, & Winter, 2012; Reed et al., 2016), has proposed removing the category F64 ‘Gender identity disorders’ from the ‘Mental and Behavioural Disorders’ chapter. The Working Group has instead proposed the inclusion of a new code, called ‘Gender incongruence’ in a new ICD-11 chapter called ‘Conditions related to sexual health’. The Group has proposed two diagnostic entities, ‘Gender incongruence of adolescence and adulthood’ (GIAA) and ‘Gender incongruence of childhood’ (GIC); the latter to be used with gender diverse children under the age of puberty. All these proposals are available online in the ICD-11 Beta Draft (all proposals pending approval in 2018). It is worth noting, on the matter of GIC, that agreement within the WGSDSH was less than unanimous, and that Working Group members, with co-authors, have published different rationales supporting (Drescher, 2014; Drescher, Cohen-Kettenis, & Reed, 2016a, 2016b) or criticising the proposed code (Winter, 2014, 2015; Winter, De Cuypere, Green, Kane, & Knudson, 2016; Winter, Diamond et al., 2016; Winter, Ehrensaft, Pickstone-Taylor, De Cuypere, & Tando, 2016).

The trans depathologisation movement, consisting of trans activist academics, supported by the broader LGBTI movement, human rights bodies, health professionals and scholars, has reviewed

<table>
<thead>
<tr>
<th>Version</th>
<th>Section</th>
<th>Diagnostic category</th>
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<tr>
<td>DSM-III</td>
<td>Psychosexual Disorders / Gender identity disorders</td>
<td>302.60 Gender identity disorder of childhood</td>
</tr>
<tr>
<td>(APA 1980)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R</td>
<td>Disorders usually first evident in infancy, childhood, or adolescence / Gender Identity Disorders</td>
<td>302.60 Gender identity disorder of childhood</td>
</tr>
<tr>
<td>(APA 1987)</td>
<td></td>
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<tr>
<td>DSM-IV</td>
<td>Sexual and Gender Identity Disorders / Gender identity disorders</td>
<td>302.xx Gender Identity Disorder .6 in Children</td>
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<tr>
<td>(APA 1994)</td>
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<tr>
<td>DSM-IV-TR</td>
<td>Sexual and Gender Identity Disorders / Gender identity disorders</td>
<td>302.xx Gender Identity Disorder .6 in Children</td>
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<td>(APA 2000)</td>
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<tr>
<td>DSM</td>
<td>Gender Dysphoria</td>
<td>302.6 Gender Dysphoria in Children</td>
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<td>(APA 2013)</td>
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critically the definitions and criteria of the trans-related diagnostic categories in DSM-5 and the ICD-11 Beta Draft. On one hand, it has observed a tendency towards a more gender-inclusive and less pathologising language. On the other, it has criticised the continuing diagnostic classification of gender diversity and gender development processes as a mental disorder in DSM-5, as well as connotations of psychopathologisation in the concept ‘Gender incongruence’ in the ICD-11 Beta Draft. It has also criticised the continuing diagnostic classification of gender diversity in childhood, in both DSM-5 and the ICD-11 Beta Draft (Asia Pacific Transgender Network [APTN], 2016; Global Action for Trans Equality [GATE], 2013a, 2013b, 2015; Global Action for Trans Equality & International Campaign Stop Trans Pathologization [GATE & STP], 2014; Gender DynamiX, TIA, & SHE, 2014; ILGA-Asia, 2015; ILGA World, 2016; Iranti-org, 2017; International Campaign Stop Trans Pathologization [STP], 2013a, 2013b, 2014, 2015, 2016; Transgender Europe [TGEU], 2014a, 2014b, 2015). Activism and scholarship for trans depathologisation has focused increasingly on arguments for removing diagnostic categories targeting gender diversity in childhood, for promoting affirmative approaches for those children in healthcare and in schools, and for opportunities for legal gender recognition for minors.

The demand to remove the GIC code from ICD draws on critical voices from activists and academics over recent decades that have reflected on the history of diagnostic classifications of gender diversity in childhood in the DSM, questioning the appropriateness of such practices (Bartlett, Vasey, & Bukowski, 2000; Bryant, 2006; Ehrensaft, 2012; Hill, Rozanski, Carfagnini, & Willoughby, 2006; Human Rights Commission [HRC], 1996; Langer & Martin, 2004; Lev, 2006; National Gay and Lesbian Task Force, 1996; Spade, 2006; Vasey & Bartlett, 2007; Wilson, 1998; Winters, 2008). They have stressed that gender diversity is not a pathology, and have criticised the Western perspective that prompts us to view it as such. Furthermore, they noted the risks arising from a pathologising perspective. These include heightened risks of discrimination, stigmatisation and coercive treatments directed against gender diverse children, as well as of the reproduction and reinforcement of the binary gender system.

From a historical perspective, some of the mentioned authors have examined the reasons for gender diversity in childhood becoming a target for medico-psychological interest and intervention in the 1960s and 1970s (Bartlett et al., 2000; Bryant, 2006; HRC, 1996; Langer & Martin, 2004; Lev, 2006; Wilson, 1998; Winters, 2008). They have addressed the scientific interest in the expression of femininity in children assigned as boys, the perceived need to ‘prevent’ transsexualism in adolescence and adulthood, and the emergence of so-called reparative therapies or conversion therapies.

Several authors have critiqued the concept of pathology itself, have noted the risks where conflicts with societal norms are viewed as ‘disorders’, and have questioned the discursive production of a ‘normal childhood’ in the diagnostic discourse (Bartlett et al., 2000; Langer & Martin, 2004; Spade, 2006; Winters, 2008). This critical scholarship that preceded the current trans depathologisation framework has also stressed the benefits of affirmative approaches in supporting gender diverse children (Hill et al., 2006; HRC, 1996; Langer & Martin, 2004).

The current debate has benefited from contributions from activist networks, professional associations, clinicians, researchers and other scholars, as well as statements by the European Parliament.
This policy paper addresses the discussion on the GIC proposal from a depathologisation and human rights perspective, reviews papers that explore the impact of the diagnostic classification of gender diversity in childhood and recommends, among other proposals, the abandonment of the ICD-11 GIC proposal.

Methodology
A systematic literature review was conducted, identifying peer-reviewed publications in PubMed and Scopus in English by means of the search terms ‘Gender identity disorder of childhood’, ‘Gender dysphoria in children’ and ‘Gender incongruence of childhood’. The publication timeframe was January 2009–August 2017. A total number of 40 articles were identified. Sixteen publications, either in English or in Spanish, were added that were related to the topic but were not included in PubMed or Scopus. After excluding repetitions and papers which were not focused on the current debate regarding the GIC code, 23 publications were reviewed. In addition, 21 statements and reports published by activist networks, 4 from professional associations and 1 document signed by health professionals and researchers were included in the revision process. Within a larger number of strategic documents related to gender identity, 2 strategic documents issued by the European Parliament were identified that explicitly addressed the diagnostic classification of gender diversity in childhood.

A sociological discourse analysis was conducted, focused on exploring arguments in favour and against the GIC code. The identified arguments were categorised as being in favour of or against the diagnostic classification of gender diversity in childhood. They were also arranged into thematic sections, with a focus on the arguments against the GIC code, and relating them to previous publications. Finally, recommendations for the ICD revision process were identified, as offered by individual authors, activist networks, professional associations and human rights bodies. The first author conducted the review process and all authors participated in the analysis, writing and revision of the paper.

Results and discussion: current discussion on the GIC code
In this section, we review the arguments for and against inclusion of the GIC code in ICD-11. The multiple arguments against inclusion of the GIC code in the ICD-11 have been described in greater detail, as they represent an emerging perspective that critiques the current dominant position; a position that advocates a diagnostic classification of gender diversity in childhood and thereby defends the status quo.

Arguments for a maintenance of the GIC code in the ICD-11
A review of the literature identifies the following arguments for maintaining the GIC code in the ICD-11: (1) facilitation of access to state-covered and private healthcare for gender diverse children and their parents, (2) monitoring and documentation of gender diversity in childhood, facilitating subsequent access to hormone blockers in adolescence, (3) support for accommodations that may be made at school and (4) promotion of training and research (Beek et al., 2017; De Cuypere, Knudson, & Green, 2013; Drescher, 2014; Drescher et al., 2016a, 2016b; Jokić-Begić et al., 2016; Khorashad et al., 2016; Meyer-Bahlburg, 2017; Moser, 2017; Reed et al., 2016; Rodrigues Lobato et al., 2016; Winter, De Cuypere et al., 2016; WPATH, 2015; Zucker, 2017). Some authors propose modifications in the wording and diagnostic criteria of the code ‘Gender incongruence of childhood’ (Beek et al., 2017; Meyer-Bahlburg, 2017; Moser, 2017; Zucker, 2017).

Arguments for a removal of the GIC code from the ICD-11
The literature review spotlights various arguments for abandoning the GIC proposal. The literature draws on material focused on the ICD-11 proposals, including scholarly papers, as well as reports,
Statements and press releases from international and regional activist networks and organisations, statements by professional associations, clinicians and researchers, and documents issued by the European Parliament.


Over the last few years, international and regional activist networks have published communiqués, press releases and reports demanding the abandonment of the GIC proposal (APTN, 2016; GATE, 2013a, 2013b, 2015, 2016a, 2016b; ILGA World, 2016; Iranti-org, 2017; STP, 2012, 2013a, 2013b, 2014, 2015, 2016; TGEU, 2014a, 2014b, 2015). Regional meetings involving activists, clinicians and researchers in Cape Town, South Africa (Gender DynamiX et al., 2014) and Taipei, Taiwan (ILGA-Asia, 2015) have issued statements demanding the abandonment of the GIC code. In 2016, clinicians and researchers working on trans issues were invited to sign a statement supporting the abandonment of the GIC proposal (Winter, Riley et al., 2016). By 31 August 2017, 231 clinicians and researchers had signed the statement, among them the Board of CPATH (the Canadian Professional Association for Transgender Health).

Clinicians, academics and activists recently called for abandonment of the GIC proposal in submissions to the Lancet Psychiatry (Cabral, Suess, Ehrt, Seehole, & Wong, 2016; Winter, Ehrensaft et al., 2016), in The Lancet in a series on Transgender Health (Winter, Diamond et al., 2016), in the Archives of Sexual Behaviour (Cabral Grinspan, 2017; Riley, 2017; Suess Schwend, 2017; Winter, De Cuypere et al., 2016) and in other platforms (Suess Schwend, 2015, 2016; Winter, 2014, 2015).

Finally, in the political context, in the so-called Ferrara Report, and in a related resolution on the situation of fundamental rights in the European Union, the European Parliament (2015a, 2015b) calls for the abandonment of the GIC proposal.

The European Parliament (…) calls on the Commission to intensify efforts to prevent gender variance in childhood from becoming a new ICD diagnosis; (European Parliament, 2015b, p. 28)

The specific arguments against a diagnostic classification of gender diversity in childhood are reviewed below.

**Gender diversity in childhood is not a pathology**

Gender diversity is not a pathology. We therefore feel that no pre-pubertal children should be given a diagnosis based on their gender identity or expression. (Gender DynamiX et al., 2014, p. 1; ILGA-Asia, 2015, p. s.p.)

International and regional networks and individual authors from different continents have highlighted that gender diversity is not a pathology, whether in adolescence and adulthood or in childhood. They highlight that rather it is an aspect of personality development; an aspect protected by human rights conventions (including, for children, those conventions concerned with the rights of the child) (APTN, 2016; GATE, 2016a, 2016b; Gender DynamiX et al., 2014; ILGA World, 2016; ILGA-Asia, 2015; Iranti-org, 2017; STP, 2013a, 2013b, 2016; Suess Schwend, 2015, 2016, 2017; Winter, 2014, 2015; Winter, Diamond et al., 2016).

**Pathologisation of gender diversity in childhood is a Western phenomenon**

The view of gender-different children as sick and in need of health care is a culturally-specific one, not only modern but also peculiarly Western in origin. (Winter, 2014, p. 4)

Several of the reviewed documents note that the conceptualisation of gender diversity in childhood as a problem, disorder or illness is a Western phenomenon (GATE, 2013a; GATE, & STP,
2014; Iranti-org, 2017; STP, 2013a, 2013b; Suess Schwend, 2016; Winter, 2014, 2015; Winter, De Cuypere et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016). They observe that suffering or distress is commonly absent in gender diverse children growing up in non-Western cultures with affirmative attitudes towards gender diversity, and that in such cultures gender diverse children are not seen as being in need of healthcare. Authors denounce the Western character of the concept of gender transition, as well as the ethnocentric bias inherent in diagnostic criteria. They draw attention to the global consequences stemming from pathologising children’s gender diversity in the Western context. This analysis draws on earlier critical reviews of the Western character of diagnostic classification systems established in the DSM and ICD, and of the contemporary medical model of transsexuality. Such reviews note culturally specific forms of gender diversity outside the Western world (Gómez, 2004; Hirschauer, 1997; Meyerowitz, 2004; Nanda, 2014; Newman, 2002; Vasey & Bartlett, 2007).

A further cultural element is observed in the way that, among clinicians, support for abandonment of the GIC proposal appears to be linked to the funding and reimbursement arrangements in the healthcare system in which one works (Cabral Grinspan, 2017; Riley, 2017; Suess Schwend, 2017; Winter, 2015; Winter, De Cuypere et al., 2016; Winter, Diamond et al., 2016).

Lack of clinical utility, validity and predictive capacity

Children do not have medical needs related to gender diversity, such as hormone therapy or surgical procedures, that require a specific diagnosis. Instead, their primary needs are for information, counseling, and support, which the ICD can facilitate access to via other means, such as Z codes. (GATE, 2013a, p. 5)

A high number of papers, reports and statements highlight the lack of clinical utility of a diagnostic classification of gender diversity in childhood (APTN, 2016; Cabral et al., 2016; Cabral Grinspan, 2017; GATE, 2013a, 2016b; GATE, & STP, 2014; Gender DynamiX et al., 2014; ILGA-Asia, 2015; ILGA World, 2016; Iranti-org, 2017; STP, 2013a, 2013b, 2015, 2016; Suess Schwend, 2015, 2016, 2017; TGEU, 2014a, 2014b, 2015; Winter, 2014, 2015; Winter, Diamond et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016). They emphasise that gender diverse children below puberty do not need hormone therapy or surgical procedures. Indeed, they note that it would not be clinically indicated or ethical to perform bodily modifications before puberty, as such practices would violate the children’s right to bodily integrity.

Furthermore, these authors stress the risks these diagnostic categories present in terms of an increased medicalisation and pathologisation of gender diversity in childhood (Iranti-org, 2017; STP, 2012, 2013a, 2013b; Suess Schwend, 2015, 2016, 2017; Winter, 2015).

The reviewed documents highlight the importance of supportive environments (e.g. professionals in the health and educational sector who are open to a diversity of gender expressions and identities, including non-binary options), and contact with activist groups and networks (ILGA World, 2016; Iranti-org, 2017; STP, 2013a, 2013b, 2015, 2016; Suess Schwend, 2016, 2017; TGEU, 2015; Winter, De Cuypere et al., 2016; Winter, Diamond et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016; Winters, 2008). Winter, Ehrensaft et al. (2016) stress the good mental health of pre-pubertal children who are allowed to engage in social transition, with reference to a recent study published by Olson, Durwood, DeMeules, and McLaughlin (2016). The importance of support from the family, the broader social network and peer groups is also mentioned in other studies (Katz-Wise et al., 2017; Riley, Sitharthan, Clemson, & Diamond, 2013).

Finally, the reviewed documents question the validity and predictive capacity of diagnoses for gender diverse children, due to the impossibility of predicting the development of gender expressions, trajectories and identities from childhood into adolescence and adulthood (GATE, 2013a; Iranti-org, 2017; Suess Schwend, 2017; Winter, De Cuypere et al., 2016). A recent study further confirms the variety and complexity of gender identity pathways observed in trans youth, including non-binary gender expressions and identities (Katz-Wise et al., 2017).
**Access to healthcare for pre-pubertal children**

Affirmative counseling, information and support should be made available by way of non-pathologising alternatives. This should be made accessible both for a child, parents and other significant persons in the child’s life. (Gender DynamiX et al., 2014, p. 2; ILGA-Asia, 2015, p. s.p.)

The documents reviewed take into account the potential health needs of gender diverse children, such as psychological support related to experiences of discrimination on grounds of gender expression and identity (APTN, 2016; Cabral Grinspan, 2017; Gender DynamiX et al., 2014; ILGA World, 2016; ILGA-Asia, 2015; Iranti-org, 2017; Riley, 2017; STP, 2012, 2013a, 2013b; Suess Schwend, 2015, 2016, 2017; Winter, De Cuypere et al., 2016; Winter, Diamond et al., 2016; Winter, Riley et al., 2016). They stress the importance of giving access to affirmative and non-pathologising support for those children and parents who require it; at the same time highlighting the importance of a protection from non-consensual treatments, medicalisation and pathologisation. While some gender diverse children do not need access to professional psychological support, recent studies confirm the importance of making available this type of service (as well as peer support) (Dierckx, Motmans, Mortelmans, & T’sjoen, 2016; Katz-Wise et al., 2017; Olson-Kennedy, 2016; Riley et al., 2013).

A number of documents reviewed argue that, where information, counselling and other support is needed for those children, parents and others, it is possible to facilitate access to such services, by including ‘gender expression and gender identity’ in existing Z codes related to counselling and experiences of discrimination and social exclusion, and by creation of new Z codes (GATE, 2013a; Iranti-org, 2017; Riley, 2017; STP, 2013a; Suess Schwend, 2016; Winter, De Cuypere et al., 2016; Winter, Diamond et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016; Table 3).

Furthermore, some authors have argued that access to gender-affirmative treatments in adolescence and adulthood (covered by the code ‘Gender incongruence of adolescence and adulthood’) should not require a previously documented history of a gender-based diagnosis in childhood, but should instead be based on a human rights approach and informed consent model (APTN, 2016; Gender DynamiX et al., 2014; ILGA-Asia, 2015).

**Risk of discrimination and stigmatisation**

[Di]agnosing gender-diverse children just because of who they are and how they express themselves reinforces and institutionalises cisexism and transphobia in psychomedical settings—and in society as a whole. (Cabral et al., 2016, p. 405)


### Table 3. Z codes proposal.

**GATE (2013a)**

Inclusion of the concept ‘sexual orientation, gender identity and expression in existing Z codes (chapter XXI in ICD-10 and chapter 24 in the ICD-11 Beta Draft)

- Z60.4: ‘Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behaviour, sexual orientation, or gender identity or expression.’
- Z60.6: ‘Persecution or discrimination, perceived or real, on the basis of membership of some group (as defined by skin colour, religion, ethnic origin etc), rather than personal characteristics. Excludes social exclusion and rejection (Z60.4).’

Creation of new Z codes (chapter XXI in ICD-10 and chapter 24 in the ICD-11 Beta Draft)

- Z70.4: ‘Counseling for a child to support gender identity or expression that differs from birth assignment.’
- Z70.2: ‘Counseling for families and service providers related to the gender identity or expression of a child.’
De Cuypere et al., 2016; Winter, Diamond et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2017). This risk is considered similar to the stigmatising effect of the ICD-10 code ‘Gender identity disorder of childhood’ and DSM categories ‘Gender identity disorder in children’ (DSM-IV) and ‘Gender dysphoria in children’ (DSM-5), as reported in previous studies (Bartlett et al., 2000; Bryant, 2006; Langer & Martin, 2004; Winters, 2008).

The reviewed documents also argue that the diagnosis may prompt or reinforce parents’ impressions that there is something wrong with their children, i.e. that they have a health problem, illness or mental disorder (Riley, 2017; Winter, Riley et al., 2016). Furthermore, they highlight a risk of indirectly pathologising homosexuality; a risk linked to gender expressions which run contrary against stereotypes associated with gender assigned at birth (Cabral et al., 2016; GATE, 2013a; Winter, Diamond et al., 2016).

Furthermore, the reviewed authors question the conceptualisation of social conflicts as an individual pathology, as well as the reinforcement of gender binarism, cisexism and transphobia that are all implicit in the diagnostic classification (Cabral et al., 2016; Suess Schwend, 2016). These concerns about the pathologising effects of trans-specific diagnoses are linked to a broader denunciation of the dynamics of stigmatisation and discrimination related to mental health issues, chronic diseases, bodily diversity or other intersectional characteristics (Cabral, 2009, 2011; Suess Schwend, 2016).

**Bioethical concerns**

Medically unnecessary diagnostic processes may contribute to increased stigmatization and discrimination in children with gender expressions and trajectories that from cultural expectations associated with the gender assigned at birth, thereby posing a risk of breaching the bioethical principle of ‘nonmaleficence’. (STP, 2013a, pp. 3–4)

Ethical concerns about breaches to the principle of nonmaleficence are heightened in the context of a lack of professional consensus regarding diagnostic classifications of gender diversity in childhood (Cabral et al., 2016; GATE, 2013a; GATE & STP, 2014; Iranti-org, 2017; Suess Schwend, 2015, 2016; TGEU, 2015).

Winter, Ehrensaft et al. (2016) point out that the GIC proposal was not unanimous among members of the WGSDESH. This lack of unanimity was evident elsewhere. A WPATH Consensus Meeting convened in 2013 showed a split position (14 in support, 14 in opposition) on the issue of the GIC code (De Cuypere et al., 2013). In a WPATH membership survey conducted in December 2014 (Winter, De Cuypere et al., 2016; WPATH, 2015), 51.1% of the 241 members who completed the survey opposed the GIC code and 47.47% supported the code. Opposition to the GIC proposal was greatest outside the US; 63.1% of the non-US members were against the code, with 36.1% in favour (Winter, De Cuypere et al., 2016; WPATH, 2015).

Regarding other ethical concerns, the reviewed documents indicate the risk that a GIC diagnosis could aggravate discrimination and stigmatisation, increasing the risk of anxiety, anguish and depression among the children diagnosed (GATE, 2013a, 2015; Iranti-org, 2017; STP, 2013a, 2013b; Suess Schwend, 2016; TGEU, 2015). They express also concern about the risk that the code could be used as an indirect justification for so-called reparative therapies or conversion therapies. These potential harmful consequences contradict the principle of non-maleficence and the medical imperative ‘First, do no harm’ (STP, 2013a, 2013b; Suess Schwend, 2015).

**Human rights perspective**

In addition to the bioethical concerns, the proposed GIC category may also contradict international human rights standards, particularly those concerning the rights of the child. (GATE, 2013a, p. 9)

The reviewed documents also use human rights arguments against the GIC code, mentioning as key documents the Convention on the Rights of the Child, the General Comments of the Committee on the Rights of the Child, as well as the Yogyakarta Principles (Cabral Grinspan, 2017; GATE, 2013a; GATE, & STP, 2014; STP, 2013a, 2013b; Suess Schwend, 2015, 2016, 2017; TGEU, 2015;
Winter, 2014). They variously refer to the child’s best interests, the right to physical, psychological, emotional and social development, the right to the protection of the individual personality, and to protection from discrimination (Cabral Grinspan, 2017; GATE, 2013a; STP, 2013a, 2013b; Suess Schwend, 2016, 2017). They call attention to the right to the enjoyment of the highest attainable standard of health, to good sexual and reproductive health, to information and participation in decision-making in accordance with children’s evolving capacities, and the rights of children to express their views and for those views to be heard (Cabral Grinspan, 2017; GATE, 2013a; STP, 2013a, 2013b; Suess Schwend, 2016, 2017).

The reviewed documents also refer (taking into account the children’s specific vulnerability) to the right to protection from harmful medical practices (Cabral et al., 2016; Iranti-org, 2017; STP, 2013a, 2013b; Suess Schwend, 2016). They note, in this connection, the risk of the diagnosis being used to justify reparative or conversion therapies. They emphasise that ‘protected status’ of gender diverse children is considered as a human right that must not depend on a diagnosis (Cabral Grinspan, 2017; Riley, 2017; Suess Schwend, 2017).

**Inconsistency with other WHO proposals**

WHO proposes to delete the ICD-10 block F66 ‘Psychological disorders associated with sexual development and orientation’, including F66.0 ‘Sexual maturation disorder’, F66.1 ‘Ego-dystonic sexual orientation’ and F66.2 ‘Sexual relationship disorder’ (Cochran et al., 2014; Reed et al., 2016). Documents reviewed highlighted that these codes currently also apply to children and adolescents with diverse sexualities, gender expressions and identities (Cabral et al., 2016; Cabral Grinspan, 2017; GATE, 2013a; GATE & STP, 2014; Iranti-org, 2017; Suess Schwend, 2016; Winter, 2014, 2015; Winter, De Cuypere et al., 2016; Winter, Diamond et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016). In consequence, a double standard is evident in the current proposals as they relate to children. Young persons with non-heterosexual sexualities would no longer receive a diagnosis, but children with gender expressions and identities that differ from the sex assigned at birth would continue to be pathologised by means of the GIC diagnosis.

Furthermore, it is argued that if the GIC category is included in ICD-11 so that gender diverse children and their parents can get access to psychological support, then the result may be an undermining of the case for removing that diagnosis from the chapter on ‘Mental and behavioural disorders’.

**Opportunities for research and training without need of a diagnosis**

We do not believe that research or training in relation to childhood gender diversity would suffer if there were no GIC diagnosis in ICD-11. (Winter, Riley et al., 2016, s.p.)

The argument that the existence of the GIC diagnostic code facilitates research and training is countered by observations about what happened to research and training in the area of sexual orientation after homosexuality was removed from the diagnostic manuals. According to some of the reviewed documents, removal of the homosexuality diagnosis did not result in a reduction of the scientific production on the topic, but instead simply resulted in a re-orientation of the research focus away from medical sciences and towards social sciences (Cabral Grinspan, 2017; Iranti-org, 2017; Riley, 2017; Suess Schwend, 2017; Winter, 2014, 2015; Winter, De Cuypere et al., 2016; Winter, Ehrensaft et al., 2016; Winter, Riley et al., 2016).

**Conclusions**

Depathologisation and human rights perspectives open up a paradigm change in the conceptualisation of gender diversity in childhood. Instead of understanding childhood gender diversity as
pathology – a problem of the child that requires diagnostic classification and clinical surveillance – such perspectives present gender diversity in childhood as a human right. While this paradigm change has been taking place over several decades, it has prompted more prominent discussion in the last ten years, and in the last two years has found a place on the agenda of regional human rights bodies. There is now a growing debate on the impact of a diagnostic classification of gender diversity in childhood, though research on gender diverse children raised in supportive environments without a diagnosis is still scarce. The same is true of research that includes the voices of gender diverse children. We believe that future research should address these gaps.

Children with gender expressions and identities that differ from the gender assigned at birth may not need medical assistance related to the process of exploring gender (even counselling), especially in affirmative and supportive environments.

The literature review indicates that some children and parents, but not all, may need psychological support. This support is needed to deal with discrimination and stress that can occur in binary and cisnormative social, family and educational contexts; particularly where there are intersectional inequalities related to social class, ethnicity, bodily diversity, health status and geopolitical context. To provide this support, healthcare and educational professionals are needed who recognise and respect gender diversity, and practice affirmative approaches. A diagnostic classification for gender diverse children is not needed. Rather, what is needed is the creation of a world open to sexual, gender and bodily diversity. Working towards such a world is the responsibility of all in society. It should also be one of WHO’s responsibilities.

**Recommendations**

Taking into account the arguments made in the reviewed documents, the authors of this paper support WHO’s proposal to remove trans-related categories from the chapter ‘Mental and behavioural disorders’, including F64, F65.1 and F66 (as proposed in the ICD-11 Beta Draft).

However, we also recommend:

- Abandonment of the proposed GIC code for ICD-11.
- Introduction of references to ‘sexual orientation, gender identity and expression’ in Z codes related to social exclusion and discrimination (Z60.4, Z60.5, as proposed in the ICD-11 Beta Draft6) and creation of new Z code categories related to counselling for gender diverse children and their parents (Z70.2x and Z70.4), following the proposal contributed by the GATE International Expert Working Group (GATE, 2013a; Table 3).
- Field testing of Z codes proposals and alternative ‘no childhood-specific diagnosis’.
- Participation by the trans depathologisation movement in the ICD revision process. Such participation not limited to consultation, but instead involving an active participation in discussion and decision-making processes.

Furthermore, we recommend that national ministries and agencies implement training strategies for health and educational professionals, with the aim of strengthening knowledge on, respect for and support to gender diversity in childhood.

**Notes**

1. In this paper, trans is used as an umbrella term for people with gender expressions and identities that differ from the sex assigned at birth, including people who identify themselves as transexual, transgender, non-binary and/or other culturally and contextually specific self-denominations.
2. Depathologisation refers to the removal of diagnostic classifications and clinical practices that conceptualise sexual, gender and bodily diversity as a mental disorder, illness or malformation, as well as to its recognition as a human right and celebration as a relevant contribution to contemporary societies. The depathologisation
3. The Working Group has also proposed the removal of ‘Fetishistic transvestism’ (F65.1) and the category ‘Psychological and behavioural disorders associated with sexual development and orientation’ (F66) from the chapter on Mental and behavioural disorders.
4. The coverage of healthcare in general, and specifically psychological support services, and the role of ICD codes for this coverage depends on the geopolitical context and characteristics of each health system (Stuckler, Feigl, Basu, & McKee, 2016; WHO, 2010).
5. In the ICD-10, Z codes (in the ICD-11 Beta Draft: Q codes) refer to codes included in the ICD chapter ‘Factors related to health status and contact with health services’, which describe social aspects that may impact health, such as social discrimination and exclusion, as well as healthcare procedures and services (e.g. counselling services) that are not related to illness or mental disorder.
6. In the ICD-11 Beta Draft, the codes in the Chapter ‘Factors related to health status and contact with health services’ are listed as ‘Q codes’.

Disclosure statement
Sam Winter was a member of the WHO Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH), charged with reviewing trans-specific diagnostic categories in the ICD. Mauro Cabral Grinspan, Adam Smiley, Zhan Chiam and Amets Suess Schwend work in international trans or LGBT organisations. All authors are members of the International Expert Group coordinated by Global Action for Trans Equality (GATE).

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