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Review

Gender trouble: The World Health Organization, the International Statistical Classification of Diseases and Related Health Problems (ICD)-11 and the trans kids

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Abstract. The World Health Organization (WHO) is revising its diagnostic manual, the International Statistical Classification of Diseases and Related Health Problems (ICD). At the time of writing, and based on recommendations from its ICD Working Group on Sexual Disorders and Sexual Health, WHO is proposing a new ICD chapter titled *Conditions Related to Sexual Health*, and that the gender incongruence diagnoses (replacements for the gender identity disorder diagnoses used in ICD-10) should be placed in that chapter. WHO is proposing that there should be a *Gender incongruence of childhood* (GIC) diagnosis for children below the age of puberty. This last proposal has come under fire. Trans community groups, as well as many healthcare professionals and others working for transgender health and wellbeing, have criticised the proposal on the grounds that the pathologisation of gender diversity at such a young age is inappropriate, unnecessary, harmful and inconsistent with WHO's approach in regard to other aspects of development in childhood and youth. Counter proposals have been offered that do not pathologise gender diversity and instead make use of Z codes to frame and document any contacts that young gender diverse children may have with health services. The author draws on his involvement in the ICD revision process, both as a member of the aforementioned WHO Working Group and as one of its critics, to put the case against the GIC proposal, and to recommend an alternative approach for ICD in addressing the needs of gender diverse children.

Additional keywords: children, ICD, transgender, WHO.

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The International Statistical Classification of Diseases and Related Health Problems (ICD)-11 in revision

The World Health Assembly (WHA), the governing body of the World Health Organization (WHO), meets in Geneva in May every year. Next year, they will likely be invited to approve the new edition of WHO's diagnostic manual, the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11). ICD-11 has been a long time coming. It is a quarter century since ICD was last revised; the longest interval between any consecutive revisions so far. ICD is used for a wide range of purposes. Governments and others use it for surveillance and recording, and for planning of health services. Individual healthcare providers use it for diagnosis. It is the most widely used diagnostic manual; including in the area considered historically to be the front line for transgender ('trans') health – mental health. Among psychiatrists worldwide who work with patients, two-thirds in 2010–11 were reporting that ICD-10 was the diagnostic manual they most often used. That compared with approximately one-quarter for the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA).[1] ICD revisions matter.

In 2011, WHO invited this author to join its Working Group on Sexual Disorders and Sexual Health. The Working Group (11 clinician/scholars working in sexuality worldwide, and drawn from nine countries and six continents) was charged with recommending revisions to a range of sexual and gender diagnoses in ICD-10. The diagnoses looked at sat in four blocks in Chapter 5 (*Mental and Behavioural Disorders*). They were: Block F52 (*Sexual dysfunction, not caused by organic disorder or disease*); F65 (*Disorders of sexual preference*); F66 (*Psychological and behavioural disorders associated with sexual development and orientation*); and F64 (*Gender identity disorders*). These last three blocks were in a section of Chapter 5 called *Disorders of adult personality and behaviour*, alongside diagnoses like *Paranoid personality disorder* and *Pathological gambling*.

The Working Group looked at the clinical and socio/legal issues linked to the diagnoses we were charged with examining. It studied the research and clinical literature, discussion papers, listened to special invitees, and read submissions and proposals from professional and community organisations. Throughout 2012, the Working Group participated in extended meetings in

Geneva, held conference calls and exchanged what seemed like countless emails. General overviews of the recommendations are available elsewhere.[2,3] Many of them concerned the wording of the diagnostic criteria for particular diagnostic categories. These aside, the major recommendations were as follows:

a. That there should be a new ICD chapter exclusively concerned with sexuality and gender.
b. That the *Sexual dysfunction* diagnoses (ICD-10's Block F52) should be placed in that chapter, and that all relevant diagnoses (inorganic dysfunctions in the ICD-10's Chapter 5, and organic dysfunctions in other chapters of ICD) should be brought together into one place.
c. That the *Disorders of sexual preference* (F65), essentially a set of 'paraphilic' behaviour patterns, should be renamed as *Paraphilic disorders*, and should be revised so that solitary and consensual behaviours are no longer pathologised. The Working Group recommended that *Fetishism*, *Fetishistic transvestism* and (consensual) *Sadomasochism* should be removed from ICD. There was no clear consensus on whether the remaining diagnoses (diagnoses such as *Pedophilia*, *Exhibitionism* and *Voyeurism*) should be placed in the sexual and gender health chapter (this author thought they should), or remain among the mental and behavioural disorders.
d. That the whole of Block F66 (*Psychological and behavioural disorders associated with sexual development and orientation*) should be abandoned. This block includes diagnoses such as *Sexual maturation disorder* (distress arising out of uncertainty about one's sexual orientation) and *Egodystonic sexual orientation* (distress arising from awareness of one's sexual orientation). The Working Group was aware that these diagnoses have the effect of pathologising same-sex orientation. After all, people are seldom distressed about being straight. The Working Group argued that there was no place for such categories in ICD. Rather, it recommended that those individuals who seek counselling for issues related to sexual orientation might, in the absence of any clinically significant depression or anxiety, do so via 'Z' codes. The 'Z' codes are located in Chapter 21 (*Factors Influencing Health Status and Contact with Health Services*). This chapter consists of non-pathologising codes, which simply document the circumstances in which individuals seek health care. Detailed arguments for these recommendations are available elsewhere.[4] Discussion on Z codes will continue later in this paper.
e. That the various trans-related diagnoses in Block F64 (the *Gender identity disorders*), primarily consisting of *Transsexualism* (for adolescents and adults), and *Gender identity disorder of childhood* (for children under the age of puberty), should be discarded and replaced with just two diagnoses: *Gender incongruence of adolescence and adulthood* (*GIAA*), and *Gender incongruence of childhood (GIC);* this latter one is for children below the age of puberty. The Working Group recommended that these diagnoses be placed in a chapter other than *Mental and Behavioural Disorders*. The preferred option was for placement in a dedicated chapter on gender incongruence. In the event that a dedicated chapter was not possible, the Working Group recommended that these diagnoses go into the proposed chapter on sexuality and gender.

The recommendations on *gender incongruence* are discussed more fully elsewhere.[5]

Presently it should be noted that the Working Group took the view that the classification of trans people's experiences as mentally disordered was an accident of sexological history, and that it was not supported by the available evidence. The Working Group was also aware that the classification has had terrible consequences for trans people. First, it has undermined their hopes for gender identity recognition; when a transgender woman is seen as a mentally disordered person, she is likely to be seen as a mentally disordered man. Second, it has undermined their access to health care, leading to problems in getting insurance coverage, undermining patient autonomy and aggravating the tendency of healthcare providers to act as gatekeepers.[5] Third, and much more broadly, it adds to the stigma that trans people already face throughout their lives. Across much of the world, trans people are seen as violating laws of nature or God's will, or as sexual deviants or pretenders/deceivers. The stigma prompts prejudice and discrimination, harassment and abuse. Many trans people live with the threat of violence. These experiences serve to drive them to the edge of society, where many become socially isolated and economically and legally marginalised. Many experience poor social and emotional well-being, and become depressed and/or anxious. Many become involved in risky situations (such as sex work) and risky patterns of behaviour (self-harm, substance abuse and unsafe sex). Large numbers live with HIV or other sexually transmissible infections (STIs). These experiences have elsewhere been called a stigma-sickness slope.[6] The view of trans people as mentally disordered adds to the stigma they have to face.[7]

The Working Group passed its recommendations up through the WHO administrative structure; through two Advisory Groups (in Mental Health and in Genito-Urinary and Reproductive Medicine) and further upwards to the ICD Revision Steering Group. At the time of writing, WHO appears to have accepted most of the Working Group's recommendations. As indicated earlier, WHO hopes for WHA approval of ICD-11 in May 2018.

The ICD-11 Beta Draft is available on the Internet.[8] It contains the proposed new chapter, now titled *Conditions Related to Sexual Health*. The chapter contains two *Gender incongruence* diagnoses, one for adolescents and adults, and the other for children below the age of puberty. It contains an enlarged range of sexual dysfunctions (organic and inorganic). The disorders associated with sexual orientation have been removed. There is a reduced *Disorders of sexual preference* section (now renamed *Paraphilic disorders*), with *Fetishism*, *Fetishistic transvestism* and consensual *Sadomasochism* removed. Sadly though, in this last area, WHO has retreated somewhat from the Working Group's original recommendations, inserting a proposal for a diagnostic category called *Paraphilic disorder involving solitary behaviour or consenting individuals.* As the name suggests, this diagnosis re-pathologises behaviour patterns the Working Group sought to depathologise.

WHO's backtracking on the *Paraphilic disorder* recommendations serves to underline a key point; that none of the recommendations made by the Working Group (and for that matter none of the content on the ICD-11 Beta Draft) can be considered final. As the Beta Draft site itself proclaims, the draft is not final, and is updated on a daily basis. 'It is **not approved** by WHO' (WHO's own emphasis).[8] If there is one thing this author learned in his work with WHO, it is that the ICD process is as often influenced by politics as it is by medical considerations. Indeed, the WHA, which will have the job of approving ICD-11, is itself a political organ, consisting of delegations from the 194 member States. Given the provisional nature of the ICD-11 recommendations, and the geopolitics around sexuality, the prospects for a chapter on sexual health, as well as for *Gender incongruence* to be placed in that chapter, should both be considered less than secure. Those involved in sexual health would be well advised to lobby their professional organisations (domestic and international), as well as the Australian Department of Health, to encourage them to give full support to both the chapter and the placement of *Gender incongruence of adolescence and adulthood* (GIAA) in that chapter.

The case for supporting WHO's proposal for a *Gender incongruence of childhood* (GIC) diagnosis is far less certain. In what follows below, this author draws on his involvement in the ICD revision process, both as a member of the WHO Working Group and as one of its critics, to put the case against the GIC proposal, and to recommend an alternative approach for ICD-11 to take in addressing the needs of gender diverse children.

The trouble with GIC

Before proceeding further, this author will share something about process in the Working Group. The Group split into subgroups for some of its work. Discussions about the diagnoses for trans people were delegated to a small subgroup consisting of three clinician/scholars. The GIC proposal was not formally discussed in the full Working Group. From early on, the case for the GIC diagnosis seemed uncertain. It is intended for use with pre-pubertal children who are engaged in a developmental process of exploring and learning to embrace and express an identity at odds with what the world expects of them. The proposal appears to pathologise (perhaps unintentionally) a fundamental aspect of developmental diversity. This author's own misgivings about the proposal formed through discussions with trans activists. The misgivings grew as independent expert reviews came in. Two reviewers focussed their attention on the GIC proposal; both questioned the need for the diagnosis. Despite the reviews, the WHO Secretariat stifled attempts to have the Working Group re-examine the proposal. Rather, it went straight on to conduct field studies. Two have been published; one for Mexico (focusing on adults, and the case for removing diagnosis from the mental disorders chapter),[9] and one extending across Britain, Belgium and The Netherlands (examining the views of both trans people and professionals on issues relating to both the GIAA[10] and GIC[11] proposals). WHO seems intent on retaining the proposed diagnosis.

What then are the problems with the GIC proposal? First, regardless of where in ICD-11 the GIC diagnosis is placed, it has the effect of pathologising the experiences of young children below the age of puberty who are exploring their gender identity or incorporating that identity into a broader sense of who they are, becoming comfortable expressing that identity, and managing any adverse reactions from others. These are all developmental processes. The view that they represent pathology is a very modern and Western one. In several cultures worldwide, these experiences, which we call here gender diversity, would not be regarded as pathology.[12,13] Given a supportive environment, gender diverse children who are allowed to explore, embrace and express their gender identity enjoy good adjustment.[14] Rather, distress occurs when the child's gender identity, and opportunities to express it, are denied.[15–18]

There is also the question of what purpose a diagnosis can serve for these children. Unlike transgender adolescents and adults, gender diverse children below the age of puberty have no need of somatic gender-affirming health care. These children need neither puberty suppressants nor masculinising or feminising hormones or surgery. They simply need the opportunity to explore, embrace and express their sense of who they are. They may also need support and information along the way, including to prepare them for the adverse reactions of others. Exploring, embracing and expressing identity. This is a developmental process; it does not warrant a diagnosis. Indeed, a diagnosis wrongly signals to the child and their family that there is something wrong or improper with the child.

A comparison is useful here. Ethnic minority children (or indeed children who are of mixed ethnicity) may go through a lengthy process of exploring their ethnic identity, learning to embrace and become comfortable expressing it, and learning to deal with the behaviour of those who are racist. The process may be a challenging one. Nevertheless, ICD-10 does not contain a diagnosis called *Ethnic identity disorder of childhood*; and there is no proposal for an ICD-11 diagnosis called *Ethnic incongruence*. Rather, any child seeking and receiving support in regard to these sorts of identity issues might do so through the Z codes. Two obvious ones are in Block Z71 (*Persons encountering health services for other counselling and medical advice, not elsewhere classified*). They are Z71.8 (*Other specified counselling*) and Z71.9 (*Counselling, unspecified*). Where a child is encountering racism, then two codes from Block Z60 (*Problems related to social environment*) might be relevant: Z60.4 (*Social exclusion and rejection*) and Z60.5 (*Target of perceived adverse discrimination and persecution*).

There is a closer comparison available; in the area of sexual orientation. As indicated earlier, there are currently several diagnoses in ICD-10's Block F66 that appear to target same-sex sexual orientation and identity (e.g. *Sexual maturation disorder* and *Egodystonic sexual orientation*). The exploration of sexual orientation, the incorporation of that orientation into one's sense of self, and the expression of that orientation are all developmental processes. For same-sex oriented people, learning to deal with homophobia presents an additional developmental challenge. Again, the process is one of exploring, embracing and expressing an aspect of oneself. Again, the need is for support and information. To its credit, the Working Group took the view that developmental processes of this sort should not be pathologised. It recommended that these diagnoses be removed from ICD. The ICD-11 Beta draft reflects these recommendations.

The Working Group further recommended that, so long as there were no clinically significant problems of depression or anxiety (for which there are already generic ICD diagnoses available), individuals coming into contact with services regarding issues related to sexual orientation should do so by way of non-pathologising Z codes, currently in Chapter 21 (*Factors Influencing Health Status and Contact with Health Services*).[4] Initial discussions in the Working Group focussed on ways in which codes in Block Z60 and Z70 could be used to frame and document these services. Block Z70 (*Counseling related to sexual attitude, behaviour and orientation*) includes codes such as Z70.1 (*Counselling related to a person's sexual behaviour and orientation*) and Z70.2 (*Counselling related to sexual behaviour and orientation of a third party*). The latter would be relevant in attempts to counsel parents and teachers. Block Z60 (*Problems related to social environment*) might be relevant for a person encountering stigma and prejudice on the basis of their sexual orientation. The block includes codes such as Z60.4 (*Social exclusion and rejection*) and Z60.5 (*Target of perceived adverse discrimination and persecution*).

It is difficult to see why a similar non-pathologising approach could not be taken with gender diverse children below the age of puberty who are engaged in the same sorts of developmental processes as these young people are. One group is engaged in a process of exploring, embracing and expressing their sexual orientation. The other is in a process of exploring, embracing and expressing their gender identity. Both groups face the challenge of prejudice.

A way forward: Z codes for gender diverse children

In April 2013, a Civil Society Expert Group convened by GATE (Global Action for Trans* Equality)[a] met in Buenos Aires to examine the WHO ICD proposals related to trans people. This author was a member of that group. The Group listed the circumstances in which gender diverse children, below puberty, might benefit from access to healthcare services. To quote the report of the Expert Group, these circumstances are:

> '*Access to supportive counseling: Z codes can be used when coding is required for a child to access counseling services related to gender identity, gender expression, or gender-role transition, but where there is no psychopathology and a mental disorder, diagnosis is not appropriate. These codes can also be used to provide support and services to parents and other relevant adults in properly coping with the needs of gender-variant children.*
>
> *Access to school in authentic roles: Z codes can be used in specific circumstances in which diagnostic coding is required by local laws or policies in order to secure access to education for children who have transitioned to an affirmed gender role that differs from the sex they were assigned at birth. For instance, in some jurisdictions, school records, name usage, pronoun usage, and access to appropriate facilities for these children may require some kind of diagnostic framework.*
>
> *Modify/contextualise mental health codings: Z codes can be used in conjunction with other diagnostic codings to modify their context and identify special needs. In the case of gender variance, this may include children who are severely distressed with their natal sex characteristics; who are anxious about impending pubertal changes that are wrong for them; or who have separately been diagnosed with mood, anxiety, or other mental health disorders (F-codes in Chapter 5 of the ICD-10). For example, a child with gender variance experiencing symptoms of depression or anxiety related to anatomy or birth-assigned sex will likely have very different needs from a child with symptoms of depression and anxiety but no indications of gender variance. Without this differentiation in diagnostic coding, children with gender variance might be denied support for their gender expression or social transition and only offered psychotropic medications to treat depression or anxiety. Z-codes clarifying the specific circumstances of children with gender variance could be combined with mental health F-codes to provide this clarity when needed.*
>
> *Establish history prior to puberty and adult diagnosis: Z codes can be used for prepubescent children who may need to establish a documented history of their need for access to puberty-blocking medications at a later age. The current WPATH* [World Professional Association for Transgender Health] *Standards of Care, for example, require* '*a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),*' *a criterion that can be met by Z codes.*'[19] (Civil Society Expert Group report, unnumbered pages)

Taking into account these needs, the flawed GIC proposal, and the ways in which Z codes are already used in ICD in similar contexts, the Civil Society Expert Group proposed four Z code amendments aimed at enabling the framing and documenting of appropriate services for gender diverse children below the age of puberty. They are summarised below.

Proposal 1. Z60.4 (*Social exclusion and rejection*): 'Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behaviour', in the Z60 block (*Problems related to social environments*).

The Civil Society Expert Group proposed amending the code to:

> 'Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance,

[a]GATE uses the asterisk here to reflect the various identities trans people have worldwide.

> illness or behaviour, **sexual orientation, or gender identity or expression.**' (amendment in bold).

The Civil Society Expert Group noted that the WHO Working Group had already informally proposed that category Z60.4 be amended to include 'sexual orientation, gender identity and expression'; the amendment they were proposing was therefore a very minor one indeed.

Proposal 2. Z60.5 (*Target of perceived adverse discrimination and persecution*): '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)'. Again, this code is in the Z60 block (*Problems related to social environments*).

The Civil Society Expert Group proposed amending the code to:

> 'Persecution or discrimination, perceived or real, on the basis of membership of some group (as defined by skin colour, religion, ethnic origin, **sexual orientation, gender identity or expression,** etc.) rather than personal characteristics.' (amendment in bold)

Again, the Civil Society Expert Group noted that the WHO Working Group had already informally proposed that category Z60.5 be amended to include 'sexual orientation, gender identity and expression.' Once again then, the proposed amendment was very minor.

Proposal 3. The third code proposed by the Civil Society Expert Group would be a new one, to be placed in an existing block, Block Z70 (*Counseling related to sexual attitude, behaviour and orientation*). The Civil Society Expert Group proposed an amendment to the name of the Block, to read:

> *Counseling related to sexual attitude, behaviour and orientation*, ***or gender identity or expression.*** (amendment in bold).

With the name thus amended, the new Z Code proposed by the Civil Society Expert Group was:

> *Counseling for a child to support gender identity or expression that differs from birth assignment.* (Code number to be determined later)

Proposal 4. Finally, the Civil Society Expert Group proposed a new code, again in the renamed Block Z70, in this case to frame and document support services targeting parents and other adults (e.g. teachers) working with a gender diverse child. There is already a code Z70.2 for *Counseling related to sexual behaviour and orientation or third-party advice sought regarding sexual behaviour and orientation of child, partner or spouse*. The Civil Society Expert Group proposed a new code (code number to be determined later), to read:

> *Counseling for families and service providers related to the gender identity or expression of a child.*

Is there a case for GIC?

Is there anything to be said for the GIC proposal? Arguments for GIC include that it provides a basis for fostering research, for supporting training for healthcare providers, and access to services for these children. Furthermore, without such a ICD-11 diagnosis, all these things will suffer.[2,11,20–24] These arguments are deeply flawed.

First of all, the argument that the GIC diagnosis will promote research and training. On this we can learn from what happened when the *homosexuality* diagnosis was removed from the ICD. In the early 1990s, around the time of the removal, fewer than 1000 journal papers on the topic were published each year. Nowadays, the annual figure is nearly 3500. Moreover, ~200–250 of those papers focus on training and support for professionals (Barrett and Winter unpubl. data). Few would deny that healthcare services are far better equipped nowadays to support same-sex attracted people than they were in the early 1990s. This progress was made without a *homosexuality* diagnosis. The massive amount of research has helped. Perhaps the absence of a diagnosis helped too.

Next, the argument that that the GIC diagnosis will promote access to services. In fact, this argument is about funding and reimbursement. The logic is that in some health systems, it is more difficult to get funding and reimbursement through Z codes, and that as a consequence, without the GIC diagnostic category, funding for this sort of health care for children may no longer be available. The specialist gender centres may no longer get funded. Insurance companies may no longer be willing to reimburse parents and healthcare providers. Parents may not be able to afford to take their children to clinicians. In effect, the argument, at least in relation to gender diversity in early childhood, is that our notion of sickness should be driven by our need for healthcare dollars. For those who believe that healthcare funding should be driven by the needs of the sick, this argument appears to put the cart before the horse. It is also one that would have us create a diagnostic category of 'ethnic incongruence', so that we can more easily offer services to the youngster exploring their ethnic identity, and learning to embrace and express it. It is one that would have us return *homosexuality* to ICD, to facilitate funding and reimbursement when same-sex attracted people come to us for consultation. Instead, of course, the Working Group and WHO propose removing the last (F66) residues of that old diagnosis from the manual.

Finally, the argument that the diagnosis confers a protected status, facilitating legal protections and accommodations for gender diverse children in school; for example, in matters of names, pronouns, uniforms, toilets and any gender-segregated teaching. However, the idea that a diagnosis facilitates these sorts of accommodations rests on the belief that gender diversity is indeed a medical problem. It is worth noting that schools worldwide regularly make arrangements to accommodate other forms of student diversity without imposing diagnosis as a prerequisite. Children from religious minorities get their needs met in school without a medical diagnosis. So too do children who have second language needs (though here the school may seek the opinion of an independent professional as to the extent and nature

of the need). We simply do not see these children as having a medical condition; diagnostic categories for these children actually do not exist. Rather, we see these children in terms of social diversity, and their diversity is accommodated not on the basis of a medical diagnosis, but on the basis of social need, as well as our values in regard to social inclusion and social justice.

The same arguments apply in regard to accommodations for gender diversity. If we no longer see gender diversity in young children as a medical condition, we free ourselves to accommodate their diversity by reference to their circumstances and their needs, and our own aspirations for a socially inclusive and just world.

Where do people stand on this issue?

Unease about the GIC proposal has grown over these last 5 years. As we have seen, early opposition came from the GATE Expert Group.[18] Subsequent statements have come from the European division of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe),[25] International Campaign Stop Trans Pathologisation (STP),[26] Transgender Europe (TGEU),[27] and Asia-Pacific Transgender Network (APTN).[28] Other voices have come in the form of statements issued at international conferences in Cape Town[29] and Taipei.[30] The European Parliament has weighed into the debate, issuing a report (the 'Ferrara Report') in 2015, and passing an resolution calling on the European Commission to 'intensify efforts to prevent gender variance in childhood from becoming a new ICD diagnosis'.[31] This call was reaffirmed in a European Parliament Resolution passed in September that same year.[32]

Clinicians and researchers, as well as international trans activists, have recently taken to the established academic literature to express their misgivings about the proposal.[33,34] Within the World Professional Association for Transgender Health (WPATH), there is clearly a split of opinion on the matter. The Association recently conducted a survey of its members on the matter of the GIC and Z code proposals. The survey reported a relatively even balance of opinion among its 241 respondents, with 51% opposing the GIC proposal and 48% in favour.[35] With regard to the Z code proposals, ~36% of participants supported the use, while 8% opposed them; the rest declined to share a view. The study has generated several commentaries, again evenly split on the debate.[22–24,36–38]

The majority of the WPATH membership is US-based, as were the respondents in the WPATH study. An interesting feature of the WPATH survey results was that support for GIC was rather weaker (and support for Z codes rather stronger) outside the USA than inside. One possibility is that this is due to trans-Atlantic differences in how health systems are organised, with private health insurance (and issues around reimbursement) playing a particularly important role in the US. At any rate, it does seem that the constraints of health systems can influence the views of their stakeholders. Similar cross-national differences were evident in one of WHO's own field studies; a study of the views of trans people and health professionals in Britain, Belgium and The Netherlands.[11] British respondents voiced less support for the GIC proposal (and more enthusiasm for the use of Z codes) than did their counterparts in Belgium and The Netherlands.

Finally, there is the 'Berlin Statement', an online text opposing the GIC diagnosis and advocating the use of Z codes; in 2016, it was signed in the space of 10 weeks by over 200 professionals working in trans health and rights worldwide. The signatures represented ~2400 years' experience working in trans health and rights, of which ~1400 years were clinical work.[39]

In view of the strong opposition to this proposal within the international trans community, and the deep split in the views of trans health professionals on this matter, it is not surprising that WPATH and the World Association for Sexual Health (WAS) in July 2017 issued a joint statement calling on WHO to consider further the proposed diagnosis, and to consult comprehensively on it with the transgender community.[40]

The debate on GIC continues. For this writer, and many others interested in the health and rights of trans people, the GIC proposal is inappropriate, is clinically unnecessary, risks harm and is inconsistent with WHO's approach in regard to other developmental processes in childhood and youth, including those linked to sexual orientation. The arguments for the GIC proposal are flawed or self-centred. There is a better alternative. Those opposed to the GIC proposal continue to speak up, arguing that children exploring, embracing and expressing gender identity should not be categorised as sick. It will be a sad reflection upon WHO if, when ICD is approved next year, the proposed GIC diagnosis remains. Stakeholders in Australia who have misgivings about the GIC proposal should speak up in their professional associations and ensure that their voices are heard by their national Departments of Health.

Conflicts of interest

The author was a member of the WHO Working Group on Sexual Disorders and Sexual Health, as well as a member of the Civil Society Expert Group convened by GATE (Global Action for Trans* Equality). He therefore was active in discussions that generated both sets of proposals discussed here. Apart from this, he declares no conflicts of interest.

References

1 Reed GM, Correa J, Esparza J, Saxena S, Maj M. The WPA-WHO global survey of psychiatrists' attitudes towards mental disorders classification. *World Psychiatry* 2011; 10(2): 118–31. doi:10.1002/j.2051-5545.2011.tb00034.x

2 Reed GM, Drescher J, Krueger RB, Atalla E, Cochran SD, First MB, Cohen-Kettenis PT, Arango-de Montis I, Parish SJ, Cottler S, Briken P, Saxena S. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry* 2016; 15(3): 205–21. doi:10.1002/wps.20354

3 Chou D, Cottler S, Khosla R, Reed G, Say L. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. *Reprod Health Matters* 2015; 23(46): 185–92. doi:10.1016/j.rhm.2015.11.008

4 Cochran SD, Drescher J, Kismodi E, Giami A, Garcia-Moreno C, Atalla E, Marais A, Vieira EM, Reed GM. Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD- 11). *Bull World Health Organ* 2014; 92(9): 672–9. doi:10.2471/BLT.14.135541

5 Drescher J, Cohen-Kettenis P, Winter S. Minding the body: situating gender identity diagnoses in the ICD-11. *Int Rev Psychiatry* 2012; 24(6): 568–77. doi:10.3109/09540261.2012.741575

6 Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. *Lancet* 2016; 388(10042): 390–400. doi:10.1016/S0140-6736(16)00683-8

7 Winter S, Chalungsooth P, Teh YK, Rojanalert N, Maneerat K, Wong YW, Beaumont A, Ho LMW, Gomez FC, Macapagal RA. Transpeople, transprejudice and pathologization: a seven-country factor analytic study. *Int J Sex Health* 2009; 21(2): 96–118. doi:10.1080/19317610902922537

8 World Health Organization. ICD-11 Beta Draft [Internet]. Geneva: World Health Organisation; 2015. Available online at: http://apps.who.int/classifications/icd11/browse/l-m/en [verified 22 April 2017].

9 Robles R, Fresán A, Vega-Ramírez H, Cruz-Islas J, Rodríguez-Pérez V, Domínguez-Martínez T, Reed GM. Removing transgender identity from the classification of mental disorders: a Mexican field study for ICD-11. *Lancet Psychiatry* 2016; 3(9): 850–9. doi:10.1016/S2215-0366(16)30165-1

10 Beek TF, Cohen-Kettenis PT, Bouman WP, de Vries ALC, Steensma TD, Witcomb GL, Arcelus J, Richard C, Elaut E, Kreukels BPC. Gender incongruence of adolescence and adulthood: acceptability and clinical utility of the World Health Organization's proposed ICD-11 criteria. *PLoS ONE* 2016; 11(10): e0160066. doi:10.1371/journal.pone.0160066

11 Beek TF, Cohen-Kettenis PT, Bouman WP, de Vries ALC, Steensma TD, Witcomb GL, Arcelus J, Richard C, De Cuypere G, Kreukels BPC. Gender incongruence of childhood: clinical utility and stakeholder agreement with the World Health Organization's proposed ICD-11 criteria. *PLoS ONE* 2017; 12(1): e0168522. doi:10.1371/journal.pone.0168522

12 Costa L, Matzner A. Male bodies, women's souls: personal narratives of Thailand's transgendered youth. Philadelphia: Haworth; 2007.

13 Besnier N, Alexeyeff K, editors. Gender on the edge: transgender, gay and other Pacific Islanders. Hong Kong: Hong Kong University Press; 2014.

14 Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics* 2016; 137(3): e20153223. doi:10.1542/peds.2015-3223

15 Ehrensaft D. Gender born: gender made. Raising healthy gender-nonconforming children. New York: Workman Publishing; 2011.

16 Ehrensaft D. The gender creative child: pathways for nurturing and supporting children who live outside gender boxes. New York: The Experiment; 2016.

17 Ehrensaft D. Gender nonconforming youth: current perspectives. *Adolesc Health Med Ther* 2017; 8: 57–67. doi:10.2147/AHMT.S110859

18 Pepper R, Brill S. The transgender child: a handbook for families and professionals. San Francisco: Cleis Press; 2008.

19 Global Action for Trans* Equality (GATE). Critique and alternative proposal to the "gender incongruence of childhood" category in ICD-11: report of the Civil Society Expert Working Group. Buenos Aires: Global Action for Trans* Equality; 2013. Available online at: https://globaltransaction.files.wordpress.com/2012/03/critique-and-alternative-proposal-to-the-_gender-incongruence-of-childhood_-category-in-icd-11.pdf [verified 22 April 2017].

20 Drescher J. Queer diagnoses revisited: the past and future of homosexuality and gender diagnoses in DSM and ICD. *Int Rev Psychiatry* 2015; 27(5): 386–95. doi:10.3109/09540261.2015.1053847

21 Drescher J, Cohen-Kettenis P, Reed G. Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *Lancet Psychiatry* 2016; 3(3): 297–304. doi:10.1016/S2215-0366(15)00586-6

22 Jokić-Begić N, Altabas V, Antičević V, Arbanas G, Begic D, Budi S, Dumić M, Grubić M, Grujić J, Jakušić N, Stipančić G, Šarić D, Žegura I. Croatia needs a gender incongruence diagnosis for prepubertal children. *Arch Sex Behav* 2016. doi:10.1007/s10508-016-0906-0

23 Lobato MIR, Saadeh A, Cordeiro DM, Gagliotti DAM, Brandelli ÂC, Fontanari AMV, Filho CB, de Garcia CCG, da Silva DC, Salvador J, Schwarz K, Schneider MA, Brambila MI, Giardin A, Monteiro LM, Soll BMB, Real AG. Gender incongruence of childhood diagnosis and its impact on Brazilian healthcare access. *Arch Sex Behav* 2016. doi:10.1007/s10508-016-0864-6

24 Khorashad BS, Talaei A, Bordbar MRF, Modares-Gharavi M, Vakili R, Razavizadeh RT, Koohestani L, Afkhamizadeh M. Iranian gender-nonconforming children will not benefit from the omission of gender incongruence in children diagnosis. *Arch Sex Behav* 2016. doi:10.1007/s10508-016-0888-y

25 International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA). Statement on gender incongruence of childhood. [Internet]. Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association; 2016. Available online at: http://ilga.org/what-we-do/gender-identity-and-gender-expression-program/gender-incongruence-childhood/ [verified 22 April 2017].

26 International Campaign Stop Trans Pathologisation. Reflections from STP regarding the ICD revision process and publication of the DSM-5. Granada: International Campaign Stop Trans Pathologisation.2013. Available online at: http://www.stp2012.info/STP_Communique_August2013.pdf [1 August 2013].

27 Transgender Europe TGEU calls upon WHO to support gender variant children, not label them as "sick". Berlin: Transgender Europe; 2015. Available online at: http://tgeu.org/support-gender-variant-children/ [verified 22 April 2017].

28 Asia Pacific Transgender Network (APTN). Understanding the ICD: its history, organisation, and engaging Asia and the Pacific in the revision process. Bangkok: Asia-Pacific Transgender Network; 2016 Available online at: https://static1.squarespace.com/static/53cf9459e4b0a5929855f337/t/ [verified 22 April 2017].

29 Mokoena N, Ramphele L, Pickstone-Taylor S, Nathanson R, de Villiers A, Dickinson D, Mogapi S, Deyi B, Mabuza X, Ncongwane N, Musikanth C, Moodley T, Moodley M, Toker B, Addinall R, Klopper T, Kheswa S, Kirsten L, Engelbrecht C, De Larch G, Roberson C, Theron L, Thomas E, Kokome L, Bowey G, McLachlan C, Gonyela V, Nel K, West T, Kgositau TR, Petersen A. Cape Town Declaration: Gender incongruence in childhood. Cape Town: declaration of the 2nd Trans* Health, Research and Advocacy Conference; May-June 2014. Available online at: http://www.genderdynamix.org.za [verified 22 April 2017].

30 International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA). Statement by the ILGA Asia trans* pre-conference (Taipei) on gender incongruence in childhood. Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association; 2015. Available online at: http://ilga.org/the-ilga-asia-trans-pre-conference-statement-on-gender-incongruence-in-childhood/ [cited 22 April 2017].

31 European Parliament. Annual report on human rights and democracy in the world 2013 and the European Union's policy on the matter. Strasbourg: European Parliament; 2015. Available online at: http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&mode=XML&reference=A8-2015-0023&language=EN [verified 22 April 2017].

32 European Parliament. European Parliament resolution of 8 September 2015 on the situation of fundamental rights in the European Union (2013–2014) (2014/2254(INI)). Strasbourg: European Parliament; 2015. Available online at: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P8-TA-2015-0286+0+DOC+PDF+V0//EN [verified 22 April 2017].

33 Cabral M, Suess A, Ehrt J, Seehole J, Wong J. Removal of gender incongruence of childhood diagnostic category: a human rights

perspective. *Lancet Psychiatry* 2016; 3(5): 405–6. doi:10.1016/S2215-0366(16)30043-8

34 Winter S, Ehrensaft D, Pickstone-Taylor S, DeCuypere G, Tando D. The psycho-medical case against a gender incongruence of childhood diagnosis. *Lancet Psychiatry* 2016; 3(5): 404–5. doi:10.1016/S2215-0366(16)30042-6

35 Winter S, De Cuypere G, Green J, Kane R, Knudsen G. The proposed ICD-11 gender incongruence of childhood diagnosis: a World Professional Association for Transgender Health survey. *Arch Sex Behav* 2016; 45(7): 1605–14. doi:10.1007/s10508-016-0811-6

36 Riley E. Being human. *Arch Sex Behav* 2017. doi:10.1007/s10508-017-0941-5

37 Suess-Schwend A. Gender diversity in childhood: a human right. *Arch Sex Behav* 2017. doi:10.1007/s10508-017-0938-0

38 Cabral MC. Right answers. *Arch Sex Behav* 2017. doi:10.1007/s10508-017-0943-3

39 Winter S, Riley E, Pickstone-Taylor S, Suess A, Winters K, Griffin L, Ehrensaft D, Tando D, Russell H, Alegre BR, De Cuypere G. The "gender incongruence of childhood" diagnosis revisited: a statement from clinicians and researchers. 2016. Available online at: https://docs.google.com/forms/d/1aSlSKqyZi6zC3-gWm320dFRYawDEwlkM8KerkyN3pg4/viewform [verified 22 April 2017].

40 World Professional Association for Transgender Health. Forthcoming ICD-11 proposed draft may contain hope for transgender health 2017 [cited 2017 July 30]. Available online at: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3928 [verified 14 September 2017].