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# The Proposed ICD-11 Gender Incongruence of Childhood Diagnosis: A World Professional Association for Transgender Health Membership Survey

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**Abstract** ICD-11 (the eleventh edition of the World Health Organization International Statistical Classification of Diseases and Related Health Problems) is due for approval in 2018. For transgender health care, the most important proposals for ICD-11 are as follows: (1) the five ICD-10 diagnoses (most notably Transsexualism and Gender Identity Disorder of Childhood) currently in Chapter 5 (Mental and Behavioural Disorders) will be replaced by two Gender Incongruence diagnoses, one of Adolescence and Adulthood and the other of Childhood (GIC), and (2) these two diagnoses will be located in a new chapter provisionally named Conditions Related to Sexual Health. Debate on the GIC proposal has focused on whether there should be a diagnosis for young children exploring their identity and has drawn on a number of arguments for and against the proposal. The World Professional Association for Transgender Health conducted a survey to examine members' views concerning the GIC proposal, as well as an alternative framework employing non-pathologizing Z

Codes. The survey was completed by 241 (32.6 %) out of 740 members. Findings indicated an even split among members regarding the GIC proposal (51.0 % [ $n = 123$ ] opposing and 47.7 % [ $n = 115$ ] supporting the proposal). However, non-US members were overall opposed to the proposal (63.9 % [ $n = 46$ ] opposing, 36.1 % [ $n = 26$ ] supporting). Across the sample as a whole, and among those expressing a view about Z Codes, there was substantial support for their use in healthcare provision for children with gender issues (35.7 % [ $n = 86$ ] of the sample supporting vs. 8.3 % [ $n = 20$ ] rejecting).

**Keywords** ICD-11 · Gender Incongruence of Childhood · Gender dysphoria · World Professional Association for Transgender Health · WHO

## Introduction

The World Health Organization (WHO) is responsible for developing and disseminating the International Statistical Classification of Diseases and Related Health Problems (ICD) (World Health Organization, 1990). In the area of mental health, ICD is the most widely used diagnostic manual, with a recent study across 44 countries reporting that 70 % of psychiatrists seeing patients use it more commonly than any other classification system in their day-to-day clinical work (64 % when weighted by country) (Reed, Mendonça Correia, Esparza, Saxena, & Maj, 2011). Worldwide, there is a variation. For example, the figure is 80 % across Europe (weighted 81 %), with some countries yielding particularly high figures (UK, 86 %; Germany, 96 %). By contrast, the corresponding figure in the USA (home of DSM-5) is 1 %, a figure matched nowhere else in the study (and surpassing only Kenya).

ICD (currently in version 10) contains a number of diagnoses related to transsexual, transgender, and gender-variant

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people. They appear in the Mental and Behavioural Disorders chapter, in a section called Disorders of Adult Personality and Behaviour, and in a subsection called Gender Identity Disorders. There are a number of disease diagnostic codes in this section. The main ones are Transsexualism (used with adolescents and adults) and Gender Identity Disorder of Childhood (used with children below the age of puberty). Others are Dual-role Transvestism, Other Gender Identity Disorders, and Gender Identity Disorders, Unspecified (World Health Organization, 1990).

WHO is reviewing the current edition. It is expected that ICD-11 will be approved by the World Health Assembly in 2018. Because of ICD's influence on global health policy and the structure and functioning of healthcare systems throughout the world, it is important to ensure that the categories and descriptions of conditions in the new edition are as fit for use as possible. Clinical utility and access to care are important issues, in the area of mental health as elsewhere (Reed, 2010). With this in mind, WHO has researched the views of psychiatrists worldwide on diagnostic issues (Reed et al., 2011). However, WHO has also needed to bear in mind the other uses to which ICD is put, beyond clinical practice, including research, teaching and training, health statistics, and decisions on public health (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011). WHO has also borne in mind human rights considerations (Kismödi, 2015). As part of the revision process, WHO convened in 2012 a Working Group on Sexual Disorders and Sexual Health (WGSDSH), which the following year made recommendations for diagnostic reform in a number of areas in sexuality and gender currently covered by ICD-10 (including in areas relevant to trans people and their healthcare providers).

The two most important WGSDSH proposals relevant to trans health care are as follows. Firstly, it is proposed that the current ICD-10 diagnoses will be replaced by two others, named Gender Incongruence of Adolescence and Adulthood (GIAA) and, for children below the age of puberty, Gender Incongruence of Childhood (GIC). For the clinical description of the proposed GIC diagnosis at time of writing, see "Appendix". Secondly, it is proposed that these two diagnoses will be removed from Chapter 5 (the Mental and Behavioural Disorders chapter) and placed elsewhere (Drescher, Cohen-Kettenis, & Winter, 2012). The WGSDSH preference was for a separate chapter focused entirely on gender incongruence. A second preference (less ideal but still avoiding the double stigma that arises out of a mental disorder classification) was for placement in a new chapter focused on conditions related to sexual and gender health. Current WHO thinking, evident on the Web-based ICD-11 beta draft, is that these diagnoses should be located in a new chapter entitled Conditions Related to Sexual Health (World Health Organization, under continuing revision). We note that, while placement in this chapter is preferable to placement in the chapter on mental disorders, the title of this proposed chapter runs

the risk of encouraging perceptions among healthcare providers that gender incongruence is about sex and not gender.

As indicated earlier, the WGSDSH has made a number of other proposals related to sexuality and gender. For example, there is currently a section in ICD-10's Chapter 5 headed Psychological and Behavioural Disorders Associated with Sexual Development and Orientation (Code F66). This section currently contains a number of diagnoses that may be used with people facing challenges related to their sexual orientation or gender identity. These diagnoses include Ego-dystonic Sexual Orientation (for those who are distressed by an awareness of their sexual orientation or gender identity) and Sexual Maturation Disorder (for those whose distress arises out of uncertainty about their sexual orientation or gender identity). WHO is proposing to remove this block entirely. A key argument is that these are residual diagnoses for homosexuality (Cochran et al., 2014). The WGSDSH has also proposed that a range of solitary or consensual sexual patterns in ICD-10 (e.g., Fetishistic Transvestism [F65.1]) should be removed (World Health Organization, under continuing revision).

The World Professional Association for Transgender Health (WPATH) is a nonprofit, multi-disciplinary organization working for transgender health worldwide. It publishes the influential Standards of Care, currently version 7, providing guidelines for the provision of health care for transsexual, transgender, and gender nonconforming people (WPATH, 2011). In February 2013, WPATH, in response to a request from the WHO for its views on the ICD proposals, convened a consensus meeting in San Francisco at which invited clinicians and others (including WHO staff and trans community members) were able to discuss the proposals (which at that time had not yet been made fully public). While there was broad consensus agreement with the bulk of the WHO proposals related to trans health, there was no consensus in regard to the GIC proposal. A final vote by private ballot on whether there should be a GIC diagnosis was tied, with 14 for and 14 against (De Cuypere, Knudson, & Green, 2013).

Arguments for a GIC diagnosis included that it facilitated access to care, to reimbursement, and to professional training and that it made possible a "protected status" (de Vries, 2014; Menvielle & de Vries, 2013). Other arguments made reference to the syndromic nature of gender incongruence and noted the evidence indicating the discriminant and predictive validity of diagnoses in the area of childhood gender incongruence. It is also argued that a diagnosis provides an opportunity for parents to make choices about what is in the best interest of their child (Zucker, 2015). Arguments against the diagnosis ranged from anthropological (in a number of cultures, the children who would be pathologized by this diagnosis are not usually seen as sick at all) to clinical (prepubertal children do not need substantial medical support, but instead need the psychological space, support, and information to explore who they are, become comfortable with their gender identity and its expression, and learn how to handle hostility in others). There is also a political

argument that notes WHO's inconsistency in proposing a GIC diagnosis while simultaneously proposing the removal of pathologizing F66 diagnoses used with youth exploring and learning to accept and handle responses to their sexual orientation (Ehrensaft, 2011, 2012, 2013; Winter, 2013, 2014, 2015). It is also argued that there are alternative approaches to facilitate research, funding, and access to health care for children with gender issues, just as there were when the pathological diagnosis of homosexuality was removed from ICD and DSM (Pickstone-Taylor, 2003).

Since February 2013, the GIC debate has perhaps become even more vigorous. In May 2013, GATE (Global Action for Trans\* Equality), an international organization promoting trans people's rights, convened its own experts' meeting on this topic in Buenos Aires. The meeting incorporated input from 26 trans community activists, researchers and academics, clinicians, lawyers, sociologists, and others and proposed, on health and rights grounds, abandonment of the GIC proposal. Instead, the GATE Expert Group proposed that such health care as may be needed by prepubertal gender-incongruent children (and their caregivers) should be primarily provided by way of Z Codes. (GATE Civil Society Expert Working Group, 2013). Z Codes are non-pathologizing, non-disease categories currently located in a chapter called Factors Influencing Health Status and Contact with Health Services and are used "when a person who may or may not be sick encounters the health services for some specific purpose, such as ...to discuss a problem which is in itself not a disease or injury" or "when some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury" (WHO, 1990, Web version, 2015). The GATE group noted that Z Codes already exist that can, with minor modifications and additions, do the job of documenting contacts between gender-incongruent children and health services (e.g., in the Z70 block: Counseling related to sexual attitude, behavior, and orientation). It also noted that, where any young children are experiencing clinically significant depression and anxiety linked to their gender issues and merit a depression or anxiety diagnosis, Z Codes could be appended to those diagnoses to indicate the nature of the issues experienced by the child (GATE, op.cit.)

The proposed use of Z Codes in this area is somewhat controversial. On the one hand, Z Codes are very commonly employed to guide and document provision of health care. On the other hand, they can in some parts of the world sometimes present reimbursement challenges for healthcare providers. Reimbursement issues do not appear to have prevented WHO from incorporating into its ICD-11 beta draft a WGSDSH proposal to use Z Codes in place of the F66 diagnoses mentioned earlier (Cochran et al., 2014).

Other voices questioning the GIC proposal include: Transgender Europe (TGEU) (Transgender Europe, 2014), the Inter-

national Campaign Stop Trans Pathologization (International Campaign Stop Trans Pathologization, 2013), and the International Lesbian, Gay, Bisexual, Trans and Intersex Association (International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2016). In Cape Town in May 2014, a group of over 30 healthcare providers, lawyers, trans community leaders, and parents attending a regional conference on trans health issued a statement opposing the proposed diagnosis (the "Cape Town Declaration," Mokoena et al., 2014). In October 2015, a group of 37 trans activists, advocates, clinicians, and researchers issued a similarly worded declaration (the "Taipei Declaration," Lama et al., 2015) at the ILGA Asia Conference. More recently, an online statement signed by clinicians and researchers in the field (the "Berlin Statement") has attracted, at the time of writing, almost 200 signatures from professionals in 31 countries across six continents. They represent almost 2500 years of work in transgender health and rights, and almost 1500 years of clinical experience (Winter et al., 2016). Finally, in an unusual concern with diagnostic procedures, a report of a European Parliament committee (the so-called Ferrara Report published in July 2015) called on the European Commission to "intensify efforts to prevent gender variance in childhood from becoming a new ICD diagnosis" (European Parliament Committee on Civil Liberties, Justice and Home Affairs, 2015). This call was reaffirmed in a European Parliament Resolution passed in September 2015 (European Parliament, 2015).

Meanwhile, there has been a degree of unease among some WPATH members about the absence of consensus on the GIC proposal evident at the 2013 San Francisco consensus meeting. It was felt that WPATH, the largest association of professionals in transgender health, in which perhaps an increasing number of members are working with children, should take a second more comprehensive look at the GIC proposal. WPATH leadership (Board of Directors and Executive Committee) decided to do so by way of a Web survey concerning the proposed diagnosis. It was intended that the survey would provide a more definitive WPATH view for consideration by WHO.

## Method

### Participants

All WPATH members (740 at the time of the survey) were sent an e-mail inviting them to participate in a survey on the GIC proposal, accessed through a link on the WPATH Web site: [www.wpath.org](http://www.wpath.org). The survey was constructed using Survey Monkey. Participants were provided with background information on the proposal, similar to what has been provided here. Participants were able to complete the survey between December 15, 2014, and January 15, 2015.

## Procedure and Measures

The first section of the survey involved demographics, including: the region in which the participant works or worked (11 categories provided), category of membership (full, associate, or student); whether he or she works (or has in the past worked) in transgender health care, and for how long (1–5 years, 5–10 years, and more than 10 years), in what capacity (8 categories provided—several responses were possible), client group served (three categories provided: adults, adolescents, children below the age of puberty—more than one response was possible), and whether he or she prescribes/has prescribed puberty blockers. The second (main) section of the survey presented questions about the WHO GIC proposal and an alternative approach to facilitating and recording health care involving Z Codes (i.e., along the lines of the GATE proposal). The third section focused on views regarding the name Gender Incongruence of Childhood and invited additional comments. The questionnaire was developed by the first two authors and went through several drafts. It was also reviewed and was endorsed by senior members of the WPATH leadership and two internationally known commentators on the GIC proposal: one a recognized advocate of the proposal and the other an opponent.

Key questions (in the second and third section) were as follows:

1. Do you think a disease diagnosis Gender Incongruence of Childhood should be included in ICD-11? Response options: yes or no. Participants then indicated their reason for their answer. Six categories of reason were provided for those opposing the proposal which were: the diagnosis is pathologizing, stigmatizing/discriminating, has limited utility, has limited validity, Z codes provide a more appropriate method of enabling and documenting health care, and other. Five were provided for those supporting the proposal which were that the diagnosis: enables access to care, enables reimbursement, facilitates professional training and research, provides the child protected status, and other. Participants were able to choose more than one option.
2. If there is no disease diagnosis at all in ICD-11, what is your view on the use of non-disease Z Codes (either existing, new, or amended) as the primary means of documenting the gender-related issues of these children? Response options were: support, neutral, or reject.
3. If there is a GIC disease diagnosis, what is your view on which chapter it should be placed in? Response options were: support the WHO proposal for placement in a new chapter on Conditions Related to Sexual Health, neutral, support remaining in the Mental and Behavioural Disorders chapter, and other suggested locations.
4. What are your views on the proposed name Gender Incongruence of Childhood (instead of the current name Gender Identity Disorder of Childhood)? Response options were agree, neutral, disagree, or other suggested names.

There was a final item that invited other comments to pass on to WHO. By completing the survey, the members indicated their agreement to participate, and their understanding that WPATH might communicate the results with WHO and other entities with a valid interest in WPATH's opinion on this topic. No personal participant information would be revealed.

## Statistical Analysis

Only a few participants ( $n = 3$ ) omitted to answer the question "Do you think a disease diagnosis GIC should be included in ICD-11?" They were excluded from the GIC analysis. The percentages of responses supporting and opposing the GIC proposal were therefore computed as a proportion of the total number of supporting and opposing responses. The analysis of responses to the Z Code issue also focused on comparing the percentages of supporting and opposing responses. A large proportion of participants were undecided on the question of Z Codes. In order to avoid bias when comparing percentages of supporting and opposing responses, these percentages were computed as a proportion of the total number of supporting, opposing, and neutral responses.

For the GIC data, a one-sample  $t$  test between percentages was conducted comparing the percentages of responses supporting and opposing the GIC proposal. Additional analyses were conducted in which the binary response variable was analyzed as a function of four categorical independent variables (IVs): geographical region (Australia and Oceania, Canada, USA, Western Europe, other), region in which participant works and lives (USA, non-USA), number of years working in transgender health care (1–5, 6–10, more than 10), and the age group served (children and adolescents only, adults only). Each independent variable was crossed with the binary response variable, and the resulting contingency table was subjected to a  $\chi^2$  test of independence. The  $\chi^2$  test was deemed appropriate because all expected cell frequencies were greater than five, and the percentages of responses supporting and opposing the GIC proposal summed to 100. Following a significant  $\chi^2$ , a one-sample  $t$  test was conducted at each level of the IV comparing the proportions of supporting and opposing responses. Following a nonsignificant  $\chi^2$ , a one-sample  $t$  test was conducted comparing the marginal proportions of supporting and opposing responses. For the Z Codes data, one-sample  $t$  tests were used to compare the proportions of participants supporting and rejecting the use of Z Codes.  $\chi^2$  tests were not used for these comparisons because the percentages of supporting and opposing responses summed to less than 100. In all analyses, the per-test alpha level was .05, in keeping with the exploratory nature of this study.

## Results

### Demographics

Of the 740 WPATH members at the time of the survey (the end of 2014), a total of 253 responded to the survey. Of these, there were 241 valid completed surveys, representing 32.6 % of the membership. Our response rate compared favorably with the mean of 33 % reported for e-mail surveys in a recent review of research using this methodology (Shih & Fan, 2009). Indeed, it compared well with the 34 % response rate reported for WHO's recent international survey of psychiatrists' views concerning the ICD mental disorders chapter (Reed et al., 2011, cited earlier). It also substantially exceeded the 12.4 % response rate reported in Vance et al.'s (2010) international survey on the views of organizations working with trans people toward DSM diagnostic reform regarding the gender identity disorder diagnosis.

Table 1 shows the region in which participants were located, along with those for the entire WPATH membership at the time of the survey. Sample proportions appeared similar to that of the entire membership in all categories. The majority of participants (137 or 56.8 %) were identified exclusively as mental health professionals, in line with their proportion as 48.8 % of WPATH members. Fifty-six (23.2 %) were identified as physicians (27 identifying as physicians who prescribe hormones, 18 as primary care physicians, 9 as surgeons, and 2 as other specialisms). Fifteen participants were identified as human rights activists, with another 8 identifying as lawyers, and 27 as others.

Sample proportions for all other areas of involvement in transgender health were in line with proportions for the membership as a whole. Among other sample characteristics of interest, a total of 215 (89.2 %) out of 241 participants indicated they were currently providing health care or related services to transgender clients/patients (or had done so in the past). A total of 138 (57.3 %) participants had worked more than 10 years in transgender health care, while 42 (17.4 %) had worked five years or less in the field. Eighty-seven (36.1 %) worked with children.

The group of participants was representative for the total WPATH membership concerning geographical location as well as profession.

### Overall Support for the GIC Proposal

For the question: "Do you think a disease diagnosis Gender Incongruence of Childhood should be included in ICD-11?" a total of 115 (47.7 %) participants answered "yes" and 123 (51.0 %) answered "no." Three (1.2 %) participants abstained.

The difference in proportions of "yes" and "no" responses was not significant,  $t(237) < 1$ .

### Support for the GIC Proposal According to Geographical Region

The 5 (geographical region)  $\times$  2 (support vs. oppose) contingency table is shown in Table 2. The  $\chi^2$  test of independence was significant,  $\chi^2(4) = 10.35$ ,  $p = .035$ , indicating that the difference between the proportions of participants supporting and opposing GIC varied across the five regions. Australia and Oceania was the only region for which there was a significant difference between percentages supporting and opposing the proposal. For the other four regions, there was no significant difference. As noted earlier, 70 % of psychiatrists worldwide appear to use ICD more commonly than any other manual (Reed et al., 2011). Within the USA, home of DSM-5, this figure drops to 1 %. Given the number of US participants in this study, and the likelihood that they might have less acquaintance with ICD and ICD Reform, we decided to compare the responses of US participants with those of participants elsewhere. The 2 (US vs. non-US)  $\times$  2 (support vs. oppose) contingency table is reported in Table 3. The  $\chi^2$  test of independence was significant,  $\chi^2(1) = 5.48$ ,  $p = .019$ , indicating that the difference between the proportions of participants supporting and opposing GIC varied across the two groups. Among non-US participants ( $n = 72$ ), there were significantly more participants opposed to the GIC proposal than there were supporting it, 63.9 versus 36.1 %,  $t(71) = 2.46$ ,  $p = .017$ . For US participants ( $n = 166$ ), the difference between the proportions of participants supporting (53.6 %) and opposing GIC (46.4 %) was not significant,  $t(165) < 1$ .

### Support for the GIC Proposal According to the Number of Years Working with Trans people

The 3 (number of years)  $\times$  2 (support vs. oppose) contingency table is shown in Table 4. The  $\chi^2$  test of independence was non-significant,  $\chi^2(2) < 1$ , indicating that the difference between the proportions of participants supporting and opposing GIC was invariant across the three groups.

### Support for the GIC Proposal According to the Age Group with Which Participants Work

The 2 (age group served)  $\times$  2 (support vs. oppose) contingency table is shown in Table 5. The  $\chi^2$  test of independence was non-significant,  $\chi^2(1) < 1$ , indicating that the difference between

**Table 1** Geographical location of participants

	Participants		% <sup>b</sup>	WPATH membership	
	<i>n</i> = 241	% <sup>a</sup>		<i>n</i> = 740	%
Australia and Oceania	8	3.3	34.8	23	3.1
North America: Canada	21	8.7	38.2	55	7.4
North America: USA	169	70.1	30.9	546	73.8
Western Europe	29	12.0	30.2	96	12.9
Other	14	5.8	26.4	53	7.1

Other: Africa, Asia, Caribbean & Central America, Eastern Europe, Middle East, South America, Worldwide

%<sup>a</sup> Participants as percentage of overall sample

%<sup>b</sup> Participants as percentage of WPATH members located in that region

**Table 2** Distribution of the members supporting or opposing the GIC proposal, according to their geographical region

	Support GIC		Oppose GIC		<i>p</i> value
	<i>n</i> = 115	%	<i>n</i> = 123	%	
Australia and Oceania	1	11.1	8	88.9	.006
North America: Canada	7	33.3	14	66.7	.120
North America: USA	89	53.6	77	46.4	.352
Western Europe	14	48.3	15	51.7	.856
Other <sup>a</sup>	4	30.8	9	69.2	.16

<sup>a</sup> Other: Africa, Asia, Caribbean and Central America, Eastern Europe, Middle East, South America

**Table 3** Distribution of respondents supporting and opposing the GIC proposal according to the region in which they work and live

	Support GIC		Oppose GIC		<i>p</i> value
	<i>n</i> = 115	%	<i>n</i> = 123	%	
US members	89	53.6	77	46.4	.352
Non-US members	26	36.1	46	63.9	.017

the proportions of participants supporting and opposing GIC was invariant across the two groups.

### Arguments For and Against the GIC Proposal

The most commonly endorsed arguments to support the GIC diagnosis were that a diagnosis would: enable access to care (79.1 % of the participants supporting the GIC proposal); give “protected status” (54.5 %); facilitate reimbursement (54.7 %); and facilitate training and research (49.5 %). The most commonly endorsed arguments to abandon the proposal were that the GIC diagnosis would be: pathologizing (53.6 % of those opposing the proposal); stigmatizing/discriminating (50.4 %); of limited utility (39.0 %); and of limited validity (34.1 %).

### Support for the Use of Z Codes

For the question “If there is no disease diagnosis at all in ICD-11, please tell us what is your view on the use of non-disease

“Z” Codes (either existing, new or amended) as the primary means of documenting the gender-related issues of these children?” it was evident from participants’ responses that, where a view was expressed, Z Codes drew substantial support. Overall, 86 (35.7 %) participants supported the use of Z Codes compared with 20 (8.3 %) rejecting them and 135 (56.0 %) either neutral or leaving their response blank. A one-sample *t* test comparing the proportions supporting and rejecting the use of Z Codes was significant,  $t(240) = 7.04, p < .001$ , indicating that a significantly greater proportion of participants supported the use of Z Codes. Support was evident both within and outside the USA. It was also evident regardless of how long participants had worked in trans health care and with which client age group they worked. The results of the one-sample *t* tests are shown in Table 6.

It can be seen in Table 7 that support for Z Codes was particularly strong among those who were opposed to GIC. Among them, 48.8 % supported Z Codes, as compared to 4.1 % opposing. The difference in proportions was highly significant

**Table 4** Distribution of respondents supporting and opposing the GIC proposal according to the number of years working with trans people

	Support GIC		Oppose GIC		<i>p</i> value
	<i>n</i> = 113	%	<i>n</i> = 112	%	
1–5 years	22	53.7	19	46.3	–
5–10 years	25	52.1	23	47.9	–
More than 10 years	66	48.5	70	51.5	–
Marginal proportions	113	50.2	112	49.8	.952

**Table 5** Distribution of respondents supporting and opposing the GIC proposal according to the age group with which they work

	Support GIC		Oppose GIC		<i>p</i> value
	<i>n</i> = 111	%	<i>n</i> = 113	%	
Adults and adolescents only	71	51.8	66	48.2	–
Children only	40	46.0	47	54.0	–
Marginal proportions	111	49.6	113	50.4	.905

( $p < .001$ ). However, there was also substantial support for Z Codes even among those who supported the GIC diagnosis: 22.6 % supporting, as compared to 12.2 % rejecting ( $p = .057$ ). A large number of others (65.2 %) expressed a neutral view or did not express a view.

### Placement of the Proposed GIC Diagnosis

In response to the question about where the proposed GIC diagnosis, if approved, should be located in ICD-11, 41.1 % ( $n = 99$ ) of participants supported the WHO proposal for placing it (presumably alongside GIAA) in a new chapter with the putative title Conditions Related to Sexual Health. Only 7.5 % ( $n = 18$ ) had the view that it should be placed in the Mental and Behavioural Disorders chapter (the current location for the various gender identity disorder diagnoses). Another 19.5 % ( $n = 47$ ) of participants remained neutral, while 10.4 % ( $n = 25$ ) made other suggestions and 21.5 % ( $n = 52$ ) did not respond. The support for the Chapter Conditions Related to Sexual Health was significantly above that for its retention in the Mental and Behavioural Disorders chapter,  $t(240) = 8.54$ ,  $p < .001$ .

### The Proposed Name for GIC

In response to the question about the suggested name “Gender Incongruence of Childhood” for the proposed diagnosis, 51.0 % ( $n = 123$ ) agreed with the choice of name, while only 13.7 % ( $n = 33$ ) were opposed. Another 17.8 % ( $n = 43$ ) were neutral, while 8.3 % ( $n = 20$ ) suggested other options, and another 9.1 % ( $n = 22$ ) did not respond. The number supporting the proposed

name was significantly greater than the number opposing it,  $t[240] = 8.12$ ,  $p < .001$ .

### Discussion

WHO can take reassurance from WPATH members’ support for the proposal to place the Gender Incongruence of Childhood diagnosis in a chapter on sexual health, as well as on the choice of name for any such diagnosis. But beyond that, there is an even division of opinion as to whether there should be a GIC diagnosis in ICD-11 at all. Around half said yes, the most common argument being that it enables access to care, provides “protected status” to the child, and facilitates reimbursement. The other half said no, commonly arguing that it would result in pathologization, stigma, and discrimination. The split in opinion echoed WPATH’s ICD Consensus meeting in San Francisco in 2013 (De Cuypere et al., 2013). Elsewhere there are strong voices of opposition to the GIC proposal. GATE (GATE Civil Society Expert Working Group, 2013), International Campaign Stop Trans Pathologization (2013), Transgender Europe (2014), and the International Lesbian, Gay, Bisexual, Trans and Intersex Organisation (ILGA, 2016) have issued statements opposing the proposal. Groups at two conferences (Lama et al., 2015; Mokoena et al., 2014) and a large number of researchers and clinicians (Winter et al., 2016) have also issued statements. A key European Parliament Committee (European Parliament Committee on Civil Liberties, Justice and Home Affairs, 2015) and the European Parliament itself (European Parliament, 2015) have each called upon the European Commission to oppose WHO’s GIC proposal. Together

**Table 6** Distribution of respondents rejecting or supporting the use of non-disease Z Codes as primary means of documenting the gender-related issues of children according to their location, the number of years working in trans health care, and the age group with which they work

	Reject Z codes		Support Z codes		Neutral/Blank		<i>p</i> value <sup>a</sup>
	<i>n</i> = 20	%	<i>n</i> = 86	%	<i>n</i> = 135	%	
US members	16	9.5	51	30.2	102	60.3	<.001
Non-US members	4	5.6	35	48.6	33	45.8	<.001
1–5 years	1	2.4	13	31.0	28	66.7	<.001
5–10 years	3	6.3	18	37.5	27	56.2	<.001
More than 10 years	15	10.9	50	36.2	73	52.9	<.001
Adults/adolescents only	11	7.9	42	30.0	87	62.1	<.001
Children	9	10.3	36	41.4	42	48.3	<.001

<sup>a</sup> One-sample *t* test comparing proportion supporting against proportion rejecting

**Table 7** Distribution of the respondents' views on Z Codes, according to their views on a GIC diagnosis

	Support Z codes		Reject Z codes		Neutral and Blank		<i>p</i> value <sup>a</sup>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Support GIC	26	22.6	14	12.2	75	65.2	.057
Oppose GIC	60	48.8	5	4.1	58	47.1	<.001

<sup>a</sup> One-sample *t* test comparing proportion supporting against proportion rejecting

these voices come from an internationally wide range of stakeholders in transgender health and rights.

It is apparent from our analysis that US respondent views on the GIC proposal are overall finely balanced, but that, viewed as a whole, respondents elsewhere are overall opposed to the proposal and that, furthermore, where they express a view, they are (viewed as a whole) particularly likely to support a Z code approach, along the lines of GATE's proposal. In some places (e.g., Canada and Australia/Oceania), there are indications (though significant only in the latter case) that opposition to the GIC proposal is particularly strong, although the data are small and further research on this is indicated. It is possible that the geographical divergence is related to the very different health systems in which participants in this study work, with those in at least some socialized health systems less dependent on the use of pathologizing codes than those, such as in the USA, working in health systems in which the need for insurance company reimbursements predominates in healthcare policy. The Z Code results in this study seem particularly interesting. A large number of participants appeared undecided on the question of Z Codes. This may, of course, reflect a lack of familiarity with the GATE proposal or Z Codes more generally. Unfamiliarity with these codes may have been particularly relevant in the USA, where a high percentage of participants (60.3 %) were neutral or left this item blank. Overall across our sample, 81.1 % of those who expressed a view on Z Codes supported them and only 18.9 % rejected them (a ratio of 4:1 in favor of Z Codes).

As one might expect, there was a significant link between support for Z Codes and opposition to the GIC proposal. US-based respondents, the source of greatest support for the GIC proposal, were least in favor of Z Codes. Yet, even in the USA, 30 % supported the use of Z Codes. Indeed, support for Z Codes was strikingly consistent, with support outweighing rejection regardless of whether participants worked in the USA or outside, regardless of how long they had been working with trans people, and regardless of the age group worked with.

The opinions, here expressed, are the opinions of an apparently representative part of the WPATH membership, all professionals working in the transgender field. It would be interesting to know what opinions mental health professionals more generally (not just specialists in the field) have on this issue, as well as parents of children covered by this proposed diagnosis. It would also be useful to know what arguments these views are based on. It is evident that the USA (and US institutions) tends to dominate in international discussions on trans health care. DSM-5 (like DSM-IV before it) is influential far beyond the clinics in which it is used. Within WPATH, the peak professional organization in the field, a majority of members are US-based. But WHO, like WPATH itself, is an international organization committed to a global perspective on health care. The challenge for WHO in making decisions on the GIC proposal (and indeed on the use of Z Codes) will be to maintain that international perspective. The challenge for WPATH in inputting into WHO's decision making will be to do the same thing: to

incorporate into its representations voices from trans healthcare providers and users worldwide.

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#### Compliance with ethical standards

**Conflict of interest** One of the authors of this paper, Sam Winter, was a member of the WHO Working Group on Sexual Disorders and Sexual Health generating the GIC proposal, as well as a group producing a counter-proposal incorporating the use of Z Codes (GATE Civil Society Experts Working Group, 2013).

### Appendix: The Clinical Description of the Proposed GIC Diagnosis (World Health Organisation, 2015)

Gender Incongruence of Childhood is characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in prepubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years and cannot be diagnosed before age 5. Gender-variant behavior and preferences alone are not sufficient for making the diagnosis.

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