other mental disorders. We concur with these important research priorities and the need to address methodological and data challenges to provide more precise estimates of the burden of mental illness than exist at present, which are needed to inform the development of a health system's response commensurate with the burden. Notwithstanding methodological challenges, 0% attribution of chronic pain syndromes to mental illness underestimates the mental illness burden, as does the attribution of 100% self-harm burden to the category of injuries.[2] Ferrari and colleagues[3] proposed a partial correction, reattributing 0·9% of global disability-adjusted life-years (DALYs) to mental illness, but erred on the side of caution by imposing a ceiling of 68·3% to suicides attributable to mental illness in China and India. Phillips and colleagues' research[4] allows for a very different conclusion: it is the exclusion of subsyndromic depressive states and personality disorders that leads to underestimation of the causal link of mental illness and suicide. Indeed, in later work Phillips and colleagues[4] report that underlying depression prevalence doubles when using culturally appropriate probes. Exclusion of more than a third of self-harm DALYs from mental disorders leads to unjustified underestimation of the burden of mental illness in view of the under-reporting in many countries, including in China and India, due to stigma, which compounds the exclusion of personality disorders and sub-syndromic states.

There is clearly a trade-off between upholding Global Burden of Disease assumptions and providing a more realistic estimate of mental illness burden—while noting data limitations and uncertainties—to inform policy for a specialty that for too long has been starved of attention and funding worldwide.

We declare no competing interests. RA and DV conceived and wrote the first draft. GT added to the draft. All authors contributed to the final version.

*Rifat Atun, Daniel Vigo, Graham Thornicroft
ratun@hsph.harvard.edu

Harvard T H Chan School of Public Health, Harvard University, Cambridge, MA, USA (RA, DV); and Department of Health Services & Population Research, King's College London, London, UK (GT)

1 Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. *Lancet Psychiatry* 2016; **3:** 171–78.
2 Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet* . 2013; **382:** 1575–86.
3 Ferrari A, Norman R, Freedman G, Baxter A, Pirkis J. The burden attributable to mental and substance use disorders as risk factors forn suicide: findings from the Global Burden of Disease Study 2010. *PLoS One* 2014; **9:** e91936.
4 Phillips MR, Shen Q, Liu X, et al. Assessing depressive symptoms in persons who die of suicide in mainland China. *J Affect Disord* 2007; **98:** 73–82.

The psycho-medical case against a gender incongruence of childhood diagnosis

Jack Drescher and colleagues (March, 2016)[1] highlight two controversies surrounding gender incongruent children below puberty. One controversy concerns how one helps these children. A study by Olson and colleagues[2] published in this month's *Pediatrics* offers strong support for a gender affirmative approach. They report good mental health in pre-pubertal children allowed to transition socially at home and school. Their findings feed the second controversy; whether there is a case for a diagnosis.

The gender incongruence of childhood diagnosis for ICD-11 was not unanimous in the WHO Working Group that originally proposed it. There was concern that this pathologising diagnosis would stigmatise the experiences of young children who are simply exploring their identity, and are learning to become comfortable being and expressing who they are—children whose diversity would hardly raise an eyebrow in a number of cultures worldwide.

These children have no need for puberty suppression, cross-sex hormones, or surgery. Olson and colleagues confirm what many clinicians and researchers have observed; these children just need space and support to explore and to become comfortable with their identities.[3-5]

The WHO Working Group considered the case for reform across many other sexual health diagnoses, including some that pathologise young people exploring and learning to embrace and express their sexual orientation. Thankfully, the group agreed to recommend that these diagnoses be removed.[6] It is perplexing that the same approach was not taken with pre-pubertal children exploring and learning to embrace their gender identity.

Drescher and colleagues' arguments for the gender incongruence of childhood diagnosis—for example that it will provide a foundation for research and training—appear flawed. Research needs should never dictate diagnostic categories. In any case, research into same-sex attraction and relationships has thrived since the homosexuality diagnosis was removed from the diagnostic manuals decades ago. So has our knowledge about ways of meeting the health-care needs of gay and lesbian youth.

Key trans rights organisations worldwide have spoken out against this proposal; among them Global Action for Trans* Equality, Stop Trans Pathologisation, and Transgender Europe. Importantly, the European Parliament in Sept, 2015, called on the European Commission to "intensify efforts to prevent gender variance in childhood from becoming a new ICD diagnosis". A recent study by the

For the **European Parliament resolution** see http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P8-TA-2015-0286+0+DOC+PDF+V0//EN

For the **Results of Member Survey on Gender Incongruence of Childhood (GIC) Diagnosis for ICD-11** see http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=16351&pk_association_webpage=6638

World Professional Association for Transgender Health found that a small majority of participants were opposed to the proposed diagnosis, with this majority much greater outside the USA.

The gender incongruence of childhood proposal is the most controversial proposal from this Working Group. We urge WHO to abandon the proposal for GIC, and instead employ non-pathologising Z Codes to facilitate and document health care for gender-diverse children. This approach, proposed in a Global Action for Trans* Equality document in 2013, would be entirely consistent with WHO's proposals for young people exploring, and learning to embrace and express, their sexual orientation. We see no reason why young gender incongruent children should be treated differently.

SW was a member of, and GDC was an external reviewer for, the WHO Working Group on the Classification of Sexual Disorders and Sexual Rights. SW and GDC were co-researchers on a survey of WPATH members' attitudes towards the GIC proposal. SW was a member of the GATE Civil Society Experts Group. All authors are members of the No-GIC web-discussion group. DT is author of a book entitled *The Conscious Parent's Guide to Gender Identity* (in press). DE is author of a book entitled *Gender Born Gender Made* (2011) and *The Gender Creative Child* (in press). SP-T has received funding to attend meetings to discuss the GIC proposal. We declare no competing interests.

Sam Winter, Diane Ehrensaft, Simon Pickstone-Taylor, Griet De Cuypere, Darlene Tando
sam.winter@curtin.edu.au

School of Public Health, Curtin University, Perth, WA, Australia (SW); Child and Adolescent Gender Center, University of California San Francisco, CA, USA (DE); Division of Child & Adolescent Psychiatry, University of Cape Town, South Africa (SP-T); Center of Sexology and Gender, University Hospital, Gent, Belgium (GDC); and Gender Therapist, San Diego, CA, USA (DT)

1 Drescher J, Cohen-Kettenis P, Reed G. Gender incongruence of childhood in the ICD-11: controversies, proposal and rationale. *Lancet Psychiatry* 2016; **3:** 297–304.
2 Olson K, Durwood L, DeMeules M, McLaughlin K. Mental health of transgender children who are supported in their identities. *Pediatrics* 2016; **137:** 1–8.
3 Riley EA, Sitharthan G, Clemson L, Diamond M. Recognising the needs of gender-variant children and their parents, *Sex Educ* 2013; **13:** 644–59.
4 Hill DB, Menvielle D, Sica KM, Johnson A. An affirming intervention for families with gender variant children: parental rating of child mental health and gender. *J Sex Mar Ther* 2010; **36:** 6–23.
5 Menvielle E. A comprehensive program for children with gender variant behaviors and gender identity disorders. *J Homosexual* 2012; **59:** 357–68.
6 Cochran SD, Drescher J, Kismödi E, et al. Proposed declassification of disease categories related to sexual orientation in ICD-11: Rationale and evidence from the Working Group on Sexual Disorders and Sexual Health. *B World Health Organ* 2014; **92:** 672–79.

Removal of gender incongruence of childhood diagnostic category: a human rights perspective

We appreciate this opportunity to engage in the debate opened by the Personal View by Jack Drescher and colleagues, published in *The Lancet Psychiatry* (March, 2016).[1]

The authors of this Personal View state, "access to treatment for any health condition, with few exceptions, requires a diagnosis", and "children with gender incongruence need access to care that (…) is often complex and involves interventions involving families and social environments".[1] As repeatedly assessed by experts in the field,[2] gender-diverse children in supportive environments experience positive mental health. Health-care for gender-diverse children and their parents, if required, consists of provision of information, support, and counselling, and therefore there is no need to ensure access to surgical procedures or hormonal treatments. The ICD already ensures coverage of psychological support: through its chapter on factors influencing health status and contact with health services (Z codes). Otherwise, children's depression, anxiety, and distress associated with experiences of discrimination related to their gender identity and expression can be perfectly covered by existing mental health codes.

Affirming that a diagnosis of gender incongruence of childhood is necessary to provide access to the aforementioned care is a very dangerous argument. It could easily contribute to pathologising the manifestation of certain sexual orientations in childhood, which could require the same kind of professional involvement with "families and social environments" as that stated in the Personal View. Furthermore, this affirmation not only creates a double standard for gender expression or identity and for sexual orientation, but also contradicts WHO positions on homosexuality and on the deletion of F66 categories for ICD3.

The authors also state that stigma has been the key argument against the introduction of the diagnosis of gender incongruence of childhood. As human rights defenders, we advocate against all forms of violence, stigma, and discrimination associated with mental health diagnoses, including those applied to gender-diverse children. Conversely, our critique to the diagnosis is grounded on the negative human rights impact of pathologising gender diversity in childhood, for instance, by justifying atavistic so-called treatments (such as conversion therapies). Moreover, diagnosing gender-diverse children just because of who they are and how they express themselves reinforces and institutionalises cisexism and transphobia in psycho-medical settings—and in society as a whole.[4] As the authors rightly note, no agreements have been reached on this long controversy; considering that lack of agreement, taking into account those negative consequences, and applying the bioethical principle of beneficence, it is clear to us that gender incongruence of childhood should be excluded from ICD-11.

As expressed in previous interventions, we maintain that access to transitional health care must be granted on human rights standards, and we call health providers and researchers to join our struggle against the naturalisation of corporative

For the **Global Action for Trans* Equality proposal** see http://globaltransaction.files.wordpress.com/2012/03/critique-and-alternative-proposal-to-the-_gender-incongruence-of-childhood_-category-in-icd-11.pdf

For the **GATE, Global Action for Trans* Equality proposal** see http://globaltransaction.files.wordpress.com/2012/03/critique-and-alternative-proposal-to-the-_gender-incongruence-of-childhood_-category-in-icd-11.pdf