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To cite this article: Jack Drescher, Peggy Cohen-Kettenis & Sam Winter (2012) Minding the body: Situating gender identity diagnoses in the ICD-11, International Review of Psychiatry, 24:6, 568-577, DOI: [10.3109/09540261.2012.741575](https://doi.org/10.3109/09540261.2012.741575)

To link to this article: <https://doi.org/10.3109/09540261.2012.741575>

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 Published online: 18 Dec 2012.

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Minding the body: Situating gender identity diagnoses in the ICD-11

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Abstract

The World Health Organization (WHO) is in the process of revising the *International Statistical Classification of Diseases and Related Health Problems* (ICD) and ICD-11 has an anticipated publication date of 2015. The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) is charged with evaluating clinical and research data to inform the revision of diagnostic categories related to sexuality and gender identity that are currently included in the mental and behavioural disorders chapter of ICD-10, and making initial recommendations regarding whether and how these categories should be represented in the ICD-11. The diagnostic classification of disorders related to (trans)gender identity is an area long characterized by lack of knowledge, misconceptions and controversy. The placement of these categories has shifted over time within both the ICD and the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), reflecting developing views about what to call these diagnoses, what they mean and where to place them. This article reviews several controversies generated by gender identity diagnoses in recent years. In both the ICD-11 and DSM-5 development processes, one challenge has been to find a balance between concerns related to the stigmatization of mental disorders and the need for diagnostic categories that facilitate access to healthcare. In this connection, this article discusses several human rights issues related to gender identity diagnoses, and explores the question of whether affected populations are best served by placement of these categories within the mental disorders section of the classification. The combined stigmatization of being transgender and of having a mental disorder diagnosis creates a doubly burdensome situation for this group, which may contribute adversely to health status and to the attainment and enjoyment of human rights. The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health believes it is now appropriate to abandon a psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services.

Introduction

The World Health Organization (WHO) is in the process of revising the *International Classification of Diseases* (ICD-10, WHO, 1992) and the ICD-11 has an anticipated publication date of 2015. The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) is one component of this effort, whose charge includes reviewing and evaluating clinical and research data informing gender identity diagnoses since the publication of the ICD-10 in 1992. The authors of this paper, members of the WGSDSH, here summarize and present their review's findings and recommendations for the placement of gender identity diagnoses in the ICD-11. Supplementary Appendix 1 to be found online at <http://informahealthcare.com/doi/abs/10.3109/09540261.2012.741575> is a glossary of contemporary clinical and lay terms that the reader will

find relevant to understanding discussions of this patient population.

History of diagnostic classification of gender identity

Psychiatric and medical theorizing about transsexualism and transgender phenomena began in the Western world in the 19th century. Until the middle of the 20th century, with rare exceptions, transgender presentations were usually classified as psychopathological. Krafft-Ebing (1886), a psychiatrist, took this view, and documented cases of individuals who desired to live as members of the other sex and of individuals who had been born to one sex and were already living as members of the other. Historically, theories of sexuality conflated transgenderism with homosexuality. Hirschfeld (1923), also a psychiatrist, is credited with being the first

person to distinguish the desires of homosexuality (to have partners of the same sex) from those of transsexualism (to live as the other sex). These distinctions, however, were not broadly accepted by practitioners until decades later as a result of the work of Benjamin (1966), Money (1994), Stoller (1964) and Green (1974).

While physicians in Europe had begun performing sex reassignment surgery (SRS) as early as the 1920s, transsexualism and SRS entered the wider world's popular imagination when the US media sensationally reported of George Jorgensen going to Denmark as a natal man and returning to the USA in 1952 as a trans woman with a new body and a new name, Christine Jorgensen (Jorgensen, 1967). Shortly thereafter, the Danish physicians who participated in Jorgensen's SRS published a report of her medical and surgical treatment in the *Journal of the American Medical Association* (Hamburger et al., 1953).

The publicity surrounding Jorgensen's transition eventually led to greater popular, medical, and psychiatric awareness of the concepts of gender identity, and later of experienced gender, as well as recognition of an increasing number of people wishing to 'cross over' from their birth-assigned sex to another. Increased public discussions of sex reassignment and gender identity would provide those who would eventually come to identify as transsexual or transgender with a model, a category and a name for their feelings and desires (Denny, 2002). In time, what was once considered an exceedingly rare condition gradually became more publicly visible and in recent years an increasing number of nations, provinces and municipalities have enacted civil and human rights laws prohibiting discrimination based on gender identity in addition to other characteristics such as race, ethnicity, age, sex, and sexual orientation.

At the time of Jorgensen's 1950s SRS and for several decades afterwards, many mental health practitioners remained critical of sex reassignment as a treatment for gender incongruent individuals (Socarides, 1969; Hertoft & Sørensen, 1978; McHugh, 1992). As the Working Group on Sexual Disorders and Sexual Health is recommending a name change from 'transsexualism' to 'gender incongruence', when appropriate that is the term used in this paper.

As much psychiatric theorizing of that time still conflated sexual orientation and gender identity, many physicians and psychiatrists criticized using surgery and hormones to irreversibly – and in their view incorrectly – treat people suffering from what they perceived to be either a severe neurotic or a psychotic, delusional condition in need of psychotherapy and 'reality testing'. For example, the mainstream US view of the time was captured in a 1960s survey of 400 physicians that included psychiatrists,

urologists, gynaecologists, and general medical practitioners asked to give their professional opinions about what to do in the case of an individual seeking SRS that read as follows:

Since early childhood, this 30-year-old biological male has been very effeminate in his mannerisms, interests, and daydreams. His sexual desires have always been directed toward other males. He would like to be able to dress exclusively in woman's clothes. This person feels inwardly and insists to the world that he is a female trapped in a male body. He is convinced that he can only be happy if he is operated on to make his body look like that of a woman. Specifically, he requests the removal of both testes, his penis, and the creation of an artificial vagina (all of which can, in fact, be done surgically). He also requests that his breasts be made to appear like a woman's, either surgically or by the use of hormones (this, too, is medically possible). (Green, 1969, p. 236)

Green summarized the survey's findings as follows:

Eight percent [8%] of the respondents considered the transsexual 'severely neurotic' and fifteen percent [15%] considered the person 'psychotic.' The majority of the responding physicians were opposed to the transsexual's request for sex reassignment even when the patient was judged nonpsychotic by a psychiatrist, had undergone two years of psychotherapy, had convinced the treating psychiatrist of the indications for surgery, and would probably commit suicide if denied sex reassignment. Physicians were opposed to the procedure because of legal, professional, and moral and/or religious reasons. In contrast to the conservatism with which granting of sex-reassignment procedures was viewed, there was a paradoxical liberalism in the approach to these patients should they already have been successful in obtaining their surgery elsewhere. Among the respondents, three quarters [75%] were willing to allow the postoperative patient to change legal papers such as a birth certificate and to marry in the new gender, and one-half [50%] would allow the person to adopt a child as a parent in the new gender. (pp. 241–242)

Yet once-prevailing views that reject the aim of supporting transition are no longer part of the mainstream of either psychiatric or general medical thought and practice. In the 21st century, international expert guidelines support transition in carefully evaluated individuals (WPATH, 2011), although the healthcare systems in only a minority of countries around the world now cover the medical services

needed for sex reassignment (Kreukels et al., 2012; Yogyakarta Principles, 2007).

History of diagnostic placement

The placement of diagnostic categories related to gender identity has shifted over time within both the ICD and DSM classification systems. ICD-6, approved in 1948, was the first version of the ICD published by the WHO, the first version of ICD to include a classification of morbidity, and finally the first version that included a classification of mental disorders. Prior to ICD-6 and the founding of the WHO, ICD was exclusively a mortality classification. Mental disorders in general and sexual disorders in particular were not considered to be causes of mortality, so they were not included in these classifications.

In ICD-6 (1948), there is no reference to the diagnosis of transsexualism; nor does it appear in ICD-7 (1955). By way of contrast, and, as previously noted, sexual orientation and gender identity were often conflated at that time, and a diagnosis called homosexuality does appear in ICD-6 and ICD-7 as an inclusion term (that is, as an example) for the diagnostic category sexual deviation (320.6), which is further classified as a pathologic personality under the supra category of disorders of character, behaviour, and intelligence (320). Homosexuality was included as a separate diagnostic category in ICD-8, which was maintained in ICD-9 but removed from ICD-10 and replaced by egodystonic sexual orientation (F66.1) (Drescher, 2010).

The ICD-8 (1965), reflecting changing clinical and theoretical views, separated sexual deviations (302) from personality disorders (301). The sexual deviations still included homosexuality (302.0), but introduced the diagnosis of transvestitism (302.3) for the first time. Definitions of diagnostic categories were not provided in ICD-8, so the intended

meaning of transvestitism is not entirely clear. Historically, however, as exemplified in the report of Jorgensen's reassignment (Hamburger et al., 1953), the alternative spelling of transvestism was often used as an early synonym for what later came to be known as transsexualism.

Further change occurred in the ICD-9 (1975), where transvestitism was replaced by transvestism (302.3). It was defined as a 'Sexual deviation in which sexual pleasure is derived from dressing in clothes of the opposite sex. There is no consistent attempt to take on the identity or behaviour of the opposite sex.' While still in the sexual deviations category, there was now a separate and exclusionary diagnosis for a newly added diagnosis of transsexualism [sic] (302.5). Again, it is reasonable to assume that this new separation was made to accommodate a growing body of research about clinical presentations and treatment of transsexualism in the previous two decades. Ironically, research since that time suggests that the line then drawn between transvestitism and some cases of transsexualism is not as sharp as once believed (Blanchard, 1985; Lawrence, 2004).

The ICD-10 (1990) saw a significant reorganization of the classification system and some new gender identity diagnoses that reflected a growing body of clinical experience and research. Under 'disorders of adult behaviour and personality' appeared a new category of gender identity disorders (F64) which includes five diagnoses: transsexualism (F64.0), dual-role transvestism (F64.1), gender identity disorder of childhood (F64.2), other gender identity disorders (F64.3), and gender identity disorder, unspecified (F64.4).

Table 1 summarizes the placements of gender identity diagnoses in the ICD.

In a similar, if not entirely parallel manner, gender identity diagnoses underwent category migration and renaming in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (DSM). That history also reflects the shifting views about what to call the diagnosis, what it means and where to place

Table 1. Gender identity diagnoses in the ICD.

Edition	Parent category	Diagnosis name	Code
ICD-6 (1948)	N/A	N/A	N/A
ICD-7 (1955)	N/A	N/A	N/A
ICD-8 (1965)	Sexual deviations	Transvestitism	302.3
ICD-9 (1975)	Sexual deviations	Transvestism	302.3
		Trans-sexualism	302.5
ICD-10 (1990)	Gender identity disorders	Transsexualism	F64.0
		Dual-role transvestism	F64.1
		Gender identity disorder of childhood	F64.2
		Other gender identity disorders	F64.3
		Gender identity disorder, unspecified	F64.4
ICD-11 (2015) ?		Gender incongruence of adolescents and adults	?
		Gender incongruence of children (proposed)	?

it over time. As in ICD-6, -7 and -8, no mention of the diagnosis was made in either the DSM-I or II (1952, 1968). However, as in ICD-8, which preceded it by three years, DSM-II included a diagnosis of transvestitism under sexual deviations. Like ICD, it offered no description or diagnostic criteria. In 1980, a revamped DSM-III abandoned the psychodynamic theorizing of the first two manuals and adopted a neo-Kraepelian, descriptive, symptom-based framework drawing upon contemporary research findings. Zucker and Spitzer (2005) describe the environment leading to gender identity diagnoses being included in the DSM-III, and which may also have been influential for the ICD:

During the 1960s, North American psychiatry had begun to take a look at the phenomenon of transsexualism in adults (see, for example, Green & Money, 1969; Stoller, 1968). It became apparent that psychiatrists and other mental-health professionals had become increasingly aware of the phenomenon, that is, of adult patients reporting substantial distress about their gender identity and seeking treatment for it, typically hormonal and surgical sex-reassignment. Indeed, there were enough observed cases that it was possible in the 1960s to establish the first university- and hospital-based gender identity clinics for adults. Many clinicians and researchers were writing about transsexualism, and by 1980, there was a large enough database to support its uniqueness as a clinical entity and a great deal of empirical research that examined its phenomenology, natural history, psychologic and biologic correlates, and so forth. Thus, by the time DSM-III was in its planning phase in the mid-1970s, there were sufficient clinical data available to describe the phenomenon, to propose diagnostic criteria, and so on (p. 37).

Zucker and Spitzer (2005) also summarize the vicissitudes of the current gender identity diagnoses from DSM-III through DSM-IV-TR.

In the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (1980), there appeared for the first time two psychiatric diagnoses pertaining to gender dysphoria in children, adolescents, and adults: gender identity disorder of childhood (GIDC) and transsexualism (the latter was to be used for adolescents and adults). In the DSM-III-R (1987), a third diagnosis was added: gender identity disorder of adolescence and adulthood, nontranssexual type. In DSM-IV (1994, and DSM-IV-TR, 2000), this last diagnosis was eliminated ('sunsetted'), and the diagnoses of

GIDC and transsexualism were collapsed into one overarching diagnosis, gender identity disorder (GID), with different criteria sets for children versus adolescents and adults. (p. 32)

It should be further added that in addition to name changes, the diagnostic category migrated within DSM chapters. In DSM-III (1980), both transsexualism and GIDC are listed among the psychosexual disorders. In DSM-III-R (1987), both are moved to a category of disorders usually first evident in infancy, childhood or adolescence. In DSM-IV (1994) and DSM-IV-TR (2000), they are moved again to a new parent category, sexual and gender identity disorders, and transsexualism is renamed gender identity disorder in adolescents or adults. It is then clustered with the paraphilias and sexual dysfunctions. The proposals of the DSM-5 Workgroup on Sexual and Gender Identity Disorders for the DSM-5 are (1) to have one overarching diagnosis, gender dysphoria (GD); (2) to have GD include separate, developmentally appropriate criteria sets for children (gender dysphoria in children) and another for adolescents and adults (gender dysphoria in adolescents and adults; and (3) to move GD into a separate grouping from sexual dysfunctions and paraphilias. The proposed DSM-5 revisions of this category are available on line at <http://www.dsm5.org/ProposedRevision/Pages/GenderDysphoria.aspx>. Also see Cohen Kettenis & Pfäfflin (2010), Drescher (2010), Meyer-Bahlburg (2010) and Zucker (2010).

Table 2 summarizes the placements of gender identity diagnoses in the DSM.

Controversies

Gender identity diagnoses have generated several controversies in recent years that initially flared up with the formal announcements by the American Psychiatric Association of the DSM-5 revision process (Carey, 2008). These recent controversies, however, are not primarily disagreements between mental health professionals but rather of differing perspectives of mental health professions and transgender advocacy groups and differences within the lesbian, gay, bisexual and transgender community (LGBT). For example, some groups have argued that it is wrong for psychiatrists and other mental health professionals to label variations of gender expression as symptoms of a mental disorder. Others decry as unscientific, unethical, and misguided the use of the gender identity diagnoses on children to justify clinical efforts aimed at getting them to reject their expressed gender identity and to accept the sex (and gender) they were assigned at birth. Still other advocacy groups raised concerns that removal of the

Table 2. Gender dysphoria in the DSM.

Edition	Parent category	Diagnosis name
DSM-I (1952)	N/A	N/A
DSM-II (1968)	Sexual deviations	Transvestitism
DSM-III (1980)	Psychosexual Disorders	Transsexualism Gender identity disorder of childhood
DSM-III-R (1987)	Disorders usually first evident in infancy, childhood or adolescence	Transsexualism Gender identity disorder of childhood Gender identity disorder of adolescence and adulthood, nontranssexual type
DSM-IV (1994)	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults Gender identity disorder in children
DSM-IV-TR (2000)	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults Gender identity disorder in children
DSM-5 (2013)	Gender dysphoria (Proposed)	Gender dysphoria in adolescents or adults Gender dysphoria in children (Proposed)

adolescent and adult gender identity diagnoses would lead not only to loss of private and public insurance coverage for necessary medical and surgical treatment, but also to the loss of a potent, successful argument in legal cases challenging denial of such coverage to transgender individuals. Consequently, in both the DSM-5 and ICD-11 revision processes, the professionals involved have tried to find a balance between the competing issues of stigma versus access to care (Drescher, 2010).

Human rights

The relationship between psychiatric diagnosis, stigma and human rights is sharply illustrated by the history of the removal of homosexuality per se from the DSM-II in 1973 (Bayer, 1987). In the aftermath of the APA decision, with psychiatry no longer officially participating in stigmatization, a historically unprecedented social acceptance of gay men and women gradually ensued across much of the world. In many countries and cultures, although not all, there was a change in cultural beliefs about homosexuality that culminated in the contemporary international quest of gay men and lesbians for human rights, including freedom from discrimination and marriage equality (Drescher, 2012).

The movement for transgender civil rights has followed more slowly and in the wake of the larger gay rights movement. By the late 1990s, trans inclusion had become a focus of LGBT rights groups and continues to this day. Consequently, the ICD-10 diagnosis of transsexualism is an issue about which the WHO has received substantial communication and interest from various stakeholders. Many advocates, several countries, the Council of Europe Commissioner for Human Rights (2009) and the European

Parliament (2011) have taken strong positions that issues related to transgender identity should not be classified as mental disorders in the ICD-11. For example, the European Parliament resolution ‘roundly condemns the fact that homosexuality, bisexuality and transsexuality are still regarded as mental illnesses by some countries, including within the EU, and calls on states to combat this; calls in particular for the depsychiatrisation of the transsexual, transgender, journey, for free choice of care providers, for changing identity to be simplified, and for costs to be met by social security schemes.’ The document goes on and ‘calls on the Commission and the World Health Organisation to withdraw gender identity disorders from the list of mental and behavioural disorders, and to ensure a non-pathologising reclassification in the negotiations on the 11th version of the International Classification of Diseases (ICD-11).’

The ICD Working Group on Sexual Disorders and Sexual Health also received proposals calling for depathologization and removal of transgender diagnoses from the mental disorders section of the classification from a number of civil societies and professional organizations. These included the Agnodice Foundation (Switzerland), Aktion Transsexualität und Menschenrecht (Germany), Global Action for Trans* Equality (GATE), LGBT Denmark, Société Française d’Etudes et de prise en Charge du Transsexualisme (SoFECT, France), and the World Professional Association for Transgender Health (WPATH) (Knudson et al., 2010). In a survey by the DSM-5 GID sub-work group of 201 organizations concerned with the welfare of transgender people from North America, Europe, Africa, Asia, Oceania, and Latin America, a majority of 55.8% believed the diagnosis should be removed from the DSM (which

is, of course, a classification consisting exclusively of mental disorders). The major reason for wanting to keep the diagnosis in the DSM was healthcare reimbursement. Regardless of whether groups were for or against the removal of the diagnosis from the mental disorders classification, the survey revealed a broad consensus that if the diagnosis remains in the DSM, there needs to be an overhaul of the name, criteria, and language to minimize stigmatization of transgender individuals (Vance et al., 2010). Clearly, there are widespread, international objections to the stigmatization that accompanies the designation in many cultures and countries of gender identity diagnoses as mental disorders.

While reducing the stigmatization of mental disorders is important, the argument to remove a diagnostic category from the mental disorders section of the ICD simply because mental disorders are stigmatized is neither compelling nor persuasive. Psychiatric illnesses, like ‘social deviance’, often create conflicts between individuals and society. Consequently both the psychiatrically ill and minority groups are subject to stigma. Stigmatization of individuals with psychiatric disorders is a social problem across cultures. The WHO, healthcare policy makers and mental health professionals are actively engaged in trying to reduce the stigma of mental disorders in order to increase access to care and to encourage people to avail themselves of mental health services (WHO, 2012). Further, there is a general consensus that mental disorders are health conditions, otherwise why would they be in the ICD? One unintended consequence of belabouring distinctions between medicine and psychiatry, and this is a wider problem beyond the scope of this working group, is the perpetuation of existing stigma and prejudices against the mentally ill (Drescher, 2010).

However, the combined stigmatization of being transgender and of having a mental disorder diagnosis creates a doubly burdensome situation for this population that contributes adversely to their health status as well as to their enjoyment and attainment of human rights. For example, transgender people are much more likely to be denied care in general medical or community-based settings given the perception that they must be treated by psychiatric specialists, even for conditions that have nothing to do with being transgender. Difficulty in obtaining transition-related services has also led some transgender people, out of desperation, to expose themselves to significant harm, including HIV infection, through the use of black or grey market hormones, sometimes injected, and thus creating a larger public health problem.

In addition, there are unique circumstances in the case of this particular diagnosis that relate to the ability of a person to be viewed as competent to make

certain legal decisions. Government agencies in many countries have demonstrated prejudice in extending recognition of change in legal gender status on identity documents such as passports and drivers’ licenses. Courts may often rule against transgender people in child custody decisions when their mental disorder diagnosis is used by an ex-spouse to call their competence as parents into question. These are some of the factors that contribute to persuasive human rights and WHO mission-related arguments for moving the category out of the mental disorders section. Given that the WHO’s mission is the attainment by all peoples of the highest possible level of health, the WHO must consider whether a policy that appears to be having adverse health (or human rights) consequences for an identifiable group is inconsistent with its mission.

Aetiology unknown and issues of placement

From a historical perspective, the classification of gender identity diagnoses as mental disorders was serendipitous. It appears to have been based more on prevailing social attitudes at the time that ICD-8 and ICD-9 were approved, respectively, in 1965 and 1975, than of available scientific evidence. For example, if one imagines that the social narrative at that time had been that transsexualism was related to a ‘hormone imbalance’ rather than being a ‘sexual deviation’, the result could very well have been that transsexualism would be placed in the ICD-10 chapter on endocrine, nutritional, and metabolic diseases today. In fact, the aetiology of the condition was unknown when placement decisions were made in the past and remains unknown now. There are no scientifically based criteria to differentiate normal and pathological gender identity, and the manner in which any gender identity develops remains unknown and a matter of theoretical speculation. The extant scientific database cannot empirically answer the question of whether this diagnosis is purely a mental disorder or a disorder with another physical cause. There are a growing number of studies that posit physical rather than mental causes of transgender presentations (e.g. Bentz et al., 2008; Berglund et al., 2008; Coolidge et al., 2002; Garcia-Falgueras & Swaab, 2008; Henningson et al., 2005; Herbert, 2008; Knafo et al., 2005; Kruijver et al., 2000; Rametti et al., 2011; Schöning et al., 2010; Zhou et al., 1995). Further complicating matters, the criteria of distress and impairment that is often required for mental disorders of unknown aetiology are not universally applicable, as there are individuals who today present for gender reassignment who may be neither distressed nor impaired. This may be particularly true for young adolescents who are aware of the possibility of gender transition, live in an accepting envi-

ronment, and who can have access to puberty suppressing treatments until they are able to take such a decision. Finally, given that the research since the mid 20th century has distinguished between sexual orientation and gender identity, the continued linkage of gender identity diagnoses with paraphilias and diagnoses of sexual dysfunction in the classification system appears to be both outdated and inappropriate.

In other words, while scientific knowledge and social attitudes have changed substantially in the nearly 40 years since ICD-9 was approved, this aspect of the classification has remained essentially the same. Further, based on the classification of gender incongruence as a mental disorder, as well as the need to distinguish it from other mental disorders, many countries require psychiatrists and other mental health professionals to act as gatekeepers to transition services for transgender people. In some countries, transgender people wishing to transition must prove to psychiatrists that they are the 'right' kind of transgender and that they have been so for a sufficiently long period of time in order to qualify for services. This has created some controversy, as many individuals seeking transition do not otherwise have a mental disorder or desire mental health treatment, and the gatekeeping function may be seen as an unnecessarily burdensome requirement. How the gatekeeping role is performed has contributed to considerable tension between mental health professionals and transgender advocacy groups in some countries. Further, this requirement may strain resources in countries that have few mental health professionals.

The gatekeeping role has also sometimes interfered with the positive contributions that mental health professionals can make to the transition process. Counselling and therapeutic approaches may be very important in helping an individual prepare for and cope with the personal and social effects of transition. In this regard, the role of mental health professionals is not fundamentally different from their participation as a part of assessment and treatment for individuals undergoing other complex, life-changing medical treatments such as organ transplantation.

None of the direct treatments prescribed for the condition today could be construed as conventional mental health treatments given that standard approaches today (hormonal, surgical, voice therapy, depilation) involve changing the body and social role rather than changing the individual's mind. There is no reason to expect that this approach will change in the foreseeable future. If gender identity diagnoses were moved out of the mental and behavioural disorders section of the classification, it may be difficult to justify a continued primary

gatekeeping role for mental health professionals in the context of transition services. While the Working Group believes that mental health professionals can play a constructive role in the assessment and treatment of many transgender people as a part of their transition process, it also believes that their involvement in treatment should be based on standards of care, clinical necessity, and health system policies, rather than artificially sustained by a mental disorders classification.

Placement options

In addition to recommending a name change to gender incongruence, the Working Group on Sexual Disorders and Sexual Health has strongly recommended that the diagnoses be removed from the ICD-11's section on mental and behavioural disorders. The recommendations for possible options regarding placement are listed in descending order of preference.

Entirely separate chapter

The revised categories for gender incongruence represent highly unique clinical challenges and merit placement in an entirely separate ICD chapter that would contain no other entities.

Proposed new chapter on sexual health and sexual disorders

A second possibility would be to create a new chapter in the ICD-11 for sexual disorders and sexual health. Such a placement might be advantageous over being placed in the chapter on mental and behavioural disorders but would revert to mischaracterizing gender identity as a sexual issue as mentioned above in earlier versions of the ICD. To repeat, this could be problematic for practitioners, given that the trend in sexual research over the last 70 years has been increasingly to separate the category of gender from that of sexuality. Such a chapter would have to be clearly marked as sexuality and gender, with the gender incongruence diagnoses going into their own subsection.

Medical diagnosis

Another option is to classify gender incongruence as a purely medical condition. In 2010, for example, France removed transsexualism from its mental disorder section and placed it in the category of *maladie rare*. Another alternative would be placing GI in either the endocrinological or genito-urinary sections. Such an approach solves the problem of GI being stigmatized as a mental disorder while still

allowing access to care. On the other hand, much of the healthcare accessed by this patient population is not directly related to endocrinology, although the case could be made that other health and mental health services required are indirectly related in many cases. A genito-urinary placement is also problematic since many people who might be diagnosed with GI do not seek or require such surgery. However, this is certainly not much different from the current situation in which much of the care offered to transgender individuals with a mental disorder diagnosis is not mental healthcare.

Z codes

Chapter XXI of the ICD-10 (Z codes) consists of factors influencing health status and contact with health services. An international meeting convened by Global Action for Trans* Equality and comprising individuals working (in some cases professionally) in the fields of transgender rights and health, suggested this placement as a part of a “starfish” diagnostic model involving a decentralised system of codes, located in several blocks and chapters, which could be used by and for transgender people to gain access to health care in various health care settings, although this model was not unanimously supported by those attending the meeting (Global Action for Trans* Equality, 2012). The use of a range of codes from different chapters, anchored and linked by one or more Z codes, may serve the purpose of depathologizing and destigmatizing gender incongruence. Others have expressed concern that placement of these codes in the chapter that lists “reasons for encounters,” rather than in a chapter that lists health conditions, could interfere with access to care, given that third party payers in many parts of the world rarely reimburse services offered in relation to these types of codes.

Removal

Removing the gender identity diagnoses from the ICD would entirely eliminate the psychiatric and medical stigmatization of transgender people, much as the removal of the diagnosis of homosexuality from the DSM-II in 1973 and a from the ICD-10 in 1990 were major factors in the social destigmatization of gay, lesbian and bisexual people (Drescher, 2010). On the other hand, not having any ICD diagnosis at all would undoubtedly prove to be a significant impediment for transgender people seeking access to medical treatment and is therefore not recommended.

Conclusion

The diagnostic classification of disorders related to transgender identity is an area long characterized

by lack of knowledge, misconceptions and controversy. This has been reflected in the constant shifts in placement and renaming of these diagnoses in various editions of the ICD and DSM. During the two decades since the publication of ICD-10, there have been gains in the clinical, scientific, social, and human rights understanding of transgender people. The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health believes it is now appropriate to abandon the psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services. The Working Group and WHO have heard from international bodies, national governments, professional organizations, and civil societies about the importance of making this change. While there are multiple points of view regarding how best to achieve this, there is a notable absence of defenders of the status quo.

The recommendations and options presented here represent the initial deliberations of the Working Group on the Classification of Sexual Disorders and Sexual Health, although none of the recommendations and options presented here have been formally approved by the advisory groups to which the working group reports or by the World Health Organization. The working group is publishing the results of its initial evaluation now in order to stimulate discussion and exchange regarding how the ICD-11 classification of conditions related to transgender identity can best fulfil the purposes and aims described above. The working group believes it is important that such discussion and debate start now, before its proposals are fully formulated, and that such exchanges should be an ongoing feature of the ICD revision. The working group’s proposals will undergo expert peer review, public review and comment, and ultimately field testing, in addition to a formal review and approval process within the WHO. The proposals will be modified based on the results of each of these steps, up until the approval of the ICD-11 by the World Health Assembly, envisioned for 2015. These recommendations and options therefore represent a starting point, and the working group anticipates a rich global exchange about how best to address problems of nosology in this area, demonstrate greater clinical utility in diverse settings, improve access to health services, and support the human rights of affected populations around the world.

Acknowledgements

The authors wish to thank Geoffrey Reed, Claudia Garcia-Moreno, Eszter Kismodi and Michael First for their feedback and insights.

Declaration of interest: The authors of this article are members of the WHO Working Group on Sexual Disorders and Sexual Health, reporting to the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders and the ICD-11 Genitourinary and Reproductive Medicine Topic Advisory Group. The views expressed in this article represent the views of the authors and, except as specifically indicated, do not represent the official positions of either of these advisory groups or of the World Health Organization. The authors alone are responsible for the content and writing of the paper.

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Supplementary material available online.

Supplementary Appendix 1.