



WPATH WORLD PROFESSIONAL
ASSOCIATION for
TRANSGENDER HEALTH

WPATH ICD-11 Consensus Meeting

WPATH CONSENSUS PROCESS

Regarding
TRANSGENDER and TRANSSEXUAL-RELATED DIAGNOSES in ICD-11

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Introduction

The World Health Organization (WHO), a specialized agency of the United Nations, is responsible for developing and disseminating the International Classification of Diseases (ICD), which is the standard set of definitions of diseases and health conditions used throughout most of the world. The edition presently in use is ICD-10¹, which was completed in 1990. ICD-9 was first published in 1975. The long intervals between editions may indicate the magnitude of the undertaking inherent in revising such an important and far-reaching international document. When a new edition is prepared, it must be ratified by representatives of 194 WHO Member States, comprising the World Health Assembly (WHA, the governing body of WHO), before it may be implemented globally.

The process of developing the ICD-11 began several years ago, and is now expected to run until late 2015. Because of its influence on global health policy and the structure and functioning of health care systems throughout the world, it is important to ensure that categories and descriptions of conditions are as accurate and clinically useful as possible. The process that the WHO staff engages in to prepare a new draft is rigorous and evidence-based, and to the extent possible consensus-driven, in order to ensure that the final ratification process can proceed smoothly. Readers interested in the WHO process may learn more here: <http://www.who.int/classifications/icd/revision/en/index.html>

In 2011, the World Professional Association for Transgender Health (WPATH) President Dr. Lin Fraser appointed Drs. Griet De Cuypere and Gail Knudson to co-chair a committee composed of WPATH members charged with forming a consensus opinion about the clinical applicability and effectiveness of various diagnostic classifications in ICD-10 related to transgender identity and expression to provide commentary to the WHO as they prepared for the ICD-11 revision process. The record of the working process and consensus derived by the 2011 committee is archived with the WPATH office.

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In 2012, WPATH was approached by Dr. Geoffrey Reed of the WHO, requesting a more definitive proposal from WPATH concerning its recommended disposition of the diagnoses related to Transsexualism and Gender Identity Disorders, including feedback on the new proposed structure and content for these conditions.

To facilitate this work, WPATH reconvened its original ICD-11 committee of 11 physicians who had reviewed and commented on the ICD-10 content in 2011. To deepen the discussion, WPATH was fortunate to secure funding from an anonymous donor with supplemental support from the Open Society Foundation which enabled WPATH to invite additional participants from the global South and East, including trans activists, non-clinical experts in transgender health with medical systems expertise, and additional experts and clinicians, particularly those specialized in treating children. The full committee of 30 participants was comprised of these experts and the WPATH board of directors. This group convened in San Francisco for discussions held on February 3rd and 4th of 2013. The February 2013 meeting content, conclusions, and notation of ongoing efforts are the subject of this report. The meeting agenda is included in Appendix A, and biographies of the participants are provided in Appendix B of this report. Supplemental material, such as copies of invited digital presentations and papers that were delivered during the meeting, is presented in subsequent appendices. Copies of all materials are archived at the WPATH office.

Consensus at this meeting was based on voting by anonymous ballot following discussion of each issue, with a clear majority prevailing.

¹ In the U.S., a modification of ICD-9 remains the current edition; the U.S. Department of Health and Human Services has announced that implementation of a U.S. adaptation of ICD-10 will take effect on 1 October 2014.

WPATH ICD Discussion Meeting, February 3 & 4, 2013

AIM

The meeting was designed to facilitate debates and to achieve consensus on the following 4 topics:

1. Deletion of the ICD-10 F66 categories
2. Deletion of the ICD-10 F65 category Fetishistic Transvestism
3. Renaming the ICD-10 F64.0 category Gender Incongruence (GI) rather than Transsexualism
 - a. Name of the category
 - b. Moving Gender Incongruence from the Mental and Behavioural Disorders chapter and alternative placement options
4. Deletion or retention of the ICD-10 F64.2 category Gender Identity Disorder of Childhood

Note: the text of the relevant ICD-10 categories is included in Appendix C.

In addition, the topic of field studies for the proposed ICD-11 categories was to be discussed.

BACKGROUND

The mission of the WHO is the attainment, by all people, of the highest possible level of health. Health classifications are the core constitutional responsibility of the WHO, whose work is ratified by international treaty with 194 countries. These 194 WHO Member States agree to use ICD as their standard for collection and reporting of health information:

- To monitor epidemics/threats to public health/disease burden
- To identify vulnerable/at risk populations
- To define obligations of WHO Member States to provide free or subsidized health care to their populations
- To facilitate access to appropriate health care services
- To use as a basis for guidelines for care and standards of practice
- To facilitate research into more effective treatments

Evidence-based practice guidelines and Standards of Care are, by themselves, not part of the classification system but are often based on ICD categories. In the health systems of most countries, the diagnosis of an ICD health condition is required for access to health services that are used for those conditions (other than, for example, routine primary care of population-based services such as vaccinations). The classification of specific conditions and the ability to examine the global burden they create based on such classification is also very important in terms of driving research in those areas. One priority that has been defined by WHO for the current revision is a focus on *clinical utility*, particularly in low- and middle-income countries, where 85% of people on the planet reside. The integrity of the ICD also depends on lack of influence from the pharmaceutical industry.

WHO recognizes that questions that have been raised about the gender identity disorders in ICD-10 are in part based on objections to the stigmatization that accompanies the designation of a condition as a mental disorder in many countries and cultures. The WHO Department of Mental Health and Substance Abuse is committed to a variety of efforts to reduce the stigmatization of mental disorders. The conditions in the mental and behavioural disorders section are not meant to indicate that the people who experience them are 'crazy' but rather to assist in the identification of people who need treatment and to assist in the selection of appropriate services. However, WHO also recognizes that the current nexus of stigmatization of transgender people and mental disorders has created a doubly burdensome situation for this population and the best resolution will likely be to develop an appropriate category or categories in another section of the ICD. The best solution would almost certainly not be to remove the

condition from ICD entirely. The Parliament of the European Union, for example, has called on WHO to ensure a ‘non-pathologising reclassification’ in the ICD-11.

An added level of complexity is that children presenting as transgender raise an additional set of questions about what constitutes appropriate responses and treatment. For example, most cases of childhood gender dysphoria do not persist into adulthood, while a minority of individuals do go on to seek gender transition in adolescence and adulthood. WHO is also attempting to examine the appropriate classification of gender dysphoric child populations, and whether or not such classification is necessary in order to facilitate appropriate treatment.

WORKING GROUP ON THE CLASSIFICATION OF SEXUAL DISORDERS AND SEXUAL HEALTH AND INITIAL RECOMMENDATIONS

WHO believes that a broader base of scientific knowledge, more cultural understanding, and greater justification of clinical utility should be brought to bear in order to consider the appropriate classification of both transgender and sexual health issues in the ICD-11. To assist in the process of developing recommendations in these areas for ICD-11, the WHO Department of Mental Health and Substance Abuse and Department of Reproductive Health and Research appointed an international and multidisciplinary expert Working Group on the Classification of Sexual Disorders and Sexual Health that comprised 11 experts representing all WHO regions. The Working Group developed initial proposals related to sexual disorders and sexual health in the ICD-11 based on a review and evaluation of available scientific evidence, as well as clinical and policy information on use, clinical utility, and experience with relevant ICD-10 diagnostic categories within various health care systems and other settings.

After initial proposals for ICD-11 were developed, they underwent peer-review by 12 experts from all over the world. The Working Group’s proposals were overwhelmingly supported by peer reviewers. In addition to recommendations provided by WPATH, WHO has also received recommendations in this area from other organizations, including Global Action for Trans* Equality (GATE), the Agnodice Foundation (Switzerland), Aktion Transsexualität und Menschenrecht (Germany), the American Psychological Association (USA), LGBT Denmark, Revise F65 (Norway), and the Société Française d’Etudes et de prise en Charge du Transsexualisme (France). Relevant input was also provided by the government of several WHO Member States, the Council of Europe, and the European Parliament. All of this material was considered by the Working Group in the development of its proposals.

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The Working Group’s initial recommendations, which were reviewed at the meeting, include the following:

- A reconceptualization of ICD-10 category F64.0 Transsexualism as ‘Gender Incongruence of Adolescence and Adulthood’, characterized by ‘a marked and persistent incongruence between an individual’s experienced gender and the assigned sex’.
- A reconceptualization of ICD-10 category F64.2 Gender Identity Disorder of Childhood as ‘Gender Incongruence of Childhood’ characterized by ‘a marked incongruence between an individual’s experienced/expressed gender and the assigned sex in pre-pubertal children’.
- Deletion of the ICD-10 category of F64.1 Dual Role Transvestism.
- Moving the Gender Incongruence categories out of the ICD-11 chapter on Mental and Behavioural Disorders. There are various options for the placement of this category; the option with the broadest support across the ICD revision is to create a new chapter on conditions related to sexuality, of which Gender Incongruence would be a part.
- Elimination of many existing F65 categories, specifically those that involve consensual or solitary activity that is not distressing to the individual, including F65.1 Fetishistic Transvestism.
- Elimination of all existing categories under “Psychological and Behavioural Disorders associated with Sexual Development and Orientation” (F66), including F66.0 Sexual

Maturation Disorder; F66.1 Egodystonic Sexual Orientation, and F66.2 Sexual Relationship Disorder. ICD-10 indicates that all of these categories may be assigned based on sexual orientation or gender identity.

FIELD TESTING OF THE PROPOSALS

As a next step, WHO will subject the Working Group's initial recommendations to field testing in a variety of relevant health care settings in different WHO regions, particularly in low- and middle-income countries. The purpose of field testing is to assess:

- The acceptability of the proposals to health professionals and to the affected communities;
- The reliability and the coherence of the constructs;
- The global clinical utility of the proposed categories, definitions, and diagnostic guidelines;
- The validity of the categories as predictors of health care needs; and
- The usefulness of the categories in accessing health care services.

Based on the peer review process and comments received so far from professional groups and civil society, WHO has indicated that the greatest question about the above proposals concerns the need for a category of Gender Incongruence of Childhood. There appear to be different, valid perspectives on this issue. Therefore, the clinical utility and need for this category, as well as the potential consequences of its use, will be a particular focus of field testing. If such a category is retained in ICD-11, it will be placed in the same chapter as 'Gender Incongruence of Adolescence and Adulthood'.

The field tests will involve internet-based methodologies to assess acceptability and feasibility, and subsequently clinic-based methodologies to assess the use of the classification by health professionals and clients in real-life settings. Country based field tests will be conducted within a multi-stakeholder process including the involvement of academic institutions, government ministries with special attention to the ministry of health, civil society, professional associations and other relevant actors.

The field study process will also include review and analysis of legal and policy issues that affect the utilization of health services by the affected populations.

WHO has invited WPATH to collaborate actively in the field testing process.

Discussion of the Working Group Recommendations

The meeting focused on a discussion of 1) the Working Group proposal to delete the ICD-10 categories of Psychological and Behavioural Disorders associated with Sexual Development and Orientation (F66), 2) the Working Group proposal to delete the category F65.1, Fetishistic Transvestism; and 3) the proposed reconceptualization of Gender Identity Disorders and Gender Incongruence; and 4) the proposal to move the Gender Incongruence categories out of the ICD chapter on Mental and Behavioural disorders.

A summary of the issues raised and the final vote on each proposal is provided below. The voting group was composed of 30 participants, with one participant, Mauro Cabral of GATE, choosing not to vote on any of the questions because, as he stated, members of GATE do not believe diagnoses should be voted upon. His participation in discussion was welcomed and encouraged.

1) Psychological and Behavioural Disorders associated with Sexual Development and Orientation (ICD-10 F66)

After a short debate ², the group conducted a secret ballot on the question whether to remove or retain this diagnostic category in ICD-11.

Outcome: There was a unanimous decision (29/29) to delete all of the F66 diagnoses.

2) Fetishistic Transvestism (FT) (ICD-10 F65.1)

Two presentations (see Appendix D) summarized the following options:

1) For deletion of the diagnostic category:

Classifying Fetishistic Transvestism (FT) under the mental disorder section was described as originally thought to be a protective measure to prevent people who cross-dress from being sentenced to death in some countries. On the other hand, this diagnosis can be seen as adversely stigmatizing and discriminatory. To help to combat this stigma, the Swedish version of ICD-10 has declassified FT.

2) For retention of the diagnosis:

A counterpoint presentation described a diagnostic category of Fetishistic Transvestism strictly limited to patients with FT who meet defined clinical significance criteria, e.g., impairment in one or more important areas of functioning, significant distress, and/or engaging in high-risk behaviors likely to lead to negative consequences as a result of cross-dressing.

Discussion:

The participants debated the issue of how people who cross-dress and who have symptoms of depression, anxiety, sexual dysfunction, or other symptoms worthy of treatment would be classified. Suggestions included deleting the FT diagnostic category but using other diagnostic categories for treatment (e.g., symptom-based conditions like anxiety disorder, depressive disorder, or disorders of sexual functioning).

Anecdotal experience was discussed by participants with experience in this area. Although some participant clinicians do not use this diagnostic category, some clinicians have seen men who

² This debate was informed by an unpublished paper, supplied confidentially from WHO, entitled Rationale for F66 Deletion 2012 09 12.

are adversely affected by their obsession with cross-dressing. This form of transvestism is often sexually oriented, distressing to the client and/or to their partners, and sometimes negatively affecting their social relationships and functioning. One participant presented his personal clinical experience with men who cross-dressed in ways that involved substantial personal risk to their careers and to their safety, in the absence of distress, and therefore suggested that high-risk behaviors be considered as part of the clinical significance criteria, similar to the approach that has been taken in the past by the Diagnostic and Statistical Manual (DSM) system.

Other clinicians are convinced that this behavior is an Obsessive-Compulsive disorder, or an Impulse Control Disorder (with sexually motivated cross-dressing), although medication trials of antianxiety and antidepressant drugs have not supported this approach. Another diagnostic name that was suggested was Impulsive/Compulsive Sexual Behavior.

Some clinicians thought that the significant driver in cross-dressing is often gender dysphoria, and that there may be an overlap between the two conditions, especially after adolescence.

For FT, there are case reports of improvement in functioning with psychotherapy aimed at reductions in self-loathing, increasing self-esteem and self-acceptance, and reducing high-risk behaviors in those who meet criteria for FT or Transvestic Disorder.^{3 4} Despite support from some clinicians regarding the arguments for retention, the majority indicated that they felt the classification leads to more adverse discrimination and pathologization of cross-dressing.

Outcome of voting on the diagnostic category Fetishistic Transvestism: deletion - 23; retention - 4; abstention – 2 (29 votes).

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3) Transsexualism (ICD-10 F 64.0)

Proposed Name in ICD-II: “Gender Incongruence”

a. **Name:** If the category is moved from mental disorders to another chapter, the name is acceptable in the context of sexual medicine as it allows access to hormones. Some participants found the term “Incongruence” to be pathologizing because it implies norming around appearance; there was some concern that “incongruence” would be difficult to translate to other languages, implying more grotesque meanings. A new name was proposed: “gender/body divergence.” One participant who agreed that “incongruence” is pathologizing proposed “non-conforming”, and “discomfort” over “dysphoria” and “incongruence.” Participants are aware that additional suggestions for the name may come out of the field trials.

b. **Placement:** One of the proposed new chapters included sexual health and gender. Most participants liked the idea of being subsumed under sexual medicine categories, but some do not prefer that. A separate Gender chapter was suggested. Another solution discussed was to call the chapter “Sex and Gender Health.” Gender and sex are considered political issues at the UN. Different countries view sex and gender as more foreign or taboo than others, so reactions may be different. But we have to be cognizant of other pathologizing effects. Some participants want to be sure that we don’t conflate sex and gender. On the other hand, some participants felt that a chapter on sexual health will open up more opportunities for medical education and general public education on sexuality and gender issues. Some suggested merging with intersex issues, but this was not substantiated.

The clear reason for inclusion of a diagnosis anywhere is for coverage/reimbursement. Inclusion is also important with respect to legal issues, because backlash against trans

³ Brown G R: Cross-dressing men lead double lives. Menninger Letter, April, 1995.

⁴ Brown G R: Transvestism and Gender Identity Disorders. In Gabbard G (Ed.): Treatments of Psychiatric Disorders, Third Edition, APPI, Washington, D.C., Chapter 73, pages 2007-2067, 2001.

people is possible, and inclusion affords some sanction.

Outcome of voting on Placement of the diagnostic category Gender Incongruence in Adult and Adolescence: 27 remove from Mental Health Chapter, 1 retention, and 1 abstention.

Vote on renaming chapter:

- Gender Chapter: 9
- Sex and Gender Chapter: 19
- Abstention: 1

Vote on the name “gender incongruence”:

- OK with this term for this diagnostic category: 5
- Think this is the wrong term for this diagnostic category: 7
- Neutral: 15

Voting on alternate nomenclature:

- Prefer Gender/Body Divergence over Gender Incongruence: 13
- Gender/Body Divergence is about the same as Gender Incongruence: 8
- Reject Gender/Body Divergence: 2
- Prefer Gender/Body Discordance over Gender Incongruence: 1
- Prefer “Self-defined Gender Incongruence”: 0
- Prefer Gender Non-conformity over Gender Incongruence: 1

4) Gender Identity Disorder of Childhood (ICD-10 F64.2)

Proposed Name in ICD-11: “Gender Incongruence in Childhood”

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Several presentations (see Appendix E) summarized the following options:

a. For deletion of the diagnostic category

Gender variance in childhood is normal. Risks of a GI-Childhood diagnosis include: Stigmatizing children with a diagnostic label when there is no disorder⁵; diagnosis can become iatrogenic, instilling a sense in the child that “there is something wrong with me”; and a poor predictive value – 80% of children diagnosed with GID do not continue to have GID of adolescence or adulthood. One presenter suggested moving to a narrative approach for historical preservation and also emphasized the unethical position around reparative therapy. This presenter proposed using Z codes with a ‘g’ modifier for gender diversity, and advocated that we educate carriers to reimburse Z codes (Z codes are rarely reimbursed). Another presenter argued that childhood diagnoses should be removed because their existence undermines the removal of adult & adolescent diagnostic category from mental health chapter. This presenter gave many suggestions for Z codes.

b. For retention of the diagnostic category

Two presenters made a strong argument that without the diagnostic category there would be no justifiable basis for children with gender dysphoria to obtain medical or mental health services. A diagnosis may give the child a “protected status” (i.e., non-discrimination, accommodations in school). There is also a case for professional training (more competence is needed among providers) and research.

⁵ Langer, S., and Martin, J. (2004). “How dresses can make you mentally ill: Examining gender identity disorder in children.” *Child and Adolescent Social Work Journal*, 21:5-23.

According to this presenter, the ICD's purpose is not a classification system intended to "label" or "stigmatize," but the system has the opposite goal, namely to empower, emancipate, and professionalize the care that is available.

If a childhood diagnostic category were retained, it should only apply to those with a desire to be of the other gender or an insistence that he or she is of the other gender in order to not include children with 'normal' gender non-conforming or gender variant behavior, but only those children with an experienced gender incongruent with their assigned gender.

Discussion:

Some of the participants find treating gender dysphoria in childhood quite an alarming field because so little is known about it, and the parallels to homosexuality are so strong. Providers in low- and middle-income countries do not have the luxury of doing cartwheels around diagnostic categories: they must code using highly stigmatized nomenclature. Dr. Reed stated that the absence of data is alarming and vexing. We need to know these data in order to make a diagnosis: how can we do studies to validate anything about it? One participant remarks that there is a lot of research on LGB people, yet they are not classified in the ICD, implying that the argument for inclusion to drive needed research is disingenuous. One participant argued for a diagnosis that is labeled as a variation of normal development. Gay children receive treatment under alternate codes such as anxiety disorder, depression, etc. In research about messaging on gender variance, the word that comes up most often is "normal"; "normal variance, short stature" as an example; i.e., normal variant, gender development.

All participants are in agreement that these children and their families need support. Children often come to clinic at age of 7 and are assessed, etc., even though they cannot start hormone therapy until Tanner Stage 2, which may be a few years away, but a code is still needed to access these services.

As proposed by the Working Group, this category is considerably narrower than ICD-10 or DSM-IV or DSM-5, so it particularly applies only to those children who may be more likely to be persisting in their gender incongruence in adolescence and adulthood, etc. One participant noted there is no need for child diagnosis, and suggested changing the wording in Adult & Adolescent category to indicate eligibility does not depend on age, but on impending puberty, thus allowing treatment when it is needed without a childhood diagnostic category.

Outcome of vote regarding diagnostic category of Gender Incongruence in Childhood: Removal: 14, Retention: 14, one voting member was absent, having stepped out of the room; therefore there was no consensus on this discussion item.

Discussion regarding Field Trials, February 4, 2013

Proposals for content for ICD-11 will be finalized by WHO staff and posted on their ICD-11 beta platform for public review and comment. WHO staff will review the comments and consider modifications to proposals. Meanwhile, proposals will be field tested in 2013-2014, and will be modified based on results of the field studies. Identifying important questions and appropriate methodologies for field testing is even more important as an outcome of this meeting than a unified WPATH position on every issue. Field tests will be done via the internet and in selected clinics.

Internet-based studies discussion

WPATH can help by providing contact info for people who are experts in transgender care. WPATH & possibly WAS participants could have a separate registration to focus their expertise. Languages could be English, Spanish; French, etc. (maybe Russian, other languages possible—we must indicate priorities).

WPATH can help with recruiting the participants. Walter Bockting, Sam Winter, Randi Ettner, Christine Burns, Gail Knudson, Walter Bouman, Walter Meyer, Annelou De Vries, Edgardo Menvielle, Griet De Cuypere, and Ira Haraldsen will work on survey design. With respect to responses, Kevan will liaise with Gail regarding World Association for Sexual Health (WAS) participation. Cecilia Dhejne said she felt many people working in trans care in Sweden would be interested in participating, and she would encourage them to do so. WPATH can look at the registration server, notify members, and encourage them to sign in.

Concerning the design of the surveys, what are the most important things to ask the participants (our members); what are the most important aspects of their practice/diagnoses. E.g., what do you do with a set of parents who are upset about their gender-nonconforming child (vignettes)? Do you use the code or not? How do you parse the elements of the interaction *vis a vis* the codes?

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What questions would we like to ask? What terminology would people prefer? Are multiple choice questions appropriate? Using vignettes, how accurately are respondents able to make diagnoses (program can tell how long it takes, how many clicks, etc.)? Draft survey should be ready by the 1st of April 2013. Protocols for field studies about childhood gender, the policy environment in which the codes are operating, what effects are resulting from use of the new codes, etc.? October 2014 is the target completion date for the full ICD-11.

Clinic-based trials discussion

Available WHO resources are extremely limited, and can be used only to fund field studies in low- and middle-income countries. WHO plans to fund clinic-based trials in Mexico, South Africa, India, Lebanon, and Brazil. If clinics in the U.S., Canada, or Europe wish to participate in the trials, they will have to be self-funded, or secure other sources of funding to support their efforts. There was discussion about U.S. clinics that might be encouraged to try to participate in clinical trials.

With respect to both internet-based and clinic-based trials, there was discussion concerning questions about the diagnoses, and concerns about participants. These items were:

- What are the main predictors for persistence: persistence is higher in girls, and they present for treatment at age higher (the older they are when first presenting for treatment, the more likely they are to remain trans), insistence on being the other gender was predictive, but there is no 100% guarantee, while desire to be the other gender was not predictive of the outcome (they may be gender-normative, gay, or trans in adulthood). One participant noted that treatment is for the family, not the child;

- What is the pathway back for those early social transitioners should they wish to return to living as their birth sex?
- Do patients/families feel stigmatized by the diagnostic category? In more repressive countries, the diagnosis confers validation. Venezuela, for example, does not have children as patients for this, and ICD inclusion will help treatment progress. People are relieved to have a name for this condition, though not necessarily a mental health or other pathologizing diagnosis.
- Endocrinologists and pediatricians should also be surveyed/recruited to participate in field testing.

Breakout Discussions

In three small groups, participants concurrently discussed:

1. Revising the childhood diagnostic criteria (this group was led by Dr. Jamison Green)

This group elected to develop a proposal with the alternate nomenclature “Gender/Body Divergence of Childhood” to the content form for F64.2 Gender Identity Disorder in Children. In summary, the relevant changes were the definition and diagnostic guidelines:

Gender/Body Divergence of Childhood is characterized by a marked inconsistency between an individual’s experienced/expressed gender and the assigned sex in pre-pubertal children. **In pre-pubertal children, a marked divergence between the child’s experienced/expressed gender and the child’s assigned sex as manifested by:**

- **Either a) or b), which must have been expressed persistently by the child, and not just on isolated occasions or inferred by the parents from the child’s behaviour:**
 - a) A strong desire on the child’s part to be a different gender than the assigned sex, or insistence that he or she is a gender different from one’s assigned gender.
 - b) 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. For example, a child assigned at birth as a boy says he wants to be rid of his penis or a child assigned at birth as a girl says she does not want to develop breasts when she grows up.
- **Preference for social roles, clothing, make-believe or fantasy play, toys, games, or activities and playmates that are typical of their experienced rather than their assigned sex.**
- **The divergence must have persisted for about 2 years.**
- **The diagnosis can only be assigned to children before puberty (Tanner Stage II).**

The relatively high threshold created by these diagnostic requirements is intended to avoid inclusion of children who only show gender variant behaviors and interests, even when these children experience distress resulting from negative attitudes towards the gender variance. Gender variant behavior and preferences alone are not sufficient for making a diagnostic category of **Gender/Body Divergence of Childhood**.

Although some indications of **Gender/Body Divergence of Childhood** may be present when children are as young as age 2, it is not possible to perform an accurate assessment of **Gender/Body Divergence of Childhood** at this age. The requirement of the duration of about 2 years implies that the diagnosis cannot be made before approximately age 5.

Gender/Body Divergence of Childhood may be associated with clinically significant distress or impairment in social, school, or other important areas of functioning, particularly in disapproving social environments, but neither distress nor functional impairment is a diagnostic requirement.

2. Revising the adolescent/adult diagnostic criteria (this group was led by Dr. Dan Karasic)

This group elected to revise the F64.0 Transsexualism content form to reflect a name change to Gender Incongruence of Adolescence and Adulthood or Gender/Body Divergence. In addition, there was interest in having an exit clause (Post-transition). In the Definition, there was a preference for using gender identity rather than experienced gender. Also, most of the participants thought 6 months, rather than several months, was more definitive, but also wished to explicitly state “by history,” not 6 months after initial evaluation, in accordance with the accompanying text on avoiding delay of treatment. Overall, there was agreement with the tone and most of the details of the diagnostic category descriptive text.

3. Brainstorming research questions (this group was led by Dr. Walter Bockting)

I. Research Questions—General

- a. Cultural Context (e.g., implications of trajectories, access to care)
This refers to cultural differences in both the trajectory of transgender identity development and expression (or “coming out” process), as well as differences in the environment (e.g., resources and access to care). For example, research by Nuttbrock and colleagues has shown ethnic/racial as well as generational differences in self-identification, gender expression, and coming out, as well as access to care. Such differences could be even larger on a global level. Thus, how well will diagnoses and diagnostic criteria generalize across diversity in transgender identity and expression, as well as across different cultural contexts?
- b. Diagnostic vs. Descriptive terms of identities or services
Is there a need for a diagnosis? Some people in the workgroup argued for simply working with people’s expressed need for services, rather than having to arrive at a particular diagnosis first. So, if someone asks for hormones or needs help with family acceptance, why do we first need to put a label on the person, rather than simply record the request or need for services and respond to this?
- c. Stigma attached to diagnosis
To what extent (and this could vary by cultural context) is the newly proposed diagnostic category stigmatizing? Does the ability to diagnose through ICD, either for the individual or for the environment, add stigma or reduce it?
- d. Diagnosis vs. taxonomy
This is similar to b. above. Taxonomy is more descriptive; diagnosis implies more of a syndrome or pathology.
- e. What is a “good” outcome
What is the goal? For example, reduce incongruence, or accept and celebrate it?
- f. Validity and reliability of diagnoses
This is explained in WHO ICD general protocol research questions.
- g. Spectrum
Does the diagnosis cover it? Does the diagnostic category capture the wide spectrum of gender identities and expressions?
- h. Reimbursement / access to care implications.
Implications of the change in diagnostic categories to ICD-11 for health care coverage and related access to care.

- i. Placement
How does placement outside of the mental health section affect utility and access to care?

II. Child-Specific

- a. Predict persistence
Does the diagnostic category help predict persistence/desistence?
- b. Understand desistence – options about ambivalence
Desistence seems a general catch-all category, and could mean different things for different people/circumstances. Will the diagnostic category illuminate this? Or, how can we better understand the reasons/motivations/nature of desistence?
- c. Compare clinicians diagnostic perceptions vs. parents' and also vs. child's
Assess perceptions of the different parties involved in the diagnostic process, and how these might differ.
- d. Specificity / Severity – how does the diagnosis capture this?
Specificity is about the nature or type of presenting concern, severity is about the degree of, and the level of distress. These might be very important for care decisions and evaluation.
- e. Clinician doubts
How certain is the clinician of the classification/assessment of the various criteria, particularly given that a child might be indirect in expression or that the child's responses may be affected by stigma and by parental (or other people's) influences, or given that the child's gender identity and expression are in development and may be in flux?
- f. Is a diagnostic category necessary to provide care?
See b. above, under the General Questions.
- g. What are the parents' attitudes: how does this impact the application of diagnosis?
See under e. above; more specifically, how do parents' attitudes about gender ambiguity and nonconformity affect diagnosis and treatment, e.g., indication for puberty-delaying hormones? This includes issues of tolerating uncertainty.
- h. Satisfaction with process of assessment.
How is the diagnostic process perceived by the child and family? Also: how is it perceived by the clinicians and others in the clinic setting?

See also, Appendix F: Suggested Additions to the Online Survey Instrument, for additional material developed subsequent to this meeting.

What can WPATH do on its own, apart from the ICD context?

- Plan to discuss whether there should be an alternative diagnostic category for FT for the small number of patients/clients that still need intervention.
- Consider whether there are alternatives to “retention” and “deletion.”
- Could we create guidelines for parents, schools, etc., to help people understand gender variance?
- Dissatisfaction with the terminology: Consider what WPATH can do to constructively further the discussion. Consider how these terms feel or operate in non-English language contexts.
- There is clearly a need for distribution of “Best Practices” in cross-cultural contexts, and legal contexts (i.e., policy-related, e.g., age of access to care).
- Expand upon the role of WPATH in relation to WHO by obtaining consultative status. WPATH is requesting the application forms.

Conclusion

In summary, our consensus points were:

- All F66 diagnoses should be removed.
- F65.1, Fetishistic Transvestism, should be removed, but provision for clinical management should be retained under some other diagnostic category that is less stigmatizing.
- Gender Incongruence of Adolescence and Adulthood, should be removed from the Mental Health Chapter.
- Gender/Body Divergence nomenclature was somewhat preferred over Gender Incongruence, although there was general consensus in favor of the term Gender Incongruence, especially if the diagnostic category is removed from the Mental Health chapter.

We were evenly divided over whether the category Gender Incongruence in Childhood should be removed or retained, but we all agreed that children with Gender Incongruence—or Gender/Body Divergence, or Gender Dysphoria—and their families, need support, regardless of the nomenclature that is ultimately applied.

The revision of material about sex and gender is a complex and arduous process, as can be seen in the content of our meeting reported here. It is clear that work on ICD-11 will be ongoing for several years to come. WPATH members intend to be closely involved in a variety of ways, from field trials, to fine-tuning nomenclature and diagnostic criteria, and, if at all possible, to consulting with the World Health Assembly when the revision comes to a vote of the member states. Our persistent goal is to fulfill our mission of promoting evidence-based care, education, research, advocacy, public policy, and respect in transgender health.

Appendix A: Meeting Agenda

WPATH ICD-11 Consensus Meeting Agenda

Hotel Serrano, 405 Taylor Street (at corner of O'Farrell Street)
San Francisco

February 2-4, 2013

Goals of Meeting:

1. For key WPATH constituencies (Board, International Advisory Board members, ICD Consensus Committee members, and select other experts) to discuss current WHO proposals for relevant ICD-11 revisions and determine the organization's positions for communication to the WHO, the general public, and WPATH's membership.
2. After the meeting, WPATH will put these positions in writing for WHO, the general public, and talking points for its members.

Background Readings:

1. Participant bios
2. Final Agenda
3. Drescher et al Minding the Body Int'l Rev Psychiatry 2012
4. Rationale paper for Deletion of F66 Categories
5. Rationale for change in Paraphilic Disorders in ICD-11 (and deletion of TF)
6. ICD-11 Content forms for GI AA – GI C

Consensus Process:

The working definition of consensus for this meeting will be a majority of meeting participants (except for funders and WHO staff). We will attempt to achieve full group consensus, but if there is a need to take an actual vote, we will do so through a confidential ballot system, with abstentions allowed.

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ICD-11 Consensus
Process

Saturday, February 2

8:00 pm Group Dinner at the trendy south of market AQ Restaurant (aq-sf.com)
1085 Mission Street (near 7th Street)

Introduction and welcome by Lin Fraser, President WPATH

Sunday, February 3

8:00 am – 5:00 pm

Orpheum Room

8:00 am Breakfast and mingling time

8:45 am Welcome and introduction to the meeting – Griet De Cuypere, Gail Knudson, Julie Dorf

9:00 am Introductions of all participants with a planned ice-breaker activity

10:00 am **The Global Impact of the ICD-11 Changes Panel Discussion**

We begin the meeting with a brief panel of transgender activists, practitioners, and WHO staff will discuss the impact of these changes in their communities and daily lives from a variety of perspectives, as a way to give context to the work of the meeting. *Mauro Cabral, Eszter Kismodie, Jamison Green, and Christine Burns.*

11:00 am Brief background of ICD process and related WPATH activities and prior proposals – *Geoffrey Reed, WHO and Gail Knudson, WPATH*

11:30 am **Working session I: Deletion of the ICD-10 F66 diagnoses**

Review rationale paper from WHO working group on deletion of these diagnoses, and determine consensus position of WPATH.

12:00 pm Lunch Break – Lunch will be served buffet style outside of the meeting room

12:30 pm **Working Session II: Deletion of the ICD-10 F65 diagnosis Transvestic Fetishism**

Review rationale paper for Changes in Paraphilic Disorders in ICD-11 by the WHO working group. Determine WPATH position on deletion or retention of transvestic fetishism.

1:30 pm **Working Session III: Gender Incongruence**

Review rationale paper for Moving Gender Incongruence by WHO working group and determine WPATH positions on the new name of the diagnosis, moving Gender Incongruence from the Mental and Behavioral Disorders Chapter, and alternative placement options.

2:45 pm **Working Session IV -- Gender Incongrue in Childhood** Begin this more complicated discussion with evidence-based panel presentations by four experts representing both deletion and retention positions: *Sam Winter, Diane Ehrensaft, Annelou De Vries and Edgardo Menvielle*. After fuller group discussion, determine the WPATH position on deletion or retention of the diagnosis and related issues. The planning team assumes that this issue will be the most contentious and therefore may require voting.

4:45–5:00 pm Conclude day, and provide some overnight thinking assignments.

7:00 pm **Dinner Event at Dan Karasic's home**

This event is an opportunity to socialize in a relaxed environment and to meet WPATH local partners in the upcoming May CoE/WPATH National Transgender Health Summit.

Address is 86 Montezuma Street, San Francisco, CA 94110, in Bernal Heights, just south of the Mission District, and 6 km from the hotel. People should meet in the hotel lobby 20 minutes before the reception to share cabs. Dinner is Louisiana food, catered by Easy Creole. Accessibility: Getting to the reception, on the top floor of the house, requires climbing stairs. Further information: Meeting participants can reach Dan at karasic@gmail.com or at **1 415 515 9399** with any questions about the reception or their visit to SF.

Monday, February 4

8:00 – 12:00

Orpheum Room

8:00 am Breakfast and mingling

9:00 am **Discussion of Field Trials**

Geoffrey Reed will provide a brief explanation of the methodology of field trials, and current status. Group discussion will focus on providing WHO with input into where field trials would be feasible and worthwhile.

10:30–11:00 am Break up into 2-3 small groups to discuss all relevant content forms, definitions and diagnostic guidelines. One person will take extensive notes and bring back to facilitator before end of day for use in the morning.

11:00–11:30 am Finish discussion of any remaining items from prior day.

11:30 am Next Steps and Closing—*Lin Fraser and Jamison Green*

12:00 pm Boxed lunches will be available for pick up outside of the meeting room.

Appendix B: 2013 Participant Biographies



Lin Fraser

EdD
WPATH President
USA

Dr. Lin Fraser is President of WPATH. Her goals during her Presidency focus on training and education, international growth, partnering with other organizations, and expanding the use of technology (TIPT).

Dr. Fraser saw her first transgender client in 1972 and has had a private psychotherapy practice with a gender subspecialty since 1976. She is a charter member of WPATH (then HBGDA) and served as a consultant on the first Standards of Care. She presents regularly at symposia, serves on the IJT editorial board, and communicates regularly with the membership. She participates in education and advocacy through teaching, consulting, working with the judicial system, and appearing in the media to educate others about transgender health.

She served on the WPATH DSM5 Consensus Process Committee, co-chairing the adult section with WAS President Kevan Wylie and team member and clinical professor Dan Karasic. She has chaired two Strategic Planning Meetings during her Presidency and hosted the WPATH Global ICD Consensus Process meeting in San Francisco. She has presented and/or published about the theory and practice of depth psychotherapy with transgender people, eTherapy and psychotherapy in the Standards of Care and more recently about diagnoses and classification of gender diagnoses in the DSM5.

She is one of the main contributors and writers of the current WPATH Standards of Care (SOC7) and is co-founder/chair of the WPATH Global Education Initiative (GEI). <http://linfraser.com>



Jamison Green

PhD
WPATH Board President - Elect
USA

Jamison Green, PhD, is an advocate for transgender and transsexual health, civil rights, and social safety. He operates a small consulting firm specializing in transgender education and policy consulting for business, education, and government. He is on staff at the Center of Excellence for Transgender Health, in the Department of Family and Community Medicine at the University of California, San Francisco. He will take office as President of WPATH in 2014, serving in that capacity through the WPATH Symposium in Amsterdam 2016. He will serve as the technical writer for the WPATH ICD Consensus effort.



Walter Bockting

Ph.D.

WPATH Board Member

WPATH Past-President

USA

Walter Bockting, Ph.D. is a clinical psychologist and an internationally known sexuality researcher, and is Co-director of the new Initiative for LGBT Health in the Division of Gender, Sexuality, and Health, and of the New York State Psychiatric Institute / Columbia Psychiatry with the Columbia University School of Nursing'.

After received his doctoral degree in psychology from the Vrije Universiteit, Amsterdam, The Netherlands, Dr. Bockting for 20 years directed transgender health services at the Program in Human Sexuality at the University of Minnesota. He also served on the graduate faculty of Gender and Sexuality Studies and was a co-founder of the University's Leo Fung Center for Congenital Adrenal Hyperplasia and Disorders of Sex Development. Dr. Bockting's research interests include gender identity development, transgender health, sexuality and the Internet, and HIV prevention. His work has been supported by grants from the National Institutes of Health, the American Foundation for AIDS Research, and the Minnesota Department of Health.

Dr. Bockting is the author of many scientific articles and textbook chapters, and editor of five books, including Transgender Health and HIV Prevention (Haworth Press, 2005) and Guidelines for Transgender Care (The Haworth Press, 2006). He is Editor-in-Chief of the International Journal of Transgenderism, Associate Editor of Sexual and Relationship Therapy, and serves on the editorial boards of the Journal of Homosexuality, the Archives of Sexual Behavior, the International Journal of Sexual Health. He is past president and fellow of the Society for the Scientific Study of Sexuality, as well as immediate past president and a member of the board of directors of the World Professional Association for Transgender Health. In 2010-2011, Dr. Bockting served on the National Academies' Institute of Medicine Committee on LGBT health issues, research gaps and opportunities.



Gail Ann Knudson

MD, MPE, FRCPC

WPATH Secretary-Treasurer

WPATH ICD Co-Chair

WPATH Board Member

Canada

Gail Knudson MD, MPE, FRCPC, is a Clinical Associate Professor at the University of British Columbia Department of Sexual Medicine, Consultant Psychiatrist at the British Columbia Centre for Sexual Medicine at Vancouver Hospital, Medical Director of the Transgender Health Program at Vancouver Coastal Health and Faculty Development Leader for the Island Medical Program, Faculty of Medicine, University of British Columbia.

Dr Knudson is active in conducting phase III clinical trials for treating both male and female sexual dysfunction. She served as co-chair of the DSM 5 Consensus Committee for the World Professional Association for Transgender Health (WPATH), writing group member of the Standards of Care for Transgender Health (version 7) and is the current co-chair of the WPATH ICD 11 Consensus Committee.

Dr Knudson is serving her second term as the Secretary-Treasurer of WPATH and founder and former President of the Canadian Professional Association for Transgender Health (CPATH). She is the former Chair of the Sexuality Special Interest Group of the American Society for Reproductive Medicine (ASRM). She was the Scientific Chair for the International Society for the Study of Women's Sexual Health (ISSWSH) Annual Meeting held in Jerusalem, Israel, February 2012.



Andrea Martin

A.A.
WPATH
Executive Administrator

Andrea Martin is the full-time Executive Administrator of WPATH. Ms. Martin has been with WPATH for a year providing member services; upgrading and maintaining the membership website; maintaining communication with WPATH officers, board, committees and members; and assisting with editorial responsibilities for the International Journal of Transgenderism, the WPATH peer-reviewed research journal published by Taylor & Francis. Ms. Martin has an Associates of Arts degree from Peninsula College in Port Angeles, WA and is currently pursuing a Bachelor's degree at the University of Minnesota. Ms. Martin has a 6-year history in the health care field working as a clinic assistant for a transgender medical clinic in Minneapolis, MN.



Jeffrey Whitman

B.S.
WPATH
Financial Manager

Jeffrey Whitman recently accepted the position of part-time Financial Manager for WPATH. Mr. Whitman started with WPATH four years ago as the Executive Administrator. Through that time, he has assisted in organizing two symposia and contributed to the financial and membership growth of the Association to record levels. Mr. Whitman has a Bachelor's of Science in Retail Merchandising from the University of Minnesota and has two Associates degrees from Minneapolis Community and Technical College. He has over 20 years of experience in the business end of healthcare, working in hospitals and for a managed care health insurance company. He also owns his own online retail business which he currently operates on a full time basis.



Rebecca Anne Allison

MD, FACP, FACC
WPATH Board Member
USA

Rebecca Allison was born in Mississippi, and attended the University of Mississippi where she received her BS and MD degrees. She completed training in Internal Medicine and Cardiology at the University Medical Center in Jackson. Becky lost her cardiology practice in Mississippi when she began her gender transition in 1993. After completing transition, she entered a new cardiology practice in Phoenix in 1994.

In 1996, Becky established her website which became drbecky.com, and published the story of her transition year as a daily journal. “The Real Life Test” serves as a source of support and hope to many persons preparing for transition. The site also features essays on spiritual subjects, a state-by-state instruction on changing the birth certificate, and a list of therapists who treat transgender persons.

In 2004, Becky was elected to the Board of Directors of the Gay and Lesbian Medical Association, where she served as President from 2009- 2011. She is a member of the WPATH Board of Directors. In 2009 she was an invited speaker at the annual Scientific Sessions of the American College of Cardiology, speaking on Gender Identity Disorder and the DSM. For seven years, Becky and her partner, Margaux Schaffer, presented the Transgender Day of Remembrance at the Arizona State Capitol in Phoenix.



Marsha Botzer

MA
WPATH Board Member
USA

Marsha Botzer has served the Lesbian, Gay, Bisexual, Transgender and progressive communities in various roles for over 30 years.

She was an early member of Hands Off Washington, a founding board member of Equal Rights Washington, and has served as a board member of Pride Foundation, Safe Schools Coalition, Lambert House, Seattle Counseling Service, the Seattle LGBT Commission, Washington State DSHS Advisory Committee, and Equality Washington. Marsha served as co-chair of The National Gay and Lesbian Task Force in 2009-10, a position that she also held in 2005-6. She is a founding member of the Out In Front Leadership Project, and currently serves on the World Professional Association for Transgender Health board of directors. Marsha founded Seattle’s internationally known Ingersoll Gender Center.

In 2008 Marsha served as a national co-chair of the Obama Pride Campaign. In 2009 she served on the Leadership Committee for the Equality Across America March in Washington DC. In 2004 Marsha received the Horace Mann “Victories for Humanity” Award from Antioch University and the Virginia Prince Lifetime Achievement Award from the International Federation for Gender Education. In 2007 Marsha received The Task Force Leadership Award. In 2009 Marsha received the Jose Julio Sarria Civil Rights Award, and in 2011 Marsha received the Washington State GLBT Bar Association Award for Community Service.



George R. Brown

MD, DFAPA

WPATH Board Member
USA

Dr. Brown is the Program Director for Health Care Outcomes in the Office of Health Equity, Veterans Health Administration, Washington, DC, as well as Associate Chairman and Professor of Psychiatry at East Tennessee State University in Johnson City, TN.

He is currently serving his third term on the Board of Directors for WPATH, where he also serves on the Incarceration/Institutionalization Committee and the Standards of Care Committee. He is a coauthor/contributor on the last 3 versions of the Standards of Care. Dr. Brown served 12 years in the US Air Force as a psychiatrist and worked with transgender active duty service members and with Veterans during his last 19 years in the Department of Veterans Affairs. He participated on the two VA workgroups tasked with educating the field about the June, 2011 VA Directive on providing healthcare to transgender and intersex Veterans. In his current position in Washington, DC, Dr. Brown researches health care disparities within the nation's largest integrated health care organization, with transgender health care within VA being an important focus.

Dr. Brown is also actively involved in working with transgender prisoners in the United States, having had the opportunity to serve as an expert witness on key cases in the Federal Bureau of Prisons and in several federal District court venues that have resulted in greater access to healthcare for incarcerated persons with GID. Dr. Brown has published over 135 articles and scientific abstracts, as well as 22 book chapters, many of which have been on transgender healthcare issues.



Randi Ettner

PhD

WPATH Board Member
USA

A native of Lincolnwood, Illinois, Ettner completed her undergraduate degree at Indiana University, where she earned the Outstanding Psychology Student Award and was elected to Phi Beta Kappa. She then earned her M.A. from Roosevelt University. She began working with transgender people in 1977 at Cook County Hospital in Chicago, Illinois. She received her Ph.D. in psychology at Northwestern University, writing her dissertation on childbirth. Ettner had additional training at Moray House School of Education in Scotland.

Ettner is founder of New Health Foundation Worldwide and works with her husband, physician Frederic M. Ettner. She referred transgender patients to surgeon Eugene Schrang until his retirement. Ettner is a member of the American Psychological Association and is a Fellow, Diplomate, and served on the Board of Directors from 2001 to 2005 for the World Professional Association for Transgender Health.

She has helped pass anti-discrimination laws, provided testimony on behalf of trans people seeking workplace rights, and works to secure appropriate treatment for prisoners. She has also been a critic of psychologist J. Michael Bailey and his 2003 book *The Man Who Would Be Queen*. Bailey has stated his book was initially motivated by what he saw as "gross inaccuracies in Ettner's account of transsexualism." Ettner works to improve understanding of trans issues, and has spoken out against attitudes used to justify violence against trans people. She is the author of two books on transgenderism and editor of a medical and surgical text on the topic. She is the Chief Psychologist at the Chicago Gender Center.



Griet De Cuypere

MD, PhD

WPATH ICD Co-Chair

WPATH Board Member
Belgium

Griet De Cuypere is psychiatrist and psychotherapist - Coordinator of the gender team Gent University Hospital Ghent - Center of Sexology and Gender Problems Belgium.

She is Founding Member of Enigi (European Network for the Investigation of Gender Incongruence) - participating in research on gender dysphoria. As mental health professional she has given guidance to hundreds of persons with gender dysphoria for more than 25 years.

She was member of the organizing committee for the 2003 WPATH symposium in Gent, Secretary-treasurer of WPATH 2005-2007, board-member 2007- 2011 and re-elected in 2011 for another 4-year term.

Griet De Cuypere served as co-leader of the Oslo WPATH consensus Workgroup of DSM-5, was member of the writing group of the Standards of Care (version 7) and is current co-chair of the WPATH ICD-11 Consensus Committee. She is appointed as ICD-11 reviewer for the Working Group on the Classification of Sexual Disorders and Sexual Health.



Sam Winter

PhD

WPATH Board Member
China

Sam Winter works in sexual and gender development and diversity, sexual rights and health, and sex education. He has published in the fields of psychology, anthropology, history, law, and health.

Dr Winter is commissioned lead author for a paper in a short series on Transgender Health, to be published by the medical journal Lancet in 2013.

Dr Winter is deeply involved in enhancing health, rights and welfare for sexual and gender minorities. He has taken part in training for psychiatrists, psychologists and social workers working with transpeople, provided expert evidence in a number of legal and asylum cases, and is involved in the work of a large number of local, regional (Asia-Pacific) and international organisations concerned with transgender health and rights. He is one of the Directors of the World Professional Association for Transgender Health (WPATH). He was a member of a team of 34 professionals which produced the recent seventh revision of Standards of Care (SOC). He is member of the WHO Working Group appointed to consider revisions for ICD-11 in the area of Sexual Disorders and Sexual Health.



Kevan Richard Wylie

MB ChB MMedSc MD FRCP

FRCPsych FRCOG

WPATH Board Member

United Kingdom

Kevan Wylie qualified in medicine MB ChB in Liverpool in 1985, obtained his Masters in Leeds (1991) and the Diploma in Therapy with Couples (1993) and Diploma in Sexual Medicine (1994) at the University of London. He obtained his Doctorate MD researching couples and sex therapy for erectile dysfunction in 1999. With this training and the experience of working in mental health, a career change allowed Prof. Wylie to work full time in sexual medicine for the UK National Health Service from June 1999 across two hospital trusts. Kevan is Clinical Lead at the Porterbrook Clinic (sexual medicine, psychosexual and relationship psychotherapy, and transgender services) and Consultant Lead for andrology (urology) at the Royal Hallamshire Hospital in Sheffield. He is elected as a Fellow of the Royal College of Physicians of London, a Fellow of the Royal College of Psychiatrists, a Fellow of the Royal College of Obstetricians and Gynaecologists, a Fellow of the European Committee on Sexual Medicine, a Fellow of the Royal Society of Public Health and a Fellow of the Academy of Medical Educators.

Kevan is Honorary Professor at Sheffield Hallam University and Course Director of the Sheffield MSc programme on Sexual & Relationship Psychotherapy. He is Honorary Reader at The University of Sheffield where he regularly teaches student doctors, many of whom go on to undertake 6 week elective periods at his clinics. Overseas, Kevan is Adjunct Associate Professor at the University of Sydney and acts as honorary international consultant to the Global Sex Research Forum as well as serving as Visiting Professor at the Department of Sexology, Yerevan State Medical University, Armenia. Kevan was awarded the EFS Gold Medal in 2008 for his work into sexual medicine, sexology and sex education across Europe. Kevan has published in excess of 100 peer reviewed papers, 15 book chapters and is regularly invited to speak at international meetings in cities as far afield as Addis Ababa, San Diego, Tbilisi, Tehran and Tirana.

Kevan chaired the UK intercollegiate committee on androgen replacement therapy for men and women with sexual problems (issued in 2010), chaired the intercollegiate committee on standards of care for individuals with gender dysphoria that will be issued in 2013 and was a member of the WPATH committee for Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7.

Kevan acts as an Associate Editor for the Journal of Sexual Medicine and is on the editorial board and acts as a reviewer for a number of academic journals. Professor Wylie is a member of the Regional Advisory panel on research and training in Reproductive Health for the EURO office of WHO and is a trustee of the UK patient charity the Sexual Advice Association. Having completed his term as Chairperson of the British Society for Sexual Medicine (2007-2009), and various other specialist societies in recent years, Kevan is currently Vice President of EFS (2010-2014) and on the board of directors of both ISSWSH & WPATH (2009-2013). In June 2011, Kevan served as president of the World Association for Sexual Health biannual meeting held in Glasgow, Scotland. In 2012, Kevan became the president of the World Association for Sexual Health.



Walter Pierre Bouman

MD MA MSc FRCPsych UKCPreg
WPATH ICD Group
United Kingdom

Walter is a consultant psychiatrist-sexologist who works full-time as lead clinician at the Nottingham Gender Clinic in Nottingham, UK. Walter initially trained in psychiatry and psychotherapy in the Netherlands; he has over 20 years of clinical experience in general adult and older people's mental health. Walter received further postgraduate training in sexology at the Porterbrook Clinic in Sheffield and is an accredited member and supervisor of the College of Sexual and Relationship Therapists (COSRT). He is registered with the United Kingdom Council of Psychotherapy (UKCP) as a psychotherapist. He is an experienced clinical tutor and supervisor and has served The Royal College of Psychiatrists as a College Tutor, Membership Examiner and Training Programme Director. Walter is Deputy Editor of Sexual and Relationship Therapy - International Perspectives on Theory, Research and Practice.

Walter was part of the Oslo 2009 WPATH Consensus Workgroup on DSM-V. He serves as a member on The Royal College of Psychiatrists InterCollegiate Standards of Care Committee regarding Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria. Walter currently chairs the NHS Clinical Reference Group for Gender Dysphoria within the Department of Health, which is tasked to develop a National Policy and National clinical service specifications, including shared care hormone prescribing protocols for people with gender dysphoria to ensure national equity of access to NHS clinical services.



Cecilia Dhejne

MD, Clinical sexologist
(NACS)
WPATH ICD Group Sweden

Dr Dhejne is a consultant in psychiatry and a certified clinical sexologist (NACS). She is head of the Gender team at the Psychiatric clinic, Karolinska University Hospital in Stockholm, Sweden, a unit she started up in 1999. She is also serving as a consultant at the Center for Andrology and Sexual Medicine. She is a PhD student at the Karolinska Institute, working on her thesis in the field of gender dysphoria. She is a frequent lecturer for both medical students as well as physician residents in the field of gender dysphoria and sexual medicine. She serves as a medical advisor to the Swedish National Board of Health and Welfare regarding health and legal issues of gender dysphoria. During 2012, she was asked to become one of the medical advisors to the Icelandic government in their work with their gender recognition law. In 2011 she was awarded "Eldsjälspriset" by RFSU Stockholm (the Swedish Association for Sexuality Education) for her work for better health care and legal rights for gender dysphoric persons.

She is co-author of the Consensus Statement of the World Professional Association for Transgender Health on revision of the GID diagnosis for DSM 5.



Annelou De Vries

MD, PhD
WPATH ICD Group
Netherlands

Annelou de Vries is a child and adolescent psychiatrist working at the VU University Medical Center in Amsterdam. The scope of her work is consultative-liaison psychiatry at the Pediatric department, focusing on sick children with mental health problems. An important and special part of her work is dedicated to gender dysphoric adolescents. At the Center of Expertise on Gender Dysphoria at the VU University Medical Center in Amsterdam, a clinical approach was developed where adolescents with gender dysphoria may be eligible for the complete reversible medical treatment with GnRH analogues to block puberty from age 12 on before more definite decisions regarding (partially) irreversible gender reassignment are made. Apart from her clinical work with these gender dysphoric adolescents, Annelou de Vries is also involved in research and published several studies on mental health of gender dysphoric adolescents and treatment evaluation of this GnRH analogue treatment



Ira Haraldsen

MD, PhD
WPATH ICD Group
Norway

Dr. Haraldsen is trained as a neurologist and psychiatrist and serves as the Head of the Gender Clinic at the National hospital in Oslo, Norway. She works as a clinician, administrator and researcher in the field of transgender health. In 2009, Dr. Haraldsen served as local organizing co-chair of the WATH Symposium in Oslo.

Dr. Haraldsen's primary area of interest is transgender research. One of her main goals is to increase the collaboration between European and North American researchers. Being on the steering committee of ENIGI (A European network for the investigation of gender incongruence: The ENIGI initiative. Kreukels BP, Haraldsen IR, De Cuypere G, Richter-Appelt H, Gijs L, Cohen-Kettenis PT. Eur Psychiatry. 2010 Jul 8. [Epub ahead of print] PMID: 20620022.), enables her to initiate further scientific transatlantic cooperation.

She is co-author of the Consensus Statement of the World Professional Association for Transgender Health on revision of the GID diagnosis for DSM 5.



Dan Karasic

MD
WPATH ICD Group
USA

Dan Karasic, MD is Clinical Professor of Psychiatry at UCSF, where he specializes in transgender care, as well as care of HIV positive people. He is the psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and for the UCSF Alliance Health Project (for LGBT mental health), and is a longtime member of Bay Area Gender Associates. He is a member of the Medical Advisory Board of the UCSF Center of Excellence for Transgender Care, and the steering committee for the Child and Adolescent Gender Center. In May, he is again chairing the Mental Health Track of the National Transgender Health Summit, this time in collaboration with WPATH, and hopes you all will consider coming back to the Bay Area for the conference!

Dan is a past president of the Association of Gay and Lesbian Psychiatrists and a Distinguished Fellow of the American Psychiatric Association (APA), and has chaired many symposia on transgender care at APA meetings. His longtime advocacy of depathologizing nomenclature and cultural humility as a trans care provider has been reflected in his work on WPATH's SOC 7 Work Group, and in expert witness testimony that helped overturn the province of Ontario's surgery requirement to change legal gender. Dan edited the book "Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation" (2005) with Jack Drescher, MD. He has been active in WPATH's DSM V and ICD 11 committees, presenting consensus proposals to the WPATH membership for replacement of DSM's GID in Oslo in 2009 and ICD's Transsexualism in Atlanta in 2011.



Edgardo Menvielle

MD
WPATH ICD Group
USA

Edgardo Menvielle, M.D. is an Associate Professor of Psychiatry and Behavioral Sciences, at The George Washington University and an Attending Psychiatrist, at the Department of Psychiatry of Children's National Medical Center. He is also the Director of the Psychosocial Programs, Department of Psychiatry, Children's National Medical Center (Gender and Sexuality Development Program and Gender and Sexuality Advocacy and Education) and is Board Certified in General Psychiatry and Child and Adolescent Psychiatry. Dr. Menvielle has been practicing academic child and adolescent psychiatry since 1986. Since 1999, he has been engaged in providing clinical services for children and increasingly for adolescents who present with issues related to gender and sexuality. Around this time he started working with parents of children with gendervariant behaviors in a group format, a group which still meets. In 2003, together with a colleague, he published a parent guide brochure which was very well received. Inquiries from out of state parents and therapists prompted the development of an on-line group for parents, an electronic list-serve in which more than 300 families have thus far participated. Dr. Menvielle has been involved in providing consultation as well as making presentations and workshops for pediatricians, mental health professionals and educators.

He is currently involved in providing training on this topic to psychiatry residents, and other trainees in mental health disciplines. Dr. Menvielle is a Fellow of the American Psychiatric Association (APA) and Member of the American Academy of Child and Adolescent Psychiatry (AACAP), where he serves a committee member for the Sexual Orientation and Gender Identity Issues Committee (SOGIIC). He is also a collaborator in the writing of the Practice Parameters for the AACAP on sexual and gender identity issues and he is leading a task force appointed by the Washington Psychiatric Society to make recommendations to APA about GID for the DSM 5.



Walter Meyer

MD
WPATH ICD Group Former
WPATH President
USA

Dr Meyer is board certified pediatric endocrinology and child and adolescent psychiatry. He serves as Department Head of Psychological and Psychiatric Services for Children & Families – Shriners Hospitals for Children, Galveston, Texas. He is a past president of WPATH. He is co-author of the Consensus Statement of the World Professional Association for Transgender Health on revision of the GID diagnosis for DSM 5.

He served on the SOC 7 Standards of Care Writing Committee.



Tamara Adrian

JD

WPATH Int'l Advisory Group
Venezuela

Tamara Adrian Hernandez is an attorney who graduated from the Universidad Católica Andrés Bello (UCAB) and Doctor of Commercial Law at the Université Panthéon-Assas Paris. She is also a law professor at the Catholic University Andres Bello (UCAB), Central University of Venezuela (UCV) and Universidad Metropolitana (Unimet). She is a renowned activist for the rights of women, the rights of sexual minorities and LGBTI.



Christine Burns

MBE, MSc, C.Eng, MBCS,
CITP

WPATH Int'l Advisory Group
United Kingdom

Christine Burns is a specialist in Equality and Inclusion, practicing in the UK. From 2006 she chaired the transgender workstream in the Department of Health's Sexual Orientation and Gender Identity Advisory Group. In that capacity she and her committee commissioned and published a ground-breaking range of literature supporting policy makers, clinicians, patients and families and commissioned research about user experience of Gender Identity services. She personally authored the national policy guide "Trans: A Practical Guide for the NHS". She also provided project management for a Europe-wide survey of trans peoples' experiences being undertaken by an academic research team for the International Gay and Lesbian Association (ILGA) and has advised NHS clients in writing policies to commission gender identity services. Currently she is employed as a consultant to manage the Equality and Diversity programme for North West England's Strategic Health Authority ... overseeing the work of 63 separate NHS organisations. Historically she has been a business consultant for over 30 years before turning her interests to equality over 11 years ago. She was awarded an MBE in the Queen's New Years Honours list in December 2004 for her work helping to bring about the Gender Recognition Act in the UK.

Christine writes and broadcasts widely about equality issues and has podcasted many in-depth interviews with transgender subjects as well as disabled people, gay and lesbian leaders, black and minority ethnic groups and religious speakers. Her publications go under the brand "Just Plain Sense". The Just Plain Sense blog and podcast complement one-another and are both equality-themed. She is also a keen amateur photographer and integrates this into her consultancy work and blogging. At present she is working on a book about the NHS equality team's work and rejoices in having become a granny in 2010.



Dr. Mazen Ali
MD, MBBS ABPsy
WPATH Member
Bahrain

Mazen K Ali is a specialist psychiatrist at the Psychiatry Hospital, Bahrain. He completed his undergraduate studies at King Faisal University, Saudi Arabia. He completed his residency at the Psychiatry Hospital in Bahrain and passed the Arab Board in Psychiatry in 2007. He completed a two-year Fellowship at the University of British Columbia, Canada where he studied Mood Disorders, Sexual Medicine and Transgender Health (under the supervision of Dr. G. Knudson). Dr. Ali is currently working at the Psychiatry Hospital in Bahrain and has experience in working in different sub-specialties of psychiatry with a special interest in Autism and ADHD. He has published four books in Arabic in psychiatry.

Dr. Ali is also a member of the Quality Team in the hospital and is helping develop the future strategies for the improvement of psychiatric services in Bahrain and to help develop such services in the Arabian Gulf countries. Through his participation in different organizations and committees within the psychiatry hospital as well as outside the hospital, he tried to encourage the collaboration needed to provide better psychiatric services and better public education of the importance of psychiatry in our modern societies.



Mauro Cabral
WPATH Member
Argentina

Activist and scholar based in Buenos Aires, Argentina. During the last 15 years his work has been focused on the intersection between bodily diversity, biotechnology and the Law, with a particular emphasis in trans* and intersex issues. Mauro is one of the two Co-Directors and founders of GATE (Global Action for Trans* Equality), and participates in several international and regional initiatives: he co-chairs the International Reference Group on Trans* Issues and HIV/AIDS at the MSMGF and the Latin American Consortium on Intersex Issues; he is also part of the International IDAHO Committee, the International Advisory Group at the Human Rights Watch LGTB Program and the Board of the Transgender Studies Quarterly. He became a WPATH member in 2012.

From 2005 and 2007 Mauro coordinated the LAC Trans and Intersex Area at IGLHRC, and in that capacity he co-directed the first Training Institute for Trans and Intersex Activists in the region. From 2007 to 2009 he was part of Mulabi – Espacio Latinoamericano de Sexualidades y Derechos, where he coordinated the project “Institutional Violence Against Trans People”. In 2006 Mauro participated in the production of the Yogyakarta Principles and, in 2009, he edited the book *Interdicciones. Escrituras de la intersexualidad en castellano*. Mauro has published many articles, essays and translations on trans and intersex issues, and had an active role in the drafting and negotiation of the Argentinian Gender Identity Law. He lives with his partner and their dog in La Boca, Buenos Aires.



Eli Coleman

PhD
ICD Reviewer
WPATH Member
Former WPATH President
USA

Eli Coleman, PhD, director, is professor and director of the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School. He is the author of numerous articles and books on compulsive sexual behavior, sexual offenders, sexual orientation, gender dysphoria, chemical dependency, family intimacy, and the psychological and pharmacological treatment of a variety of sexual dysfunctions and disorders. Coleman is the founding editor of the International Journal of Transgenderism and is the founding and current editor of the International Journal of Sexual Health. He is past president of the Society for the Scientific Study of Sexuality, the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association), the World Association for Sexual Health, and the International Academy for Sex Research. He is the current President of the Society for Sex Therapy and Research. He has been a frequent technical consultant on sexual health issues to the World Health Organization (WHO), the Pan American Health Organization (the regional office of WHO) and the Centers for Disease Control and Prevention (CDC). He has been the recipient of numerous awards including the U.S. Surgeon General's Exemplary Service Award for his role as senior scientist on Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior, released in 2001. He was given the Distinguished Scientific Achievement Award from the Society for the Scientific Study of Sexuality and the Alfred E. Kinsey Award by the Midcontinent Region of the Society for the Scientific Study of Sexuality in 2001. In 2007 he was awarded the Gold Medal for his lifetime contributions to the field of sexual health by the World Association for Sexual Health and was appointed the first endowed Chair in Sexual Health at the University of Minnesota Medical School.



Diane Ehrensaft

PhD
WPATH Member
USA

Diane Ehrensaft, Ph.D. is an associate professor at the University of California San Francisco in the Department of Pediatrics and a developmental and clinical psychologist in the San Francisco Bay Area, specializing in gender studies/research and psychotherapy/consultation with gender-nonconforming children and their families. She is the author of *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children* (The Experiment Press, May 2011), and speaks and publishes both nationally and internationally on the subject of children's gender development and gender nonconformity.

Dr. Ehrensaft is the Director of Mental Health of the Child and Adolescent Gender Center, a University of California San Francisco-community partnership and leads the Mind the Gap consortium of child gender mental health specialists under the umbrella of the Child and Adolescent Gender Center. Dr. Ehrensaft is also on the board of Gender Spectrum.



Mariella Castro Espin

PhD
WPATH Member
Cuba

Mariela Castro Espín (born 1962 in Havana, Cuba) is the director of the Cuban National Center for Sex Education (CENESEX) in Havana and president of the editorial board of “Sexologia and Sociedad”. She is senior professor at the Medical University of Havana and adjunct senior professor at the University of Pedagogical Sciences in Havana. She is member of the Academic Committees for the Master Degree Programs on Sexuality and Community Intervention for the Daily Life Corrective Processes, President of the National Commission for Comprehensive Care to Transsexuals, main coordinator of the Educational Strategy and Awareness Campaign for the Respect of Sexual Orientation and Gender Identity, member of the International Conference on Population and Development (ICPD).

She has attended more than 100 international and national scientific congresses as a keynote speaker. She was the president of the XVI World Congress of Sexology. She is member of the Advisory Committee of the World Association for Sexual Health (WAS). She has authored and co-authored several publication in Cuba and abroad, among them: “La transexualidad en Cuba” (La Habana: Editorial CENESEX, 2008) and “Qué nos pasa en la Pubertad?” (La Habana: Editorial CENESEX, 2012). She has been awarded with the Iberico American Prix Jeunesse 2011 for inspiring, advising and writing the script of the cartoon “Pubertad”. She has also been awarded by the Society for the Scientific Study of Sexuality (ISSS) with the Public Service Award in 2009.



Alberto Roque

MD
WPATH Member
Cuba

Medical doctor, Internal Medicine specialist. Instructor professor and Adjunct researcher at the Medical University of Havana. He works on transgender health since 2004. Member of the Cuban Multidisciplinary Association for Sexuality Studies (SOCUMES), Cuban Society of Internal Medicine, the Latin American Studies Association (LASA) and The World Professional Association for Transgender Health. He is a Human Rights Educator (International Centre for Human Rights Education “Equitas”, Montreal, Canada. He has been a consultant at a scientific mission on Transgender Health Care in Guatemala. He has been a lecturer on sexual health, sexual rights and transgender health in Cuba and in several countries.



Mayra Rodríguez Lauzurique

MS, MsC.
WPATH Member
Cuba

She is Psychologist, specialist on Educational Psychology, University of Havana. She has a Master Degree on Sexology and works at the National Center for Sex Education. Senior professor and auxiliary researcher at the Medical University of Havana. Member of the Cuban Multidisciplinary Society for Sexual Studies (SOCUMES), the Cuban Society of Psychologists and the board of directors of the Latin American Federation on Sex Education (FLASSES).

Member of the National Commission for Comprehensive Care to Transsexual People. She has been the coordinator of several projects on Sexual Diversity, HIV-Aids, Sexual Rights and Sex Education. She has been a consultant for UNUSIDA, PNUD, UNFPA, COIN (Dominican Republic) and PAHO on health care and HIV prevention for transgender people. Due to her sustained and outstanding results on education and community work with trans people she has been awarded several times in Cuba.



Lazaro Hernandez Coterón

MD
WPATH Member
Cuba

Dr. Lazaro Hernandez Coterón is Creator and Head of the Multidisciplinary Group for the Study of Gender Identity Disorder in children and adolescents since 1993 until today.

- Adjunct Professor of the Graduate Program in Medical Sexology Psychiatric Research Center, Psychological and Sexology in Venezuela, and Postgraduate Research Institute approved by the National Council of Universities, Ministry of Higher Education of the Bolivarian Republic of Venezuela. Subject Sexology. Specialized Topic: Identity Disorder (appointed July 2006).
- Specialist Department Services Department, Social and Sexual Rights National Center for Sexual Education. CENESEX.
- Executive Member of the Cuban Society for the Study of Sexuality. (SOCUMES).
- Member of the Preparatory Committee on Disease Diagnostic Manual in Medical Sexology (FLASSES). MDES II, MDES II R and III
- Member of the International Organizing Committee of the First World Congress of Medical Sexology (held in Caracas from 26 to 28 March 2009). Referee of the Selection Committee of the Event Jobs
- Founding member of the World Association of Medical Sexology.
- Added Investigator University of Medical Sciences of Havana 2012.
- Academic corresponding AIMS from December 2012
- Member of the Commission | Comprehensive Cuba Transgender People
- Assistant Professor, University of Medical Sciences Habana, 2013.



Fintan Harte

MD
WPATH Member
Australia

Dr Fintan Harte is a Consultant Psychiatrist at the Albert Road Clinic, Melbourne and Head of Unit, Gender Dysphoria Clinic, Melbourne. He is an Adjunct Senior Lecturer, Department of Psychology and Psychiatry, Monash University and Senior Clinical Fellow, Department of Psychiatry, University of Melbourne. He is a founding member and current Vice-President of ANZPATH (Australian and New Zealand Professional Association for Transgender Health) and also a member of WPATH. He has published a number of articles in peer reviewed journals and is a regular speaker on aspects of gender and sexuality, both nationally and internationally. Dr Harte is a medical graduate of Trinity College Dublin and completed his post graduate psychiatric studies in the United Kingdom. He has lived in Australia since 1985.



Joanne Keatley

MSW
WPATH Member
USA

JoAnne Keatley is the Director of the Center of Excellence for Transgender Health at the University of California San Francisco. Originally from Mexico City, JoAnne received a Master of Social Welfare degree from the University of California at Berkeley. Currently, JoAnne oversees two CDC funded projects whose aim is to increase provider capacity to serve transgender people and is implementing a new 5 year HRSA funded Evaluation and Technical Assistance project that will support nine demonstration sites across the United States. Beginning at UCSF in 1999, JoAnne has directed multiple federally funded research and HIV prevention transgender projects and has consulted on transgender health at the National Institutes of Health, Center for Disease Control and Prevention, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration. JoAnne received the UCSF Chancellor's Award for LGBT Leadership in 2001, the American Immigration Law Foundation Community Service Award in 2004, a GLMA Achievement Award in 2007, the LA Children's Hospital Community Leader Angel Award in 2008, the UCSF Martin Luther King Jr. Staff Award for advancing cultural diversity and social justice on campus in January 2009, the Kaiser Permanente HIV/AIDS Diversity Award in 2010 and in 2011 was recipient of the inaugural WPATH Harry Benjamin Distinguished Educator and Advocate Award.



Simon Pickstone Taylor

MD
WPATH Member
South Africa

I grew up on the farm in South Africa near Cape Town. I did my undergraduate medical degree at Cambridge University in the UK and did the clinical years at Cape Town University. I later specialized in psychiatry on the west coast of the United States, finishing with a fellowship in Child & Adolescent Psychiatry at the University of California San Francisco in 2003. I returned to the UK and worked as a consultant first at the St Georges' University Hospital's Eating Disorder Unit both with adults and children. I then worked in Child & Adolescent Mental Health in Oxfordshire and later as part of the South London and Maudsely group.

In 2010 I returned to South Africa for the birth of our child. I have worked part time since in rural prisons, providing psychiatric care to inmates. I also have a part time psychiatric private practice seeing young people and families.

I developed a special interest in Young people with gender non-conformity during my Child & Adolescent psychiatry training. As a consultant Psychiatrist in Oxfordshire and later in the South London and Maudsely Trusts, I was the lead clinician in this area, providing consultation to clinicians working with young people with these issues. I also gave regular talks on the topic. I was also referred a number of young people with these issues and managed their care.

In South Africa I have given a number of talks on Gender variance in young people to mental health workers and medical colleagues and at the Gender Dynamix conference in 2011 in Cape Town. I have been referred a number of young people with Gender Variance or intersex issues since. I recently started a Gender Identity Development Service within the Child & adolescent mental health service at the University of Cape Town. This service provides consultation/supervision to colleagues working with young people with these issues, as well as an assessment clinic for these young people and their families. I believe this is the first of its kind in Africa."



Stephen Rosenthal

MD
WPATH Member
USA

Stephen M. Rosenthal, M.D. is a Professor of Pediatrics and Program Director for Pediatric Endocrinology at the University of California, San Francisco (UCSF). He is also Director of the Pediatric Endocrine Clinics and co-Director of the Disorders of Sex Development (DSD) Clinic. In addition, Dr. Rosenthal led an effort to create the Child and Adolescent Gender Center (CAGC), and serves as its Medical Director.

The CAGC, a UCSF/community collaborative, brings together experts from many disciplines to provide comprehensive medical and mental health care, as well as education, advocacy, and legal services for gender non-conforming/ transgender youth and adolescents.

Dr. Rosenthal received his BA degree from Yale University in 1972 and his MD from Columbia University in 1976. He completed a Pediatric Residency at Columbia University in 1979, and completed a Postdoctoral Fellowship in Pediatric Endocrinology at UCSF in 1982. He joined the faculty at UCSF in 1983, where he has since remained.

Dr. Rosenthal's research has included both basic science and clinical investigation. Dr. Rosenthal has directed a laboratory focused on the role of Insulin-like Growth Factor (IGF) signaling in skeletal muscle differentiation and in neuroblastoma tumorigenesis. Dr. Rosenthal also has a strong interest in disorders of water balance, and along with his colleagues, identified the first patients with activating mutations in the V2 vasopressin receptor causing an SIADH-like syndrome in the absence of excess anti-diuretic hormone (ADH). In addition, Dr. Rosenthal conducts research on patients with Disorders of Sex Development (DSD), and is developing a research program focused on optimizing care for transgender youth and adolescents.

His principal passion/interest outside of work is figure skating; he has competed and continues to compete in numerous adult national and international competitions.



Sahika Yüksel

MD, PhD
WPATH Member
Turkey

Sahika Yüksel, Professor Department of Psychiatry, Medical School, University of Istanbul, Turkey Since 1994: Founder and Director of Istanbul Psychosocial Trauma Program , President of Psychiatric Association of Turkey (PAT 2002-2004)

Founder member of different NGO's such as Purple Roof independent shelters for women exposed violence; Human Rights Rehabilitation Center for Torture Victims. PAT Coordinators of Disaster and Mental Health Task Group, and Women and Mental Health Executive committee member of Turkish Mental Health Policy Team, promoting to constitute Mental Health Law in Turkey between 2003-2008.

She was founder and Board Member of ESTSS (1994- 2001) and Board member of International Society of Traumatic Stress Stress (ISTSS) (2001- 2004). Coordinator of Human Rights and Social Policy Special Interest Group of ISTSS (2003-2007)

Areas of clinical specialization, teaching, research and service: Transgender people individually and in group settings evaluation and clinical treatment and forensic reports. Set up first transsexual service for in Turkey according SOC; Established therapist guided transgender groups in 1987 till 2013. Group and individual base work with TG's family.

Post-traumatic problems, particularly in women exposed to sexual violence at home and during detention; Work with NGO's on rehabilitation centers for torture victims and shelters for women exposed to sexual and physical violence; Treatment and forensic evaluation of torture survivors.



Eszter Kismödi

JD, LLM
World Health Organization
(WHO)

Eszter Kismödi is an International Human Rights Lawyer on Sexuality and Sexual and Reproductive Health. She worked as a human rights adviser at the Department of Reproductive Health and Research in WHO, Geneva during the period of 2002 -2012 and remains to be involved in WHO's work on sexual and reproductive health as a consultant. In WHO, she managed the work in relation to the integration of human rights into law, policy and programme development and implementation on sexual and reproductive health matters. She coordinated WHO's contribution to the work of international, regional and national human rights and legislative bodies on sexual and reproductive health issues. She has also worked as a patients' rights representative and attorney on medical malpractice, mental disability and patient's rights. Her working experience extends to Central and Eastern Europe, Central Asia, South- East Asia, Middle East and Africa. She holds a Master in Law (LLM) degree on international sexual and reproductive health law with a joint degree on bioethics from the University of Toronto and a degree of Jurists Doctor from University of Law, Pecs, Hungary. She is on the editorial board of Reproductive Health Matters and a founding member of the Sexual and Reproductive Health Research Network.



Rafael Mazin

MD, MPH
Pan American Health
Organization (PAHO)
USA

Rafael Mazin is the Senior Advisor on HIV/STI and hepatitis of the Pan American Health Organization (PAHO), Regional Office of the World Health Organization (WHO). Dr. Mazin is in charge of a PAHO strategy directed to focus prevention and care efforts on the populations and groups at the epicenter of the HIV epidemic in the Region of the Americas. Dr. Mazin is also responsible for an innovative strategy aimed at articulating the capacities, resources and competences of Sexual and Reproductive health services with HIV/STI prevention programs. He has coordinated the development of tools for the provision of comprehensive care to gay men and other men who have sex with men and to transgender persons. Also, he has promoted actions to eliminate homophobic bullying in schools. Dr. Mazin is member of various editorial boards of journals and publications on sexual health and sexological science. He is proficient in English, Spanish, French, Portuguese, and Italian. Dr. Mazin got his medical diploma from the National University of Mexico and his MPH from George Washington University in Washington, D.C.



Geoffrey M. Reed

Ph.D.

World Health Organization
(WHO)
Spain

Dr. Reed joined WHO in 2008 as Senior Project Officer for the Revision of ICD-10 Mental and Behavioural Disorders in the Department of Mental Health and Substance Abuse. As Senior Project Officer, he is responsible for managing all aspects of the development of the ICD-11 classification of mental and behavioural disorders, including review and synthesis of global scientific literature and other information on current use; nomination and management of expert working groups; management of expert participation in drafting; design and management of field studies and field trials throughout the revision process; and preparation of related publications. Prior to joining WHO, Dr. Reed served for more than a decade as Assistant Executive Director for Professional Development at the American Psychological Association in Washington, DC, USA, the world largest professional association of psychologists. As a part of his work with the American Psychological Association, he collaborated closely with WHO on the development of the International Classification of Functioning, Disability and Health (ICF), and directed the largest USA field study site for the ICF. He holds a doctoral degree in psychology from the University of California, Los Angeles, and completed postdoctoral training at the University of Washington. After completion of his training, Dr. Reed was a member of the research faculty of the Department of Psychiatry and Biobehavioral Sciences at the UCLA School of Medicine. His early research with the Multicenter AIDS Cohort Study focused on psychosocial predictors of HIV and AIDS progression, and Dr. Reed was named one of the 50 most innovative AIDS researchers by POZ Magazine, a magazine by, for, and about people living with HIV and AIDS. Dr. Reed's focus shifted to health system and national health policy upon moving to Washington, DC, and he continues to pursue that interest at a global level with WHO. He is a leading expert on classification in mental health, has consulted with a variety of countries and health systems, and has published numerous scientific articles in several languages in this and other health policy areas. His recent publications describe the results of large, collaborative, international field studies intended to inform early decisions about the basic structure and content of the ICD-11 classification of mental and behavioural disorders.



Rebecca Fox
Wellspring Advisors
USA

Rebecca Fox works as a Program Officer at Wellspring Advisors. In this position, she focuses on advancing lesbian, gay, bisexual, and transgender (LGBT) issues. This includes a focus on national and state advocacy, marriage equality, international and domestic transgender movements, and movement building. Prior to coming to Wellspring, she was the Executive Director of the National Coalition for LGBT Health, leading organizations nationwide to work together to improve the lives and health of LGBT people through advocacy, outreach, and education. She was also an Adjunct Professor at the George Washington University. She serves on the board of Choice USA, a national organization that mobilizes and supports the diverse, upcoming generation of leaders who promote and protect reproductive choice. Before the Coalition, Fox worked as the Assistant Director for Public Policy at SIECUS, the Sexuality Information and Education Council of the United States and at the National Partnership for Women and Families where she monitored federal level legislation pertaining to health insurance, gender-based discrimination, and reproductive rights. Her experience includes assisting in a free medical clinic for women and providing services and programming for people living with HIV/AIDS, homeless youth, and children of LGBTQ parents.



Dave Scammel
Open Society Foundations
USA

David Scamell is a joint program officer for the Open Society Public Health Program's Law and Health Initiative and Sexual Health and Rights Project. His work focuses on supporting civil society to use laws and legal tools in order to increase access to health care and advance the health-related rights of those who are marginalized because of their sexual practices, sexual orientation, or gender identity. Prior to joining the Open Society Foundations, Scamell worked on sexual health and human rights policy and advocacy in Australia.

He has a Masters in International Human Rights Law (with Distinction) from the University of Essex, and a combined Bachelor of Laws & Bachelor of Arts from the University of New South Wales.



Julie Dorf

BA
Facilitator
USA

Julie Dorf has been a leader in the LGBT rights movement for twenty years. Julie founded and directed the International Gay & Lesbian Human Rights Commission (IGLHRC) from 1990 to 2000, creating an organization that protects and advances the human rights of all people and communities subjected to discrimination or abuse on the basis of sexual orientation, gender identity or HIV status. In the past decade, Ms. Dorf has worked in philanthropy, serving as the Director of Philanthropic Services for Horizons Foundation, a foundation serving the Bay Area's lesbian, gay, bisexual, and transgender community; and as Vice President of the Vanguard Public Foundation. She has extensive experience providing philanthropic advice to individual donors, legacy planning, and donor education. As an independent consultant, Ms. Dorf has worked for Open Society Institute, Global Fund for Women, Arcus Foundation, and Fenton Communications/J-Street Project. Ms. Dorf currently serves on the board of directors or advisory boards of Human Rights Watch's LGBT Rights Program, Gender PAC, IGLHRC, and PowerPAC.

Ms. Dorf has written, spoken, and advocated extensively on social justice issues ranging from reparations for gay victims of the Nazis, Jewish-Palestinian relations, and marriage equality. She lives in San Francisco with her partner Jenni Olson, and their two girls Hazel and Sylvie.

Appendix C: Relevant ICD-10 Classifications

F64

Gender identity disorders

F64.0

Transsexualism

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex.

F64.1

Dual-role transvestism

The wearing of clothes of the opposite sex for part of the individual's existence in order to enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change or associated surgical reassignment, and without sexual excitement accompanying the cross-dressing.

Gender identity disorder of adolescence or adulthood, nontranssexual type

Excludes: fetishistic transvestism (F65.1)

F64.2

Gender identity disorder of childhood

A disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex. The diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behaviour in boys is not sufficient. Gender identity disorders in individuals who have reached or are entering puberty should not be classified here but in F66.-.

Excludes: egodystonic sexual orientation (F66.1)
sexual maturation disorder (F66.0)

F64.8

Other gender identity disorders

F64.9

Gender identity disorder, unspecified

Gender-role disorder NOS

F65.1

Fetishistic transvestism

The wearing of clothes of the opposite sex principally to obtain sexual excitement and to create the appearance of a person of the opposite sex. Fetishistic transvestism is distinguished from transsexual transvestism by its clear association with sexual arousal and the strong desire to remove the clothing once orgasm occurs and sexual arousal declines. It can occur as an earlier phase in the development of transsexualism.

Transvestic fetishism

F66

Psychological and behavioural disorders associated with sexual development and orientation

Note: Sexual orientation by itself is not to be regarded as a disorder.

F66.0 Sexual maturation disorder

The patient suffers from uncertainty about his or her gender identity or sexual orientation, which causes anxiety or depression. Most commonly this occurs in adolescents who are not certain whether they are homosexual, heterosexual or bisexual in orientation, or in individuals who, after a period of apparently stable sexual orientation (often within a longstanding relationship), find that their sexual orientation is changing.

F66.1 Egodystonic sexual orientation

The gender identity or sexual preference (heterosexual, homosexual, bisexual, or prepubertal) is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders, and may seek treatment in order to change it.

F66.2 Sexual relationship disorder

The gender identity or sexual orientation (heterosexual, homosexual, or bisexual) is responsible for difficulties in forming or maintaining a relationship with a sexual partner.

F66.8 Other psychosexual development disorders

F66.9 Psychosexual development disorder, unspecified

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ICD-11 Consensus
Process

ICD-10 F65 diagnosis Transvestic Fetishism

Cecilia Dhejne, MD, PhD student, clinical sexologist (NACS), Head of the Gender Team and consultant at the Center for Andrology and Sexual Medicine, Karolinska University Hospital, Stockholm, Sweden

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ICD-11 Consensus
Process

Background Paraphilias

- Paraphilia from Greek "love besides" (normality=majority).
- Nature or "God" created the human being with the capacity to enjoy their sexuality and to procreate.
- The need to explain and constrict non-normative behaviour or sexual behaviour which is not aimed to procreate has varied over time and has either been explained as a sin to God or as a psychiatric disease.
- We know very little of what causes patterns of sexual attractions, most likely they are driven by biology, psychosocial and cultural aspects, and the script we use to define them. They therefore differ among time periods and in different cultures.

Transvestic Fetishism

- 2,8% males and 0,4% females in a Swedish population study, had cross dressed at least once*.
- The vast majority do not seek help.
- In those who seek help it is often an early manifestation of gender dysphoria.
- Taken out of ICD 10 in some European countries, because it was pathologizing human sexual behaviour and because it was never used**.

*Transvestic fetishism in the general population: prevalence and correlates.
Långström N, Zucker KJ.
J Sex Marital Ther. 2005 Mar-Apr;31(2):87-95.

** The National Board of Health and Welfare in Sweden 2009

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ICD-11 Consensus
Process

ICD11 Paraphilic disorders

- Chosen instead of Disorder of Sexual Preference (ICD10), because all paraphilias don't meet the diagnostic criteria for having a disorder.
- It will be limited to sexual arousal patterns involving individuals who can not consent. Manifested by sexual thoughts, urges or behaviours.
- Does Transvestic Fetishism fulfill these criteria?

Reasons for the need of a diagnosis

- **Clinical utility? Important with a clear cut condition in order to choose treatment.**
Uncommon that people seek help, treatment not needed
- **Research** *important but doesn't overrule the cons*
- **Access to care if needed**
Treatment not needed and in the few cases who seek help, other diagnoses can be used
- **Public health aspects, meeting the public needs for surveillance.** *Not applicable*

Cons for a diagnosis

- **Human right aspects**, pathologizing non-harmful human behaviour.
- **Used as a tool for discrimination.**
- **Treatment might be harmful, or not needed.**

Arguments in favor of retaining a diagnosis of Transvestic Fetishism in ICD-11

January 30, 2013

George R. Brown, MD, DFAPA

Professor of Psychiatry, East Tennessee State University, Johnson City, TN, USA

Program Director, Health Care Outcomes, Office of Health Equity, Veterans Health Affairs, Washington, DC

Introductory remarks:

I was asked to present the case for retention of some form of the diagnosis Transvestic Fetishism in ICD-11 for this meeting, recognizing that many, if not most, have already made up their minds that this diagnosis does not exist, or should not exist, and is pejorative in name and intent. I am also cognizant of the draft entitled “Rationale for Change in Paraphilic Disorders in ICD-11, which proposes to limit paraphilias to those involving unconsenting parties, human or otherwise. I have not been asked to defend its title (Transvestic Fetishism) or its placement within ICD (both of which could and should be debated as well), but merely to comment on the concept of retention of this diagnosis in some form other than the proposed “Counseling related to sexual behavior and orientation”, corresponding to a Z chapter diagnosis in ICD-10. Given that the draft represents the thinking of the group, I recognize that my counterproposal stands little chance of being considered. Nonetheless, as others have spoken from their clinical perspective, I feel an obligation to do the same in the interest not of politics, but of accurate nosology.

Since many of you are unfamiliar with my work in this area, let me give you the context and perspective from which I base my position for retention in some form. I have worked both clinically and in a research context with men who describe themselves as cross-dressers for nearly 30 years. I have published descriptive work on some of the larger samples of cross-dressers and their spouses, most of whom I interviewed outside of a clinical setting, unlike most work done in this area. I published the largest study of personality characteristics and sexual functioning in cross-dressing men (a nonclinical sample, showing that they were essentially the same, as a group, as matched non-cross-dressing male controls). I was the first to gain sanction from the American Psychiatric Association to publish a large treatise on this topic in their 2 volume textbook, **Treatments of Psychiatric Disorders** with the position that, unlike in the past, a clinical significance criterion must be met for fetishes of any type, including transvestism, and that engaging in, or thinking about, cross-dressing was not in itself a disorder or a diagnosis. While this seems to be a completely uncontroversial idea in 2013, in the 1990's world of American psychiatry, this was a radical departure. All of my teaching at medical schools throughout the US have had this conceptual framework on the importance of impairment and disability in making ANY psychiatric diagnosis. I point this out because far from being an “old school” holdout for politically incorrect and socially awkward diagnoses, I have actually been an early leader in the depathologization of cross-dressing. However, my clinical experience informs my position for retention in the minority of cross-dressing men who in fact are impaired in one or more important ways by their strong interest in, and involvement with, cross-dressing, not unlike the minority of person who engage in a variety of other activities that are not, by definition, psychopathological, but when taken to excess, can result in crossing a threshold of clinical significance.

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Arguments for retention:

The ICD-11 Advisory Group has decided to use the identical definition for what constitutes a mental disorder in ICD-10:

“A clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions”.

The essence of my argument for retention of TF, in some form, is based on the fact that this definition fits the reality for some men who cross-dress, whether it is done fetishistically or not.

The draft document dated 10/11/12 on paraphilias deviates from the definition of a mental disorder that the Advisory Group itself has published. Specifically, to define a paraphilia as only existing when it affects others is a substantial deviation from the individual focus of other diagnoses in ICD. This, in essence, is defining a diagnosis in a person based solely on its effect on others, and in disregard for the effects it may have upon the individual. The symptoms I have seen in numerous patients is not due to “deviation from societal norms” or limited to the “social consequences of such deviation” (page 3, Paraphilias draft document, listed in reference section below).

In my clinical experience, I have met or treated many individuals whose cross-dressing (whether connected to sexual functioning or not) led to substantial disability in the form of anxiety, depression, resorting to substance use to cope with insurmountable feelings related to a strong drive to cross-dress, relationship problems, occupational dysfunction, suicidality, and other symptoms that they, themselves, associated with out-of-control drives or behaviors to engage in cross-dressing. Some case examples that come to mind from my practice include:

- Active duty sailors serving on nuclear submarines in tight quarters with other men who, in spite of the risk of bodily harm and loss of their jobs, could not avoid cross-dressing while deployed in spite of their desire to not suffer those potentially life threatening, and certainly career-ending, consequences. These men would self-report for treatment, whether or not they were “caught.”
- Active duty soldier who would cross-dress and repeatedly try to get through military checkpoints using a falsified identification card, knowing that if caught, he would suffer serious negative consequences to his marriage, reputation, and career. In spite of those risks, he continued to engage in those risky cross-dressing behaviors and self-reported for psychiatric care because he felt powerless to control his behavior.
- Many cases of civilian cross-dressing men who self-reported for psychiatric care, often asking for “a pill to make it go away” so they would not continue to suffer anxiety, depression, and/or the potential loss of their marriages to spouses who were not supportive of their desire to cross-dress on a regular basis, publically or otherwise. Some reported they had spouses who were tolerant, and sometimes accepting, of their cross-dressing but not to the excess levels they felt compelled to participate in cross-dressing activities.

While we could take the approach that it is society’s non-acceptance of gender variant behavior that is “to blame” for the suffering of these men (I have had no women cross-dressers request psychiatric care) similar to the arguments used for all gender variant behaviors, that seems to be of little consolation to those who dysfunctionally, obsessively cross-dress and self-identify as suffering from their overwhelming desires to do so in spite of the negative consequences of their behaviors. In many cases, spouses were directly affected and could be considered “victims” under the draft proposal’s paradigm of limiting paraphilias to those “sexual behaviors which are harmful to others” (page 3, draft proposal listed below). While the vast majority of cross-dressers would not meet a standard clinical significance criteria (or met it in the past but no longer do), clearly

there are those who do meet criteria for a diagnosis following the overarching definition used by the ICD-11 Advisory Group, and who could benefit from treatment. Treatment, of course, is not intended to eliminate the desire to cross-dress, is not “reparative” in any way, but is intended to help individuals who report they are suffering reach a level of accommodation, self-acceptance, and balance in their lives such that their symptoms and dysfunction are alleviated.

I am sensitive to the argument that elimination of the diagnosis altogether will foster societal acceptance by a complete depathologization of all cross-dressing behavior, and indeed, many would benefit from such an approach. Advocacy groups have also rallied behind the cause to eliminate any diagnostic vestiges of gender variant behavior, to preclude even the possibility of making a diagnosis associated with cross-dressing in any form. However, the patients I have seen do not read the ICD and would still suffer symptoms and/or negative consequences and would wish to seek mental health treatment nonetheless. Since the behavior is well identified and specific, to relegate it to what amounts to a wastebasket classification in the Z chapter makes little sense to me. It is specific and well described.

I am also sensitive to the argument that there would always be a way to give another diagnosis that is more politically correct as an entrée to care, for example an anxiety disorder, or depressive disorder, or marital/relationship problem, or perhaps all of these diagnoses at the same time, in addition to the Z chapter description of Counseling related to sexual behavior. This seems a bit disingenuous to me, however, and I am reminded of the risks of taking that approach for those with gender dysphoria. Certainly there are those with GD who suffer anxiety, depression, and irritability (the cardinal components of “dysphoria”), but treatment of those components without addressing the underlying actual diagnosis is generally doomed to failure as anyone who has tried to treat GD with antidepressants is well aware.

In summary, my argument/position is as follows:

1. Transvestic fetishism exists as a clinical entity for a minority of those who cross-dress.
2. “Fetishism” is accurate only for a subset of cross-dressers who meet clinical significance criteria, since sexuality is only a part of cross-dressing and may or may not be associated any longer with sexuality.
3. The absence of a diagnosis of some type that deals directly with dysfunctional cross-dressing is inconsistent with clinical realities, and is not better addressed by using surrogate diagnoses like “anxiety disorder” or “depressive disorder.” The diagnosis, if properly crafted, would meet the definition for an individual diagnosis consistent with the published ICD-11 Advisory Group’s definition of mental disorder, which carries over from ICD-10.
4. The name of the retained diagnosis should also be debated; I am not making a case for, or against, the term “transvestic fetishism” in this position paper.
5. Advocacy for human rights and changes in cultures and societies has an important role to play in how we think about the human condition. Political expediency at a national or global level should not take the place of accurate descriptions of mental health phenomena in individual people, as the law of unintended consequences could result in harming some of those we wish to help. I am reminded that the WHO Advisory Group has listed, in order of importance, the three main stakeholder groups as consumers of ICD-11 (constituent governments, health care professionals, and third, consumers/families). While governments may not be interested in the non-forensic paraphilias, certainly clinicians who see such individuals are, and in my experience, the consumers/families who self-report for care are not represented by advocacy groups, and therefore do not have a voice in this debate.
6. Retention of this diagnosis, in some identifiable form, is consistent with the stated purposes of ICD (IAG for the Revision of ICD-10, World Psychiatry 2011):
 - Clinical applications
 - Research
 - Teaching and training
 - Health statistics
 - Public health

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Appendix E: Supplemental Materials on ICD-10 F64.2

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1 February 2013

Dr Lin Fraser
President, World Professional Association for Transgender Health

Dear Lin Fraser,

I am a member of WPATH and a consultant child & adolescent psychiatrist with a special interest in Gender Variance in young people. I am also a general adult psychiatrist. It has been suggested that I should offer my recommendations to the WPATH ICD-11 Consensus Meeting through you:

My experience in training and working a psychiatrist with gender variant youth in the UK, USA and South Africa has led me to the following views:

1.) There should be no diagnosis for children with Gender Identity Variance

WHY NO DIAGNOSIS?

- These young people face enormous prejudice and hostility from society, their peers and own families, which often leads to psycho-pathology (e.g. depression and anxiety). When supported appropriately, these young people thrive in every way like their peers and exhibit no mental health problems. The only 'symptom' they show is the wish to be the opposite sex. The young people themselves do not see themselves as mentally unwell, only that they have the wrong sex bodies. To give them any diagnosis only serves to confirm that they are defective in some way and undermines their mental health further.
- As at least 80% of children lose their wish to be the opposite sex around puberty and turn out gay, I think it is entire inappropriate to give these young people anything more than a descriptive term such as gender variant. Giving them a psychiatric diagnosis is pathologising and stigmatising in all sorts of ways and adds to their already huge burden placed on these young people due to the prejudices of society. As childhood gender identity variance is a pre-homosexual phase in about 80% of cases. As we no longer view homosexuality as a disorder, it must be inappropriate to view this phase as a disorder.

Z-CODE

I believe a 'Z code' is the most that could be justified for children. I like it to the extent that it is true that gender variance is one of the "Factors influencing health status and contact with health services". However, I would argue that a descriptive term like 'gender variant child', which could have the same lack of mental health implication today as 'homosexual child', might be more appropriate. I think we are dealing with a recurring problem of asking clinicians to think 'outside the box' of their present work place. We need to be aware of what the present psychiatric diagnosis is doing and move to a healthier world for gender variant youth. Just as parents of gay youth are still seen by mental health professionals to get help in accepting and supporting their children, I think

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the transition to giving gender variant kids this help, without giving them a diagnosis, is totally possible. Any labeling in the form of a Z code or otherwise should recognise that there is a large spectrum in Gender variant people. This variation is even larger in transgender adults may wish to be themselves.

ACCESS TO CARE FOR GENDER VARIANT CHILDREN:

I have treated children and adolescents with gender variance issues in the USA, UK and South Africa. I have **never needed a diagnosis** of 'Gender Identity Disorder' in order to see or help these young people and their families. A descriptive term would always have been helpful if not central, but there were always other diagnoses that could have been used to satisfy funders, as to why the young person needed mental health intervention. I have seen children with 'gender identity disorder' living in a supportive environment who have not needed any mental health interventions at all - other than to reassure their parents that they are doing a great job. Even not having a gender identity disorder diagnosis, would not have stopped me from seeing these young people and their families. As a consultant psychiatrist I see young people who are referred to me as they **MIGHT** have a problem and it is sometimes my job to say that they do not have one. It does not mean they should not have been referred to me or that I could not have found a way of finding funding.

RESEARCH:

Some have argued that the lack of a diagnosis psychiatric or otherwise will hamper or stop research. When homosexuality was no longer pathologised, there was no such end to research. There was though a healthier shift away from the research into the 'causes' of homosexuality, as it has been accepted as a normal variant.

2.) All Gender Identity diagnoses be moved out of the mental and Behavioural Disorders Chapter (5) or F-codes

While I feel there are a lot of pitfalls in trying to find a 'cause' for transgender or gender variance, I believe the little bit of evidence we have with Congenital Adrenal Hyperplasia and Gender variance, points to the possibility of the in-utero exposure to certain levels of hormones being a factor if not a cause. The fact that we do not have the technology to prove this one way or the other at this point in time, should not result in these people being diagnosed as having a mental disorder.

It seems to me in medicine when people do not understand a situation or a condition it gets labeled as psychiatric or the person is sent to a psychiatrist. I believe this is probably what has happened in the case of transgender. I feel that it would be more appropriate, based on the evidence that we have, that transgender or gender variant teenagers or adults are no longer given a psychiatric diagnosis in ICD-II, but rather an **endocrine (or medical) diagnosis**. If the cause does not lie in these fields, at least some help or the solution lies there for most.

ACCESS TO HEALTH CARE FOR GENDER VARIANT TEENS & ADULTS

We have a system in place where we have got used to having a GID diagnosis and depending on it to help young people with these issues. I am surprised by how blinkered clinicians seem to be in assuming that we cannot help these young people without the diagnosis as it stands at present. Yes, there will be significant change e.g. some major centres may have to renegotiate the label these young people are treated under, but I see no reason why appropriate discussions and changes should not be able to bring about these changes relatively easily. After all, funders will have to agree that changing the category of diagnosis will not mean that the same needs do not still need to be met in these young people, as they have been in the past. " Fix the system rather than continuing to pathologize" as colleague Antonia Caretto said.

WHAT DO GENDER VARIANT CHILDREN AND ADULTS WANT?:

As a clinician, I have found some parents relieved to be given a diagnosis, but not one child who likes to be told they have a Gender Identity DISORDER. If Gender variant kids and adults feel they do not want to be labeled with a psychiatric diagnosis, who are we as clinicians to give them one for the patronising reason that it is in their best interests to get services?! As clinicians it is our job to advocate (to funders etc.) and change the system so that when this pathologising labeling system is removed, they can still get the help they need to face the prejudices in our society. A large amount of the prejudice in our society stems from religion and psychiatry, it is high time that we own this and at wipe out the contribution from psychiatry. Some clinicians have suggested settling for some sort of compromise by still having a “non pathologising” diagnosis under mental disorders (F-codes). When it comes to prejudice be it racism, sexism, homophobia or Trans phobia, I believe these sorts of compromises are dangerous and ultimately backfire badly for those at risk.

It is always worrying to me when clinicians do not listen to their patients and at least give them the ‘benefit of the doubt’ in situations of uncertainty. If psychiatrists had done this with homosexuals, the psychiatric disorder would have been dropped long before 1973. It seems that it is much harder for clinicians to listen to children. Part of the problem also seems to be that the decisions on giving gender variant kids a psychiatric diagnosis has been by people who do not work with these kids or are closed to listening to them. This is despite the fact that gender variant kids are notably vocal about feeling they DO NOT have a mental health problem - as clinicians working with them will know. Kelly Winters feedback from speaking to TYFA parents and their kids is typical and confirms that they do not want a psychiatric diagnosis. One of our best sources for feedback from adult transsexuals could arguably be the Den Haag meeting. At the GATE meeting in Den Hague in 2011, where most of the experts present self-identified as Trans, the Z codes became a central part of the Star fish model proposed and psychiatric diagnosis was rejected. Another strong proposal that came out from the meeting was the possibility of working with both Chapter IV: Endocrine, nutritional and metabolic diseases (E 00-99), and Chapter XIV: Diseases of the genitourinary system (N00-N99).

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3rd WORLD:

As a clinician from the so called ‘3rd world’, I can only appeal to those from the ‘1st world’ to get this diagnosis removed from mental health urgently. As resources are so scarce in the 3rd world, so much understanding is reliant on what the 1st world decides in the form of ICD and DSM. There is not the luxury of time to debate the ICD in 3rd world countries. In Africa being transgender can put a person’s life at risk. A strong message from the 1st world to the 3rd that Transgender is not a mental illness (but a normal variant), is the best thing the first world can do, rather than to cast doubt on this for the sake of funding streams or any other reason.

Our challenge is to help the right minds in charge of ICD see all this. If the right changes are made in ICD-11, I believe permanent enlighten will follow. Just as it is now inconceivable to have homosexuality diagnosed as a mental health disease, I believe once it happens, we will be wondering how clinicians even questioned getting rid of transgender from mental health diagnoses. A similar process happened in South Africa where a small group of gay people enlightened Nelson Mandela while in prison on the gay issues. As a result in his first sentence of his first speech he stated that ‘never again would prejudice be allowed in the country on the basis of race, gender or SEXUAL ORIENTATION.’ As HE had said it, no one could argue and it went in the constitution at a time when it would never have been passed by the public vote. Yet since the public have been forced to consider this issue and accept it legally, it now inconceivable to most South Africans that homophobic legislation could ever be re-introduced. I hope we will see a similar shift away from Gender Identity Disorder in Children (and adults!) Sending you lots of positive thoughts and support in your preparations in this important task! Thank you for all your work.

Best wishes,
Simon

Arguments against the proposed *gender incongruence in childhood* diagnosis.

Sam Winter, University of Hong Kong

Reduced version of paper originally dated 2nd February 2013

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(birth-assigned male, later to grow into transgender woman, with mother, Myanmar (c1980))

In this document I present arguments against the draft proposal for a diagnosis of gender incongruence in childhood ('GIC').

Briefly, I believe that the proposed GIC diagnosis pathologises patterns of development that should not be pathologised, that the diagnosis is inconsistent with the approach the Working Group proposes for other children and youth (including, importantly, homosexual youth), that the pathologisation carries risks for the gender-different child (and indeed for the broader work of the Working Group), and that there are alternative ways of providing health care services for gender-different children (plus their parents, teachers and others) who may need such services.

In short the argument is for de-pathologising, rather than simply de-*psychopathologising*, gender difference in childhood.

A few words about my role in this process. I am the member of the WGSDSH⁶ (the 'Working Group') which has worked on developing the draft proposals you have in your papers. I was also

⁶ The WHO Working Group on Sexual Health and Sexual Disorders

in the small subgroup which worked on the draft gender incongruence proposals, again in your papers. With the other two members of that subgroup I am a co-author of the *Minding the Body* paper,⁷ which argues for removal of transgender diagnoses from ICD Chapter 5 (*Mental and Behavioural Disorders*), and which has, in the table on p570, drawn wide attention to a proposed child diagnosis.

I, like others, have misgivings about the GIC proposal; a proposal which focuses on gender incongruent children below the age of puberty. My concerns have grown in recent months, largely as a result of discussions with professionals and scholars working in the field. Letters from the following persons not at the meeting have been made available to participants at this meeting: **Dr Elizabeth Riley** (counseling psychologist working in Sydney, Australia), **Dr Lisa Griffin** (clinical psychologist, working in Virginia, USA), **Dr Antonia Caretto** (clinical psychologist, Michigan, USA), **Kelley Winters** (author of the book *Gender madness in American psychiatry*, currently resident in Florida USA), and **Dr Arnaud de Villiers**, medical clinician and activist on transgender health issues in Africa (Cape Town, South Africa). They all express some sort of misgiving about the child diagnosis, and many argue the sort of strategies I argue for here. Indeed my ideas have in some cases been shaped by their own.

Please note that my own misgivings place me in a minority (of one) in the small subgroup which has worked on the Working Group *gender incongruence* diagnoses. As you might expect, I am therefore not a co-author of the Background Discussion Document⁸ (provided by WHO and among your papers), recently prepared (I assume) by the other two subgroup members.

I am comfortable sharing my perspective on the proposed GIC diagnosis. My contribution to this debate is my acquaintance with the broader aspects of health and rights for transgender people, particularly as those things apply in Asia.

Here are my arguments in more detail.⁹

1: The view of gender-different children as sick and in need of health care is a culturally-specific one, not only modern but also peculiarly Western in origin.

It is clear that many transgender people worldwide¹⁰ live in cultures that are more accepting of gender difference than is the case in much of the West. Many of these cultures have a long history of inclusivity in regard to such persons¹¹, inclusivity that was anathema to European colonists and missionaries¹², but some of which survives to this day¹³. In these cultures there are often a range of identities available to young children who grow up gender-different¹⁴.

⁷ Drescher, Cohen-Kettenis and Winter (2012)

⁸ Background Discussion Document on Proposed ICD-11 Category of Gender Incongruence of Childhood.

⁹ Childhood gender diagnoses have been the subject of much criticism. The Background Discussion Document on GIC to which I referred earlier reviewed some of the published critiques in the area, most of them in relation to the old DSM-IV diagnosis, *gender identity disorder of childhood*. I will not revisit that research here. I will add though, that the above document neglects to mention publications by experienced clinicians advocating gender affirmative approaches in work with these children and critical of less affirmative (and even repressive) approaches (Ehrensaft, 2011). Other recent additions to the literature are three Australian papers examining the views of three groups of stakeholder (parents of gender-different children, professionals, and transgender adults) on the needs of needs of gender-different children and their parents. Together they indicate concurrence on the importance of freedom of expression, acceptance, respect and support for the children, and for information and support for the parents (Riley et al, 2011a,b, 2012).

¹⁰ In the Asia-Pacific alone there are an estimated 9 to 9.5 million (UNDP 2012).

¹¹ See for example Coleman et al (1992) and Urbani (2006) in relation to Myanmar; Matzner (2001) discussing Hawai'i; Schmidt (2001) discussing Samoa; Graham (2001, 2002) and Graham-Davies (2007) discussing Sulawesi in Indonesia; Jackson (2003) discussing Thailand; and Nanda (2000a,b,c) discussing Thailand, the Philippines, India and across Polynesia. Also see Peletz (2006, 2009) for a more general discussion of cultures of 'gender pluralism' in pre-modern Southeast Asia.

¹² See for example Nanda (1990, 2000a), Brewer (1998, 2001).

¹³ For example Graham-Davies (2007); Vasey and Bartlett (2007).

¹⁴ For a (non-exhaustive) list of around 50 identity labels used in the Asia-Pacific by and/or for (those we in the West would call) transgender women see UNDP (2012)

Many of these roles had (or indeed still have) particular social, cultural, or even spiritual or religious significance¹⁵. Today, in parts of the global south and east, many such children begin to identify in another gender quite early in life, doing so before puberty, and are recognized by others as being members of their affirmed gender group, even if in the modern world there are often, at home and school, limits to the degree to which they can express that identity. Those limits in any case often loosen by the time they approach school-leaving age.

Many individuals growing up in these social environments appear to enjoy (in childhood, adolescence and adulthood) relatively good psychological adjustment (despite sometimes having to endure broader societal stigma)¹⁶. Though a gender-different child's gender identity and expression may not be universally celebrated by parents and teachers, that identity and expression tends to be accepted by them as *diversity* rather than mental or medical disorder. In thirteen years working in with transgender people in Asia I recall very few informing me that their parents had taken them to see a doctor when they were a child. Asian transgender activists who have written to me since my arrival in San Francisco a couple days ago confirm that it is relatively rare for parents to do so.

The view of gender-different children as sick is therefore is a somewhat culture-specific one; not only modern but also peculiarly Western. (And it is a view that may aggravate whatever societal stigma is out there, but I'll come back to that point later).

Now let's consider what health care we actually provide to 'sick' children (those who according to this Working Group proposal would be diagnosed as gender incongruent).

2: Gender-different children have no need of hormones or surgery, or any other somatic gender health care. Insofar as they may benefit from any health care services at all (and an indeterminate number may not need it) their needs are focused on accessing counseling and (perhaps) other mental health care.

They may need support and information to help in **exploration** of their gender issues (for example 'Who am I?', 'What shall I do about it?'), ways of dealing with the challenges arising from gender **expression** (for example 'Why won't people let me be who I want?', 'Why do they treat me the way they do?', 'How should I handle this?') and arising from any bodily concerns they may have (for example 'Why do I feel this way about my body?', 'What can I do about it?', 'When?', 'With what effects?'). **Parents, teachers and siblings** may also benefit from some support information about gender issues, and from counseling as to how they should respond to their child's gender issues.

I suggest all this provides no justification for a transgender specific and pathologising diagnosis of the sort the GIC represents. Consider, for comparison, other children with identity issues, or who find themselves confronted by circumstances (either in or out of their control) which bring them pain. An ethnic minority boy may want to explore his ethnic identity, and deal with the difficult or painful challenges of living in a racist society. But we do not diagnose him as having an *ethnic disorder*. A girl with divorced parents may need to explore difficult or painful family issues, and deal with unkind teasing at school. But we do not diagnose her as having a *divorce disorder*. A girl and her parents may want her to be top in the class, and she may feel great pain for not achieving this, and experience rejection at home. But we do not give her a diagnosis of *educational aspiration disorder*. In all these cases the child needs (and a health care provider would hopefully seek to provide) information, support and a more supportive environment that enables the child's development. To But he or she would do this without pathologising the child who finds

¹⁵ A recent WHO Asia-Pacific regional consultation on transgender health, having drawn up a working definition of transgender, was at pains to add in an explanatory note: "Transgender persons in Asia and the Pacific often identify themselves in ways that are locally, socially, culturally, religiously, or spiritually defined." (WHO 2013, page 18, current author's emphasis).

¹⁶ I should stress that gender-different children in the global south and east don't always find acceptance at home and school; not even in the most inclusive societies. Nor does it mean broader societal acceptance when the child reaches adulthood. The very real difficulties facing transgender people across the Asia-Pacific, particularly in the least inclusive societies, are very well documented. For a review of much of the research see UNDP (2012).

him/herself in this situation. It is difficult to see why it should be different for gender-different children.

What about those relatively few gender-different children who actually experience clinically significant distress about their situation. They may feel suicidal. They may be on the verge of self harm. For them there are already diagnoses available, the same diagnoses that might be used with a child clinically depressed or anxious in regard to ethnic minority status, parental separation or inadequate achievement. Of course, one would want to ensure that such diagnoses are not used to justify gender reparative care. But this is where Z codes can come in (more on this later)

One does not have to think of the ethnic minority child, the child from a broken family or the child with unmet achievement goals to see an inconsistency in the way the needs of the gender-different child are addressed. A comparison is even closer to home – gay and lesbian youth. And that leads us to the next section.

3: There is a grave inconsistency in the way the Working Group proposes to address the health care needs of (on one hand) gay and lesbian youth and (on the other) gender-different children.

The WHO Working Group has recommended deletion of the entire F66 block (*‘psychological and behavioural disorders associated with sexual development and orientation’*). Used with youth, F66.0 (*sexual maturation disorder*) currently pathologises the teenager who is distressed about his uncertain sexual orientation. F66.1 (*ego-dystonic sexual orientation*) currently pathologises the teenager who, knowing her sexual orientation, wishes it were different. The first youth needs support in exploring his sexual identity, and the second youth needs help in coming to terms with it, learning to feel comfortable expressing it, and dealing with the stigma and prejudice that comes from expressing it. *These are needs that are directly analogous to those of gender-different children.*

F66.0 and F66.1 (and a third diagnosis, F66.2 (*sexual relationship disorder*)) are widely regarded as providing a final repository for the thinking that underpinned the old homosexuality diagnosis (after all, how many youth are distressed by the possibility they may eventually turn out heterosexual, or about the actual fact that they are?). Part of the concern over the F66 block is that it raises possibilities for psychopathologising sexual variation, and for prompting or justifying stigma and human rights abuses, including sexual reparative therapy.

Few reputable clinicians would disagree with the proposed deletion of Block F66, or with the proposal that those with sexual orientation issues who would genuinely benefit from mental health care could be provided access to it by other diagnostic means. Significantly, the Working Group proposes that Z Codes may be used in these cases.

The F66 proposals present a gravely inconsistent approach. The inconsistency is in the way we address the mental health care needs of (on one hand) the gay and lesbian teenager exploring and coming to terms with her *sexual orientation* (and the expression thereof) and (on the other) the gender-different child exploring and coming to terms with his gender identity (and expression thereof). For lesbian and gay youth the move is away from diagnosis that pathologises. For gender-different children the Working Group proposes that a pathologising approach continues.

This inconsistency is all the more perplexing in view of the fact that, despite their names, the current *sexual maturation disorder* and *ego-dystonic sexual orientation* diagnoses (both proposed for removal) both explicitly incorporate gender identity.¹⁷

4: There are important implications for the prospects of removing the proposed gender incongruence diagnoses from Chapter 5.

The GIC diagnosis, a transgender specific diagnosis affording access only to mental health care, may conceivably come at the price of failure in broader moves to remove both diagnoses (GIC and

¹⁷ So does *sexual relationship disorder*, though in this case children with gender identity issues are not included.

GIAA ¹⁸) from Chapter 5. Let me explain why I think this.

a. Undermining the case for removal of GIC from Chapter 5. A recommendation for a GIC diagnosis - a diagnosis aimed to facilitate health care that is exclusively *mental* health care - is fundamentally inconsistent with a recommendation to remove that diagnosis from Chapter 5 (the *mental and behavioural disorders* chapter). Indeed, with mental health care the only sort of help to be provided to the child, Chapter 5 would appear to be an obvious place for the diagnosis. The case for de-*psychopathologisation* of childhood gender difference is therefore undermined, and the case for retaining the child diagnosis in Chapter 5 is inevitably left in place for all those who would use it. This carries risks for (a) reduced recognition of gender status (e.g. the little transgender girl seen as a mentally disordered boy), (b) increased stigma, and (c) increased use of gender reparative approaches.

With regard to gender reparative approaches, the removal of F66.0 and F66.1 (diagnoses that have been used, for example in Hong Kong, to justify sexual reparative therapy) may increase the risk that some mental health care providers will resort to child gender reparative approaches, rationalised in terms of attempting to catch incipient homosexuality early and nip it in the bud. I suggest that this risk would be even higher if the proposal to remove the GIC diagnosis from Chapter 5 were to be rejected. ¹⁹

b. Undermining the case for removal of GIAA. In view of the sibling relationship between GIC and GIAA (a relationship which is noted in the GIC Background Discussion Document) the case for removing the latter from Chapter 5 may also be undermined. The prospect that both diagnoses might stay in Chapter 5 is as alarming for transgender people in the global south and east as it would be for transgender people elsewhere. The idea that transgender people are mentally disordered already has a foothold there, and it appears to contribute to the stigma that sometimes blights transgender people's lives. A recent research study in five Asian countries, as well as in the UK and USA, indicates that in Asia, as elsewhere, people who believe that transgender people suffer from a mental disorder also tend to harbour prejudiced attitudes towards them— attitudes which, if expressed in discriminatory behavior, would act to push transgender people towards the margins of society (Winter et al, 2009).

Those working in the West (or in countries influenced by the modern Western discourse on psychopathologisation) may sometimes forget that support for removal of the trans diagnoses from Chapter 5 is less than universal; there are plenty of clinicians worldwide who take a different view. Significantly, dissent was evident even among the experts WHO recently invited to review the Working Group proposals. One, from a place other than North America or Western Europe, remarked on the longstanding and broad consensus among health experts in his country that gender incongruence conditions are *mental disorders*, disorders that obviously involved a distortion of mental processes contributing to the formation of sexual identity.

In May 2015, the World Health Assembly, the governing body of WHO, is due to vote on ICD-11. Some proposals will no doubt prove more contentious than others. Insofar as there are clinicians and scholars internationally who share the views of the above reviewer, and (either as individuals or through their professional associations) have the ear of their governments, there is a risk that the proposal to remove GIC (and by extension GIAA) from Chapter 5 will be undermined.

With so many problems plaguing the GIC diagnosis, what is the way forward? The rest of this paper presents ideas. They are the product of long discussions (face to face and by e mail, with clinicians, scholars and activists worldwide.

¹⁸ Gender incongruence of adolescence and adulthood.

¹⁹ WPATH deems gender reparative approaches with children as unethical. "Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success [references supplied], particularly in the long term [references supplied]. Such treatment is no longer considered ethical." (WPATH, 2011, p16).

A way forward.

An important way forward is provided by the non-pathologising Z codes.²⁰ As is evident from the introductory material in the Z-Code chapter, these codes are designed for circumstances matching those in which gender-different children are liable to find themselves.²¹

Importantly, the Working Group document which provides a rationale for deleting the F66 proposals notes that Z codes are an alternative (and less pathologising) way of providing health care to those with sexual orientation issues who are currently at risk of receiving a F66 diagnoses. Particularly relevant here is a section entitled '*What is a disorder vs. a perceived need for mental health services?*' I quote:

.....the ICD is structured to allow for two possibilities. First, the individual might have a clinically recognizable set of set of symptoms related to particular life circumstances, such as relationship distress, that is not a mental disorder, but it co-occurs with a recognizable mental disorder, such as Major Depression. In this situation, the diagnosis of Major Depression is applied. In the second situation, the individual may have a clinically recognizable set of symptoms, or 'problems' but no underlying disorder. In this case, a Z category may be selected. The Z categories recognize that individuals can and do seek services, including mental health services, in the absence of a current mental health or behavioural disorder. For example, requesting help for tobacco cessation in the absence of tobacco dependency (Z72.0), or for assistance in developing coping skills when targeted for discrimination (Z62.5) are both types of presenting concerns that could result in classification with a Z category. A health encounter in which the person is requesting information about sexual matters in the absence of a mental disorder could be classified using a Z category as well. In this way, the ICD distinguishes between mental disorders and perceived need for mental health services in the absence of a diagnosable disorder.²²

The Working Group then goes on to make three recommendations, as follows:

- a) **The deletion of the F66 categories in their entirety:** As the review above demonstrates, the F66 categories do not meet the requirements for retention in the ICD-11. There is no evidence that they improve clinical utility, and reason to believe they create harm; no evidence of public health surveillance need; no evidence of research needs in order to track mental health morbidity; and the categories themselves raise significant human rights concerns.
- b) **The revision of several of the Z70 categories** to better address sexual health and sexual relationship concerns at a more general level. These changes would focus more clearly on common reasons for seeking services as well as remove unnecessary focus on sexual orientation that currently lacks justification.
- c) **The revision of the descriptions of the Z60.4 and Z60.5 categories to encompass sexual orientation concerns.** These changes would facilitate accurate coding of personal distress resulting from experiences with anti-gay stigma, and may also be useful as a part of public health surveillance to track human rights concerns related to sexual orientation.²³

A similar approach can be taken with those children liable, under current proposals, to be diagnosed with the pathologising GIC category. There are a number of Z codes that could prove relevant to the needs of gender-different children, to document examinations and other health encounters.

At the WPATH Consensus Meeting I presented proposals for ways in which the Z Codes could

²⁰ Z00-Z13 Persons encountering health services for examination and investigation; Z20-Z29 Persons with potential health hazards related to communicable diseases; Z30-Z39 Persons encountering health services in circumstances related to reproduction; Z40-Z54 Persons encountering health services for specific procedures and health care; Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances; Z70-Z76 Persons encountering health services in other circumstances; Z80-Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status.

²¹ Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as "diagnoses" or "problems". This can arise in two main ways:

- a. When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination or to discuss a problem which is in itself not a disease or injury.
- b. When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury.

ICD-10 online, at <http://apps.who.int/classifications/icd10/browse/2010/en#/XXI>

²² Rationale for the Deletion of the F66 Categories in the ICD-11, p3.

²³ Ibid. p21

be used to facilitate appropriate health care for those gender-different children who might benefit from it, as well as to document contact with health care services. I argued that these codes could be used to help children explore and express their gender identities (and to support their efforts to cope with stigma) in the same way that the Working Group is proposing that the Z Codes could be used with gay and lesbian youth exploring and expressing their sexual orientation (and, again, to support their efforts to cope with stigma).

I will not present my ideas for the Z Codes here. It may be that detailed proposals come out of a subsequent Consensus Meeting organised by GATE (Global Action for Trans* Equality) to take place in a few months (April 2013). For the present, I affirm that it is my view that Z Codes can be used to facilitate access to the sort of broad support from which gender-different children and their caregivers will benefit.

Importantly, where a child is genuinely suffering from anxiety and mood disorders associated with gender difference, Z Codes can be used to specify the nature of the distress, thereby enabling appropriate health care for the child involved. Further, when a child reaches puberty and is in need of puberty blockers (where they are available), Z Codes can be used to document a history of gender difference, thereby ensuring a prompt diagnosis of GIAA.²⁴ Finally, when a gender-different child seeks adaptation at school (or elsewhere) to accommodate his or her gender difference, Z Codes can be used to provide a basis for the case being made.

In short, it is clear to me that Z Codes can play an important and appropriate role in provision of health care for gender-different children in their pre-puberty years, covering a wide range of encounters with health care providers, and a variety of health care-related services appropriate to their needs.

It is to be hoped that a Z Code approach with gender-different children will make it more likely that such children do indeed grow up comfortable with their gender; in the words of Jazz, *liking who they are*.

²⁴ Gender incongruence of adolescence and adulthood.



Jazz, aged around seven

Jazz: “If someone asks me why I used to be a boy and now I’m a girl I would say I have a girl’s brain and a boy’s body, and I think like a girl but I just have a boy’s body and it’s different than you.

Mom: *Is it OK to be different?*

Jazz: Yeah

Mom: *Do you like it? .. Cos why?*

Jazz: (Nods) It’s OK to be different . It’s OK to be different ‘cos it just matters who you are. It doesn’t matter if you’re different than anybody else. It just matters of you are having a good time and you like who you are”

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Gender in Free Form: Removing a Childhood Gender Diagnosis from the ICD-11

Presented to the WPATH ICD-11 Consensus Meeting February 3, 2013

The proposed ICD-11 diagnosis of Gender Incongruence of Childhood is defined as “a marked incongruence between the individuals’ experienced/expressed gender and the assigned sex in pre-pubertal children.” According to Geoffrey Reed (2010), the major orienting principle for ICD revisions will be improving clinical utility. The collective consensus of myself and colleagues who have worked together over the past number of years on reform of gender diagnoses is that, failing to meet that criterion, a diagnosis of Gender Incongruence Childhood should be deleted from the ICD-11.

Gender as Variation not Disorder

The premise underlying the recommendation to delete the childhood diagnosis from the ICD-11 is that gender nonconformity is not a disorder of childhood but rather a healthy variation of gender possibilities that may present over the course of childhood with good effect if social supports are in place (Ehrensaft, 2011; 2013). If given the opportunity, many children will explore the margins of gender in the journey toward finding their own authentic gender self, explorations that, in their childhood imagination and creativity, may look to adults like a marked gender incongruence, including a stated repudiation of their gender assignment and associated gender behaviors. Other children with persisting gender incongruence may simply be articulating their transgender status, identifiable to themselves in early childhood and again, a variation on rather than a disorder of gender. Difficulties, if faced at all by such children, are psychosocial, rather than psychiatric, and typically come in one of two forms: 1) a discrepancy between the social norms of gender within the child’s particular culture in interaction with a lack of acceptance of that discrepancy by the child’s caretaking environment; 2) a discrepancy between the perceived gender assigned to the child on the birth certificate and the gender that child perceives him- or herself to be. Neither of these in itself qualifies as a disorder. The proposal of the working group on Classification of Sexual disorders and Sexual Health (Drescher, Cohen-Kettenis, & Winter, 2012) to move the diagnosis out of the Chapter on Mental and Behavioural Disorders into a dedicated ICD chapter would not solve the problem, as the only clinical utility applicable to pre-pubertal children is mental health care, thereby signifying that there is a mental disorder to be treated, no matter where the new diagnosis is placed.

The social acceptance of gender-nonconformity and transgender identity among both children and adults varies remarkably from one culture to another (Roscoe, 1993; Nordberg, 2010; Keeps & Summer, 2009; Lacey, 2008). In certain cultures it is seen as pathological and in need of repair; in other cultures it is seen as an acceptable, even honored position in the society. A diagnosis in an international manual of disorders that will be used for treatment, codification of public health data, research, and teaching should be universally applicable, rather than culture- bound. At present, mental health diagnoses related to childhood gender show no evidence of universal applicability, and are based on specific Western cultural values of binary gender. The proposed diagnosis of gender incongruence is not exempt.

Evidence of the cultural rather than scientific underpinnings of gender diagnoses for children can be found in the criteria for diagnosis of Gender Identity--Childhood in the DSM-IV TR (APA, 1994). A boy only has to *prefer* clothing or activities of the opposite gender; a girl has to *insist* on clothing or activities of the opposite gender. This gender difference in diagnosis is based on

cultural attitudes that allow far more latitude for girls to cross gender lines than for boys to cross gender lines. Attitudes should not shape scientific categorization of mental disorders. Whereas the GID-Childhood diagnosis will be removed from the DSM-5, these cultural biases in gender diagnostic formulations should be an historical lesson to us to continue to pay attention to the cultural lens in which we are crafting diagnoses of childhood gender nonconformity.

Securing Services for Gender-nonconforming Children sans Gender Diagnosis

As the psychologist at the newly formed Child Gender Clinic at UCSF, I have no doubt that children who are gender-nonconforming or transgender, along with their families, need comprehensive mental health services, and we must ensure that they continue to get those services. Clinical observation indicates the following main reasons for service for pre-pubertal children:

1. The child's anxiety or confusion about felt or expressed gender desires or identities;
2. The family's anxiety or confusion about the child's felt or expressed gender desires or identities
3. The child and family's need for education and support in facilitating their child's gender health;
4. The parents' and/or child's desire to be educated about possible future medical services (particularly for children who have transitioned from one gender to another earlier in their childhoods).

Later, services would include assessment for and administration of puberty blockers, hormone treatment, or surgical interventions to bring a youth's body more in alignment with their affirmed gender identity; but this would be in the purview of adolescence, not childhood. Therefore, in recommending the removal of a gender diagnosis for children from the ICD-11, it is taken into consideration that none of these children will yet be eligible for any medical interventions related to their gender (i.e., puberty blockers, hormones, or surgical procedures)

Ensuring that children continue to receive needed services for the issues listed above can be obtained with the use of Z codes, as proposed at the GATE Experts meeting in The Hague (2011), proposing a starfish approach, using either existing codes, existing codes with a "g" qualifier, or creating a new Z code specific to gender situations (disjuncture between birth certificate and affirmed gender; unsupportive environment), as the Z categories recognize that individuals can and do seek services, including mental health services, in the absence of a current mental health or behavioral disorder. Z60.4, Social exclusion and rejection, and Z60.5, Target of perceived adverse discrimination and persecution are particularly relevant codes for gender-nonconforming children. As a data point, I reviewed the Z-codes, and identified 10 existing Z-codes applicable to children I or my colleagues in the mental health consortium of the Child and Adolescent Gender Center have treated for gender issues; it appears that there is no need therefore, to create a separate Z-code for gender situations, and that making available a g modifier for "gender nonconforming child" will allow codification of families who seek out health care for their pre-pubertal children without singling out gender, just as we do not single out divorce, adoption, or loss of a parent as a unique Z code. When appropriate, the Z codes can be attached to diagnoses such as adjustment disorder, anxiety, dysthymia, depressive episodes, conduct disorders which are often the results when gender becomes a psychosocial stressor, with no necessity to categorize gender itself as a disorder.

Ensuring provision of services will also necessitate changes in the system, rather than pathologizing the child for research or fiduciary purposes. This will involve calling on insurance companies and public and private funders of psychological services to recognize z-codes as either fundable or reimbursable, just as they do for well baby check-ups; indeed, our main services for pre-pubertal gender-nonconforming children should be well gender check-ups, so to speak. Well baby check-ups do not depend on the child having a diagnosis to be checked. So too should gender non-conforming children and their families receive well-child supports that will reinforce

their child's gender well-being as the child establishes both an authentic gender identity and the chosen expressions to accompany that identity. As referenced above, the psychological sequelae of gender nonconformity already qualify many of the gender-nonconforming children in need of service for public or private insurance programs' coverage of psychotherapeutic services, and are parallel to the types of diagnoses used to secure mental health services, for example, for children of divorce, children who have lost a parent, adopted children, children conceived with the aid of assisted reproductive technology, all of whom may be faced with psychological and social stressors. Just as gay and lesbian youth have continued to receive mental health services, and most definitely in greater numbers, after homosexuality was removed as a psychiatric disorder, there is no reason we could not ensure the same for gender-nonconforming children and their families through the steps listed above. On that note, I have yet to encounter a gay person who has longed for the return of the diagnosis of homosexuality as a disorder; instead, they report that they felt affirmed and liberated by its removal, as they still find ways to get the supportive mental health services they need, as early as their childhood years, and researchers are still able to locate them for the purpose of conducting psychological studies. Further, I have yet to encounter an otherwise healthily functioning transgender pre-pubertal child who embraces a Gender Identity Disorder as a positive attribution of self; yet that child now qualifies for a Gender Incongruence Diagnosis. As a social statement, it is letting the tail wag the dog to allow policies of funding agencies dictate what is a disorder and what is not. Scientifically and ethically, it is up to mental health practitioners, researchers, and theoreticians to be the dog, that is, the collective mind that agrees on the validity and clinical utility of, or lack of, a diagnosis for childhood gender nonconformity.

Risks of a Childhood Gender Diagnosis

There are significant risk factors in maintaining a diagnosis of Gender Incongruence-Childhood or any diagnosis of gender-nonconformity in the ICD-11:

1. The diagnosis stigmatizes children with a diagnostic label when there is no disorder, which is especially risky in societies and cultures that are hostile or condemning of both children and adults who do not conform to the culture's gender norms;
2. Internally for the child, the diagnosis becomes iatrogenic, instilling a sense that there is something wrong with the child, when there is no scientific evidence that there is, and perhaps even causing the child to repress, suppress, or go into secrecy about heretofore positively embraced gender desires and feelings;
3. Whereas the diagnosis has served to alert parents to the fact that their child does have gender issues that need to be attended to, the result is not necessarily supportive or benign, and can lead to parents feeling shame and failure, rejecting their children as "gender-diseased," or seeking services to fix the problem, which involves techniques to bring their children back in line with normative gender;
4. A childhood gender diagnosis can serve as a green light to mental health practitioners whose therapeutic goal is to attempt to alter a child's gender identity or expressions so as to rid the child of the "disorder";
5. As a legal minor, the child has little recourse but to submit oneself to such reparative practices, and I would refer people to the work of Karl Bryant (2006; 2008) who conducted a retrospective sociological study codifying the harm and suffering individuals have experienced in childhood reparative psychotherapies intended to both change their gender expressions and ward off a homosexual outcome. As evidence of international concern about the risk factors related to such practices, WPATH's Standards of Care (WPATH, 2011), a recent legislative act in the state of California in the United States (Senate Bill 1172, 2012), and resolutions of both the American Psychological Association (2009) and the American Psychiatric Association (2000) all identify the harm done to minors when there are attempts to alter a child's gender behaviors, many of these attempts made with either the implicit or explicit agenda of warding off later homosexuality.
6. Rather than improving clinical utility and offering more opportunities for needed health

services, paradoxically, a childhood gender diagnosis stands to do the opposite—impose unneeded or harmful health services when, with the provision of family and social supports, a child may have needed none.

I would like to liken these risks to the situation for left-handed people. Historically and in certain cultures today, left-handedness is perceived as deviant, disordered, or even sinister. In childhood, a child observed to preference the left hand in such cultures is “counseled” away from left-hand usage, with the goal of eradicating the left-handedness and avoiding social stigma or even punishment. The treatments have proved to be successful in the behavioral manifestations—the child uses the right hand; however, the underlying “condition” of left-handedness remains intact; it is simply suppressed, with subsequent risks of stuttering, learning problems, anxiety, or other psychological difficulties. In cultures in which left-handedness is accepted as a normal variation of handedness, albeit appearing in only a small minority of the population (approximately 10% worldwide), the children are left alone to embrace their left-handedness, show no such psychological stresses, and even go on to be overrepresented in the highest echelons of the arts and sciences. I perceive the analogy is directly applicable to gender-nonconforming children as they find their place in either an unaccepting social environment that perceives them as ill or an accepting environment in society that perceives them as healthy.

Ensuring Childhood Gender Health

Whereas it has been raised that many children must have documentation of prior gender dysphoria or consistency in asserting a transgender identity to 1) be eligible for medical interventions in adolescence, including puberty blockers and cross-gender hormones, 2) receive appropriate accommodations in their schools, 3) be recognized with their full rights in legal proceedings, in principle that documentation does not require a diagnosis but rather a narrative account by the child him- or herself, by the parents, and by health providers, accruing the child’s developmental history as a gender-nonconforming, transgender, or gender questioning/exploring child. At the Child and Adolescent Gender Clinic at UCSF we are relying on just such narrative accounts in determining whether a child would be a good candidate for puberty blockers, to date finding this to be full and accurate fund of information in making treatment recommendations. If and when an assessment beyond the narrative is needed to receive health, education, or legal services, the use of the Z codes with a g modifier can be applied to assure the rights and care of the gender-nonconforming children.

To summarize, the recommendations are as follows:

1. Delete a childhood diagnosis of gender from the ICD-11;
2. Use a combination of Z codes and applicable non-gender diagnoses from the chapter on mental and behavioural problems to identify and secure health and related educational or legal services for the gender-nonconforming children and their families;
3. Take actions to create changes in the funding sources and social systems so they will recognize the need for “well gender check-ups” and the rights of gender-nonconforming and transgender children to receive the supports they need without having to carry a childhood gender diagnosis that may leave a permanent stain on their psyches.

I would like to finish with a gender call to the public from a six-year-old gender-nonconforming boy from the province of Ontario, Canada: “Let your kids be whoever they are” and, lastly, a conversation with a nine-year old transgender girl: “What would you say if someone said you had to go back to living as a boy? Response: “I’d take ‘em to court” (Pause) “Or they can take me to court.”



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ICD 11 Committee Children

theoretical issues
and pragmatic recommendations

Edgardo Menvielle

Annelou de Vries

February 3 & 4 2013



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Historical milestones (Meyer-Bahlburg 2010)

George/Christine Jorgensen in 1952

mid-1960s, the first medical school-based transsexual clinic

1979 founding of the Harry Benjamin Gender Dysphoria Association,
first version of the Standards of Care (SOC)

"gender identity disorder," was introduced with DSM-III in 1980

formulation of the Yogyakarta Principles (2007) on the application of
international human rights law to sexual orientation and gender identity

Resolution 122 of the American Medical Association "Removing
Financial Barriers to Care for Transgender Patients" (2008)

Resolution of the American Psychological Association on "Transgender,
Gender Identity, and Gender Expression Non-Discrimination," (2008)

Institute of Medicine 2011

American Psychiatric Association Taskforce 2012

*American Academy of Child and Adolescent Psychiatry Practice
Parameter 2012*

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Opinions About the DSM GID Diagnosis (Vance, 2010)

TABLE 1. Geographical Representation of Respondents

Country	Number of organizations	Percentage (%)
Western Europe	N = 14	30.6
Denmark (1)		
Finland (2)		
Germany (1)		
United Kingdom (4)		
Netherlands (1)		
Spain (2)		
Sweden (2)		
Eastern Europe	N = 7	15.5
Russia (1)		
South America	N = 12	26.7
Canada (2)		
United States (8)		
Latin America	N = 4	8.9
Brazil (1)		
Chile (1)		
Peru (2)		
Africa	N = 4	8.9
Kenya (2)		
South Africa (2)		
Oceania	N = 4	8.9
Australia (2)		
New Zealand (2)		
Asia	N = 2	4.4
Singapore (1)		
Taiwan (1)		
International	N = 2	4.4
Czech Republic (1)		
United States (1)		

TABLE 4. Organization Opinion Item Results

Response	Number of organizations	Percentage (%)
Item 4. Does your organization believe GID should also be in the DSM?		
Yes	8	22.2
No	24	66.7
Uncertain	18	51.1
Total	40	100.0
Item 5. If GID was taken out of the DSM, would mental health costs be reimbursed in your country?		
Yes	12	33.3
No	14	38.9
Uncertain	14	38.9
No response	1	2.8
Total	41	100.0
Item 6. If GID was taken out of the DSM, would physical health costs be reimbursed in your country?		
Yes	12	33.3
No	12	33.3
Uncertain	14	38.9
Total	40	100.0
Item 7. In your country, is a DSM diagnosis of GID used for official or legal purposes?		
Yes	28	77.8
No	8	22.2
Uncertain	3	8.3
Total	39	100.0
Item 8. If GID remains a disorder listed in the DSM, would you prefer to change the name?		
Yes	28	77.8
No	8	22.2
Uncertain	3	8.3
No response	0	0.0
Total	39	100.0
Item 9. If criteria for GID for children did not include cross-gender behaviors per se, would you prefer to change the criteria?		
Yes	8	22.2
No	14	38.9
Uncertain	15	38.9
No response	3	7.8
Total	40	100.0

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GID classification pro & con (Vance, 2010)

Pro: argument that without the diagnosis there would be no justifiable basis for gender dysphoric persons to acquire medical or mental health services or legal protections

Against: same diagnosis, however, may be used to discriminate against transgender persons by withholding these rights and propagating social stigmatization

the label of "mental disorder" is misused to marginalize individuals who do not conform to the social norm, as with the inclusion of homosexuality in DSM editions before 1973

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DSM **child** criteria of GID as particularly problematic

- The diagnosis in children requires the fulfillment of criteria A– D
- Theoretically, a child could fulfill the A criterion without ever saying he or she wishes to be of the opposite gender; he or she would only need to exhibit pervasive cross-gender behavior

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History DSM diagnoses (Drescher et al, 2012)

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
DSM-III-R (1987)	Disorders usually first evident in infancy, childhood or adolescence	Gender identity disorder of childhood
		Transsexualism
		Gender identity disorder of childhood
DSM-IV (1994)	Sexual and gender identity disorders	Gender identity disorder of adolescence and adulthood, nontranssexual type
		Gender identity disorder in adolescents or adults
DSM-IV-TR (2000)	Sexual and gender identity disorders	Gender identity disorder in children
		Gender identity disorder in adolescents or adults
DSM-5 (2013)	Gender dysphoria (Proposed)	Gender identity disorder in children
		Gender dysphoria in adolescents or adults
		Gender dysphoria in children (Proposed)

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History: ICD diagnoses (Drescher et al, 2012)

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 (reproposed)	?

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Table 1. DSM-III diagnostic criteria for Gender Identity Disorder of Childhood.

<p>For females:</p> <p>A. Strongly and persistently stated desire to be a boy, or insistence that she is a boy (not merely a desire for any perceived cultural advantages from being a boy).</p> <p>B. Persistent rejection of female stereotypical activities, as manifested by at least one of the following repeated assertions:</p> <ul style="list-style-type: none"> (1) that she will grow up to become a man (not merely in role) (2) that she is biologically unable to become pregnant (3) that she will not develop breasts (4) that she has no vagina (5) that she has, or will grow, a penis <p>C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)</p> <p>For males:</p> <p>A. Strongly and persistently stated desire to be a girl, or insistence that he is a girl.</p> <p>B. Endless (1) or (2):</p> <ul style="list-style-type: none"> (1) persistent rejection of male stereotypical activities, as manifested by at least one of the following repeated assertions: <ul style="list-style-type: none"> (a) that he will grow up to become a woman (not merely in role) (b) that his penis and testes are disgusting or will disappear (c) that it would be better not to have a penis or testes (2) preoccupation with female stereotypical activities or insistence by a preference for others cross-dressing or simulating female attire, or by a compelling desire to participate in the games and pastimes of girls. <p>C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)</p>	<p>Table 2. DSM-III-R diagnostic criteria for Gender Identity Disorder of Childhood.</p> <p>For females:</p> <p>A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy).</p> <p>B. Endless (1) or (2):</p> <ul style="list-style-type: none"> (1) persistent refusal to engage in male stereotypical activities, as manifested by at least one of the following repeated assertions: <ul style="list-style-type: none"> (a) wearing stereotypical male attire (clothing, e.g., boys' underwear and other accessories) (2) persistent rejection of female stereotypical activities, as evidenced by at least one of the following: <ul style="list-style-type: none"> (a) insistence that she has, or will, grow a penis (b) rejection of asserting or acting as a girl (c) assertion that she does not want to grow breasts or menstruate <p>C. The girl has not yet reached puberty.</p> <p>For males:</p> <p>A. Persistent and intense distress about being a boy, and an intense desire to be a girl, or, more rarely, insistence that he is a girl.</p> <p>B. Endless (1) or (2):</p> <ul style="list-style-type: none"> (1) rejection of male stereotypical activities, as manifested by a preference for other cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypical toys, games, and activities (2) persistent rejection of female stereotypical activities, as manifested by at least one of the following repeated assertions: <ul style="list-style-type: none"> (a) that he will grow up to become a woman (not merely in role) (b) that his penis and testes are disgusting or will disappear (c) that it would be better not to have a penis or testes <p>C. The boy has not yet reached puberty.</p>
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Table 3 DSM-IV diagnostic criteria for Gender Identity Disorder (for children)

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
In children, the disturbance is manifested by at least four (or more) of the following:
(1) repeatedly insisting to be, or becoming, that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for activities of the other sex
B. Persistent discomfort with his or her sex or sense of inappropriateness of the gender role of that sex
In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or persistent refusal to wash and/or trouble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating as a strong position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing
C. The disturbance is not consistent with a physical intersex condition
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

DSM 5 criteria [proposed]

Gender Dysphoria (in Children)
A. A strong and persistent desire to be, or to become, or to be perceived as, a different gender than he or she is assigned at birth (or to be perceived as a different gender than one's assigned gender)
B. A strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong aversion to the wearing of typical feminine clothing
C. A strong preference for cross-gender roles in make-believe or fantasy play
D. A strong preference for the toys, games, or activities typical of the other gender
E. A strong preference for playmates of the other gender
F. In boys, a strong rejection of typically masculine toys, games, and activities and a strong insistence on being and/or playing as typically feminine toys, games, and activities
G. In girls, a strong rejection of typically feminine toys, games, and activities and a strong insistence on being and/or playing as typically masculine toys, games, and activities
H. A strong desire to have primary or secondary sex characteristics of the other gender (11)
I. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of self-harm, suicide, or disability
Exclusions
With a disorder of sex development
Without a disorder of sex development

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WPATH's Critique on children's diagnosis (DeCuypere, Knudson, Bockting)

Gender role nonconformity is not uncommon among
children who go on to develop a gay or lesbian identity

prevent children with a gender variant expression
without an incongruence between gender identity and sex
assigned at birth to receive the diagnosis

"a strong desire to be of the other gender or an
insistence that he or she is of the other gender," is proposed
as required in order to qualify for a diagnosis of Gender
Incongruence in Children



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World Professional Association
for Transgender Health

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Summary: Issues Childhood Classification

- 'Stated wish to be the other gender'
 - Not all children express themselves
- Anatomic gender dysphoria
 - Not all children experience bodily dysphoria
- Distress or impairment
 - Not all children experience distress or impairment
- Gender variant development
 - Only a minority of the children will be future candidates for gender reassignment treatment
- Justifiable basis to acquire medical or mental health services or legal protections
 - Children do not require medical interventions yet, the mental health approach is 'watchful waiting', no legal consequences yet



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WPATH about DSM (DeCuypere, Knudson, Bockting)

WPATH Consensus Group felt even stronger about the need for the diagnosis to be based on distress in the case of children

this is enough of a response to the many criticisms the childhood diagnosis has received, and the decision of such European countries as Sweden and France to remove this diagnosis from their lists of recognized mental disorders

Many of the behaviours captured in the proposed criteria are seen by many as variation in normal development

WPATH workgroup charged with reviewing and making recommendations for revision considered to recommend removal of the childhood diagnosis

if a childhood diagnosis would be retained, it should only apply to those with a desire to be of the other gender or an insistence that he or she is of the other gender,

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ICD 11 proposal: Gender Incongruence of Childhood

A marked incongruence between the child's experienced/expressed gender and the child's assigned sex as manifested by all of the following indicators:

A **strong desire on the** child's part to be a different gender than the assigned sex, or insistence that he or she is a gender different from one's assigned gender.

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. For example, a child assigned at birth as a boy says he wants to be rid of his penis or a child assigned at birth as a girl says she does not want to develop breasts when she grows up.

Make-believe or **fantasy play, toys, games**, or activities and playmates that are typical of their experienced rather than their assigned sex. Gender incongruent children assigned as boys reject typically "masculine" toys, games, and activities and avoid rough-and-tumble play. Gender incongruent children assigned as girls reject "feminine" toys, games, and activities and like rough-and-tumble play.

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ICD 11 proposal (cont'd): Gender Incongruence of Childhood

The incongruence must have persisted for about 2 years.

The diagnosis can only be assigned to children before puberty.

The **relatively high threshold** created by these diagnostic requirements is intended to avoid inclusion of children who only show gender variant behaviors and interests, even when these children experience distress resulting from negative attitudes towards the gender variance. Gender variant behavior and preferences alone are not sufficient for making a diagnosis of **Gender Incongruence of Childhood**.

Although some indications of **Gender Incongruence** may be present when children are as young as age 2, it is not possible to perform an accurate assessment of **Gender Incongruence of Childhood** at this age. The requirement of a duration of about 2 years implies that the diagnosis cannot be made before approximately age 5.

Is this adequate? Minimal age? Provisional diagnosis before that age?

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Rationale ICD 11 & GI Child

- How a mental health disorder is defined affects ... legal protection available for affected people, .. payment mechanisms for mental health service systems.. -> educational system, primary care
- ..serves as an organizing principle in the education of mental health professionals (psychiatrists, psychologists, social workers, nurses) but also general medical professionals

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Rationale ICD 11 & GI Child

(International Advisory Group for the Revision of ICD-10, 2011)

- *Mental health gap* -> stigma, lack of parity in health financing
- Eligibility and treatment selection
- -> necessary; precise, valid and useful classification system
- -> my understanding of ICD's purpose:
- classification not as 'labeling' or 'stigmatizing' but with opposite goal:
- *empowering, emancipating, professionalizing care*



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Philosophical/Ethical Issues

- Over-use of diagnosis for variations in gender expression without or with minimal gender dysphoria
- Implicit assumption of continuity between childhood gender non-conforming behavior (no need for medical/surgical interventions) and Adolescent/Adult GI (need for med/surg intervention)
- Why use a potentially stigmatizing diagnosis when other diagnosis could address childhood distress? (i.e. anxiety, depression)
- “Incongruence” as an experience vs. “disorder” (as in GID), diminishes stigma



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Pragmatic Issues:

- *Access to care*: children need care, parents need it, especially as co-morbidity, especially when culture is hostile to gender/sexuality variations
- *Reimbursement*: need to be transparent, increased scrutiny of documentation
- *Professional training*: dire need of more competence among providers
- *Research*
- *Diagnosis may give a child a “protected status”* (i.e., non-discrimination, accommodations in school)



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Access to care: What is offered in specialized GI clinics?

- careful diagnostic assessment; is there GI or GV behavior only?
- Information on expected development of GI / GV behavior
- getting advice e.g. : how to deal with GV-related teasing by peers; how to deal with teachers; information on consequences of allowing children to cross-dress in certain situations, or to even socially transition etc.



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Access to care: What is offered in specialized GI clinics?

- treatment for non GV problems by someone with GV experience, so that the right treatment goals are chosen
- family treatment in cases where family / parental issues are of influence
- Comorbidities related to GI: depression, anxiety, phobias, social isolation, low self-esteem, behavioral problems
 - (52% psychiatric comorbidity, Wallien et al., 2008)



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Reimbursement: problematic?

- No such care will be reimbursed in case of removal from the ICD
- Care will not be transparent, not fulfill need for increased scrutiny of documentation
- Parents will seek other help, probably informally organized
- Quality of care will vary substantially, probably depending on by whom provided (reparative therapy?)



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Professional Training & Research

- Professionals; who will be trained when it is not in the ICD any more? dire need of more competence among providers, especially non-specialized
- More informally trained professionals, not always by board certified, won't work in the context of professional organizations (having e.g. certain quality of care standards, a disciplinary board)
- Research; who will move the field forward in developing accurate care and do further research on its effects when the diagnosis is removed?



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Diagnosis & “protected status”: Recognition

- Diagnosis may give the child a protected status, e.g. discrimination at school
- How a mental health disorder is defined affects ... legal protection available for affected people, .. payment mechanisms for mental health service systems.. -> educational system, primary care
 - (International Advisory Group for the Revision of ICD-10, 2011)



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Recommendations

- Pathology is not inherent to gender non-conformity
- Negative societal attitudes may breed psychopathology
- As a group, GNC children at risk for psychopathology
- *Keep a diagnosis for children* to facilitate access to care and professional training
- Place diagnosis outside physical disorders category and mental disorders category
- Maintain separation from Childhood Dx and Adolescent/Adult Dx
- Childhood diagnosis appropriate for children before puberty
- Children entering puberty and needing medical intervention may receive the Adol/Adult Dx

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Appendix F: Suggested Additions to the Online Registration Survey Instrument

Summary of discussion among WPATH ICD Consensus Process participants regarding the WHO-ICD Global Clinical Practice Network:

Suggested additions to the online registration survey instrument

March 15, 2013

- Add an option so registrants can indicate if they self-identify as transgender
- **What is your clinical profession?**
 - Add psychotherapy to “counseling”, so that it reads like “psychotherapy / counseling”.
 - Add additional options that broaden the scope of professions to include: researcher, speech therapist, pediatrician (specify specialty), surgeon (specify specialty), sex therapist.
- **What are your primary work settings at the present time?**
 - Add here the options of gender identity clinic, child gender identity clinic, and child mental health center.
- **Please indicate which of the following types of services you personally provide to patients.**
 - Delete “mental health”.
 - Add the following options:
 - Evaluation and management of non-psychoactive medications, with options for hormones; sexual medicine drugs, tools and devices including PDE5 inhibitors, vacuum constriction devices, lubricants, vibrators, venous rings, etcetera.
 - Surgery, with options for genital reconstructive surgery, breast/chest reconstructive surgery, other surgeries (such as facial feminization surgery, vocal cord surgery, etc.).
 - Add psychotherapy to psychological (talk) therapy, so that it reads like psychotherapy/psychological (talk) therapy.
 - Family therapy.
 - Speech therapy.
- **Please indicate which of the following types of services are provided by the people that you supervise.**
 - Delete “mental health”.
 - Same as above (under services you personally provide), add the following options:
 - Evaluation and management of non-psychoactive medications, with options for hormones; sexual medicine drugs, tools and devices including PDE5 inhibitors, vacuum constriction devices, lubricants, vibrators, venous rings, etcetera.
 - Surgery, with options for genital reconstructive surgery, breast/chest reconstructive surgery, other surgeries (such as facial feminization surgery, vocal cord surgery, etc.).
 - Add psychotherapy to psychological (talk) therapy, so that it reads like psychotherapy/psychological (talk) therapy.
 - Family therapy.
 - Speech therapy.

- **During a typical week, in what types of settings do you provide or supervise health services?**
Same as in question above about primary work setting:
-Add gender identity clinic, child gender identity clinic, and child mental health center.
- **Who is most often responsible for assigning a diagnosis ...?**
-Delete “psychiatric”.
- **During a typical week how many hours do you devote to each of the following professional activities?**
-Add options for hormone therapy, surgery, and speech therapy.
- **Please select up to three areas . . . in which you have the most knowledge and experience.**
-Delete “Mental and Behavioural Disorders”.
-Allow registrants to indicate in separate options whether they have knowledge and experience in (1) sexual dysfunctions, (2) paraphilias, (3) gender identity / transgender issues, (4) endocrinological conditions.
-If possible, combine all the other mental and behavioral disorders as one response category, so that the question reads as follows:

“Please select up to three areas related to the ICD-10 in which you have the most knowledge and experience:”

- mental and behavioural disorders
- sexual dysfunctions
- paraphilias
- gender identity/transgender issues
- endocrinological conditions
- epidemiology
- public health
- neuroscience
- other (specify)

Appendix G: Position of the Cuban Gender Team

(Submitted subsequent to the meeting, in which the Cuban Gender Team participated via Skype, and had one vote in the matters brought to question.)

National Commission for Comprehensive Care of Transsexual People (Cuban Gender Team)

Positioning on the nomenclature “gender incongruence” for classification of trans-identities in the CIE (ICD)-11

The National Commission for Comprehensive Care of Transsexual People (Cuban Gender Team) is working on the modification of the protocols of health care for transgender people in Cuba.

Our group believes that progress should be made towards psycho-depathologization of trans-sexuality and other trans identities, as expressed in the Declaration of the Cuban Multidisciplinary Society for the Study of Sexuality (SOCUMES), adopted at its General Assembly in 2010. Therefore, we support the position of the World Professional Association for Transgender Health (WPATH) on the legitimacy of multiple trans-identities and the need for psycho- depathologize them.

We do not support to uphold gender dysphoria as a requirement for transgender people, transgender or gender nonconformity to be able to access to hormone treatments and surgical sex reassignment. Not all ailments requiring health care should be interpreted as diseases. Health care is a human right. However, we understand that the current characteristics of most health systems in the world, do not allow for other alternatives.

The Cuban health system meets the standards designed by the WHO in relation to universal and free access to all services. Public health in Cuba has a social and preventive approach; it does not only focus on the attention to syndromes or diseases, but also deals with the attention to aches and social demands of quantitatively minority groups. For this reason, we advocate the possibility of including health care of trans-people in a Z Code (health ailments that are not considered diseases and contact with health services).

The insertion of transsexualism in the DSM and CIE was not based on scientific evidence, but on a pathologizing interpretation of all those expressions that deviate gender from the binary standard. Throughout history, many people have suffered -and are suffering today- from anxiety, depression and rejection to their body due to their anthropomorphic features, such as skin color, and they are not classified as mentally ill. So, we wish to imply that in the absence of scientific evidence showing that trans-sexuality and other gender identities/roles are mental disorders, we support the removal of trans identities form the section of mental illness.

At the WPATH consensus meeting on the nomenclatures proposals for health care of trans identities of CIE-11 the inclusion of the term «gender incongruence in adults and adolescents», «body-gender dissonance» and «gender incongruence in childhood» were discussed.

Our positions on these issues are:

We disagree with the use of the term «gender incongruence» because it reinforces stigma and discrimination against these people. The term incongruence implies anomaly or disorder. We do not consider gender should be deemed «incongruent» in its diverse, fluid and heterogeneous expression.

Moreover, the use of the term «body-gender dissonance» means recognizing gender construction exclusively from the sexual difference viewpoint. Many trans-people do not take the appearance of their genitals as a reference for their identity and gender role; nor does it apply to persons with ambiguous genitals who feel they belong to either gender. The term dissonance also has pathologizing implications.

For these reasons, we prefer the term «gender nonconformity» as it has no implications of abnormality or disturbance and means that, regardless of the body, the person does not identify with the legally and culturally assigned gender. The above nomenclature, although not quite perfect, can be applied also to persons who are identified as intersex or those who express a gender different from the one assigned.

In regard to «gender incongruence in childhood», we believe that it should not be considered a mental disorder and should not be included in any classification of CIE-11. The infants with gender nonconformity do not require hormone treatments until reaching puberty or surgical treatment until they reach adulthood.

Health care to this group of people consists in the psychological attention to relieve distress that the mismatch with the gender assigned at birth generates them. Most infants with gender nonconformity do not show a gender transition when they reach adolescence and adulthood. It is also essential to relieve the distress of parents and to work with the rest of the family and the school and community contexts from a more flexible and fairer gender approach.

We also reaffirm the need to consider the bioethical aspects in managing gender variant children, concerning respect for their dignity and autonomy, as well as to decide the actions of affirmation of gender identity/role together with the family, considering always the child's best interests.

Our committee is honored to have participated in the consensus meeting on the CIE-11, organized by the WPATH and a representation of a WHO Working Group for Sexual Disorders and Sexual Health and we appreciate the efforts made by its participants, organizers and especially by our friend and colleague Lin Fraser.

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