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Gender incongruence of childhood

Definition

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

Rationale

This proposal is submitted by the International Working Group consisting of trans organisations and networks, including Global Action for Trans Equality, Transgender Europe, the Asia Pacific Transgender Network, Iranti, and STP - International Campaign Stop Trans Pathologization, among others.

We propose the deletion of the entity Gender incongruence of childhood because:

GIC pathologises gender diversity. Regardless of where in ICD-11 the proposed GIC diagnosis is placed, it pathologises the experiences of young children below the age of puberty. These are children who are exploring their gender expression and identity, or are incorporating their gender expression and identity into a broader sense of who they are, becoming comfortable expressing that identity, and managing any adverse reactions from others. These developmental processes should not be seen as diseased or disordered. To pathologise those experiences is a modern and Western notion. In a number of cultures worldwide these experiences would still not be regarded as pathology.

Gender diverse children commonly experience neither discomfort nor distress. Many children who express pronounced and unwavering convictions regarding their gender expression and identity, and who have supportive families, do not display any level of distress. Rather, distress occurs when the child is taught that their genitals ought to dictate their identity and behaviour.

Gender diverse children do not need hormones or surgery. Unlike trans adolescents and adults, gender diverse children below the age of puberty have no need of gender-affirming healthcare focused on the body. These children do not need puberty suppressants, masculinising or feminising hormones, surgery, or indeed medical intervention of any type. They simply need the opportunity and freedom to explore, incorporate and express their gender expression and identity; they need support and information that enables them to do these things, as well as to manage any adverse reactions of others. These developmental challenges do not merit a diagnosis. Furthermore, a diagnosis wrongly signals to the child and their family that there is something wrong or improper with the child.

The proposal is inconsistent with proposals regarding sexual orientation . The WHO Working Group that originally generated the GIC proposal and the WHO secretariat, have taken a very different diagnostic approach to persons experiencing developmental processes linked to their sexual orientation. There are currently several diagnoses in ICD-10 Block F66 that have the effect of pathologising same-sex attraction. Examples are such diagnoses as sexual maturation disorder and egodystonic sexual orientation. These diagnoses pathologise people (often in their youth) who are exploring same-sex sexual orientation, incorporating their sexual orientation into their sense of self, learning to express their sexual orientation and managing with adverse reactions from others. These individuals benefit from opportunity, freedom,

support and information, without needing a diagnosis.

These are the same developmental processes, and the same needs, as young gender diverse children have.

Arguments for GIC are flawed. Arguments for the GIC diagnosis - for example that it will provide a foundation for research and training - appear flawed. It is very unlikely that research and training in relation to childhood gender diversity would suffer if there were no GIC diagnosis in ICD-11. One only has to look at the case of the homosexuality diagnosis. Research into same-sex attraction and relationships has thrived since that diagnosis was removed from the diagnostic manuals decades ago. Furthermore, common experience suggests that healthcare providers are better trained in the needs of gay and lesbian youth than they ever were when homosexuality was a diagnosis.

Morbidity: GIC has no utility or relevance in monitoring morbidity, as gender diversity in childhood has no direct clinical association with health risks of any kind. Incidental morbidity (i.e., caused by physical violence or suicide) can be adequately monitored with already existing codes.

A number of proposed Q codes already cover the needs of trans and gender diverse children, including:

QE63 Social exclusion or rejection

Exclusion and rejection on the basis of personal characteristics such as physical appearance, sexual orientation, gender identity and expression, illness or behaviour.

QE64 Target of perceived adverse discrimination and persecution

Persecution or discrimination, perceived as reality by an individual or real, on the basis of membership in some group (such as defined by skin colour, religion, ethnic origin, sexual orientation, gender identity and expression, etc.) rather than personal characteristics

QA15 Block on Counselling related to sexuality also contains codes covering potential needs:

QA15.1 Counselling related to sexual knowledge or sexual attitude

QA15.2 Counselling related to sexual behaviour or sexual relationships of the patient

We recommend the introduction of additional Q codes for providing access to:

Counselling related to gender identity and expression of the concerned individual before the onset of puberty.

Counselling related to gender identity and expression before the onset of puberty provided to family members.

Counselling related to gender identity and expression before the onset of puberty provided to non-familiar/institutional third parties (e.g., schools).

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There are no references attached for this proposal item