

Reflections from STP regarding the ICD revision process and publication of the DSM-5

STP, International Campaign Stop Trans Pathologization

Trans depathologization activism is presently centered around the revision process of the World Health Organization (WHO)'s *International Statistical Classification of Diseases and Related Health Problems (ICD)* (WHO 2013a), while in May 2013 the American Psychiatric Association (APA) published the DSM-5 (APA 2013a, 2013b). Given these recent events, we would like to share some reflections on both of these topics due to their current relevance to trans depathologization activism. Here we will also announce the upcoming International Day of Action for Trans Depathologization.

1. ICD revision process

As referenced in our previous communiqué (STP 2013), the approval of the ICD-11 is planned for May 2015 at the World Health Assembly (WHO 2013a). The WHO *Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH)* is now in the process of revising trans-specific categories within the ICD¹.

The ICD-11 Beta Draft is available on the web (WHO 2013b), in which the drafts of revised categories are introduced. The working group has not yet published its proposal with regards to categories related to gender transition processes.

The following reflections are based on the information available in two articles published by members of the WHO Working Group on the Classification of Sexual Disorders and Sexual Health: *"Minding the body. Situating gender identity diagnoses in the ICD-11"* (Drescher, Cohen-Kettenis, Winter 2012) and *"Controversies in Gender Diagnoses"* (Drescher 2013).

¹ See: Drescher, Cohen-Kettenis, Winter 2012: 568; Drescher 2013: 9.

Will to abandon the psychopathological model

We positively value the Working Group's will to abandon the psychopathological model in relation to trans-specific categories (Drescher, Cohen-Kettenis, Winter 2012: 575)².

We hope that this desire is translated into the removal of categories/blocks F64, F65.1 and F66 from the ICD.

Placement proposals for a new trans-specific category in the ICD

We agree with the proposal of introducing a non-pathologizing category of trans-specific health care in the ICD, outside of chapter V ('Mental and Behavioural Disorders'), with the goal of facilitating its public coverage in various places throughout the world (Drescher, Cohen-Kettenis, Winter 2012; Drescher 2013).

With regards to options mentioned as preferable in Drescher, Cohen-Kettenis and Winter's article (2012) in terms of the placement of a new category (proposal of a new section or inclusion within a sexual health section), we appreciate the opportunities inherent in both options. At the same time, we believe it is important that the section itself and the contents of the trans-specific category have a non-pathologizing standpoint. In the case of a sexual health chapter, we disagree with the mention of 'disorder' in the chapter's title, as specified in both reviewed articles (*'Sexual Health and Sexual Disorders'*) (Drescher, Cohen-Kettenis, Winter 2012: 574; Drescher 2013: 11).

'Gender Incongruence'

We are critical of the title "*Gender Incongruence*" proposed for the trans-specific category (Drescher, Cohen-Kettenis, Winter 2012: 569; Drescher 2013: 11). We view the concept of 'incongruence' as pathologizing the moment prior to transition and the process of gender transition in itself, while also establishing a normative state of 'congruence'. Additionally, the psychological-psychiatric character of the term concerns us, due to its continual conceptualization of gender transition as psychological problem, even if the category were placed outside of Chapter V in the ICD, thereby encouraging the continuation of current clinical practices of psychological-psychiatric evaluation in accessing trans-specific treatments. We also disagree with the term '*Gender/Body Divergence*' proposed by WPATH, *World Professional Association for Transgender Health*, in a recently published document (WPATH 2013: 2).

² "The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health believes it is now appropriate to abandon the psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services" (Drescher, Cohen-Kettenis, Winter 2012: 575).

In a previous STP communiqué (2012), we put forth our proposals for the title and contents of a non-pathologizing category for trans-specific health care in the ICD-11. We continue to recommend that a descriptive category of health care processes related to gender transition is placed outside of Chapter V in the ICD, under the title 'Trans Health Care' or 'Health Care related to Gender Transition', with the objective in mind of facilitating its public coverage, while minimizing the pathologizing weight of a classification of gender transition processes.

'Gender Incongruence of Childhood'

Similarly, we are deeply concerned by the proposal of a specific category for children (*"Gender Incongruence of Childhood"*) in the ICD-11, mentioned both by Drescher, Cohen-Kettenis and Winter (2012: 570)³ and Drescher (2013: 11)⁴.

We think it is important to emphasize that the exploration of gender expressions and trajectories during childhood that are different from the gender assigned at birth, is not necessarily related to an experience of distress or conceptualized as disease, disorder or condition in need of health care, especially in affirmative cultural contexts⁵.

In some cases, children with gender expressions, trajectories and identities that differ from the gender assigned at birth may require psychological and social counseling in relation to an exploration of gender expressions or experiences of discrimination, in the same way that parents and other people in their close social environments might. In order to access this kind of support, we don't believe a specific category in the ICD would be necessary, but instead the availability of professionals with a framework that is both non-pathologizing and open to gender diversity. So as to facilitate public coverage of these counseling services, the concept of 'gender identity' could be included in the Z codes related to counseling or experiences of discrimination. Finally, we deem important the possibilities of connection with activist groups and networks.

Therefore, we consider the inclusion of a specific category of 'Gender Incongruence of Childhood' in the ICD-11 as lacking in clinical use, as well as increasing the risk of pathologizing and medicalizing children's free exploration of gender expressions, trajectories and identities. We identify children as being especially vulnerable to situations of discrimination, medical abuse or conversion therapies, due to the frequent lack in recognition of their participation rights in clinical decisions⁶. Medically unnecessary diagnostic processes may contribute to increased stigmatization and discrimination in children with gender expressions and trajectories that differ

³ In the article authored by Drescher, Cohen-Kettenis and Winter (2013: 570), the exact phrasing used is *"Gender incongruence of children"*.

⁴ Drescher (2013:11) refers to *"Gender Incongruence (GI) of Adolescence and Adulthood and GI of Childhood"*.

⁵ See, among others: Gómez (2004); Vasey, Bartlett (2007).

⁶ See: Ansara, Hegarty (2011).

from cultural expectations associated with the gender assigned at birth^{7, 8}, thereby posing a risk of breaching the bioethical principle of “*nonmaleficence*” (Beauchamp, Childress 1999 [1979]: 114). Furthermore, a diagnostic classification of gender diversity in children could create a contradiction with principles established in international Human Rights agreements, among which are the Convention of the Rights of the Child (UN 1989 [1990]), General Comments N° 7, 12-15, 17 from the Committee on the Rights of the Child (UN 2005; 2009; 2011; 2013a,b,c), recent resolutions by the Human Rights Council (UN 2012, 2013d), as well as the Yogyakarta Principles (2007). These documents affirm children’s right to protection against discrimination and violence, abuse and maltreatment, the right to the enjoyment of the highest attainable standard of health, the right to the protection of their best interests, the right to free expression and recognition of their views, the right to be heard and participate in health decisions, as well as a recognition of their vulnerability to risks.

It is for the above mentioned reasons that we are not in agreement with the proposal of including a ‘Gender Incongruence of Childhood’ category in the ICD-11. Due to the inherent risks in this category, we also don’t consider convenient its inclusion in the field tests that the WHO will conduct within the ICD revision process (Drescher, Cohen-Kettenis, Winter 2012; WHO 2013c).

Finally, we believe it is of utmost importance that drafts written by the *Working Group on the Classification of Sexual Disorders and Sexual Health* are published as soon as possible, in order to provide the opportunity for in-depth evaluation of their proposal, and so as to initiate a collective debate among trans activist groups regarding content and placement.

Demands directed to the WHO

Consequently, the demands we direct to the World Health Organization (WHO) continue to be as follows:

- The complete removal of blocks / categories F64, F65.1 and F66 in chapter V of the ICD.
- The inclusion of a non-pathologizing reference to trans-specific health care, as a health process not based on illness or disorder, outside of chapter V of the ICD-11.
- The removal of the proposal of including a ‘Gender Incongruence of Childhood’ category in the ICD-11.

⁷ See: Bryant (2006); Langer, Martin (2004).

⁸ Studies from different regions worldwide show that children with gender expressions that differ from social expectations have a high exposition rate to situations of discrimination and stigmatization. See, among many others: GLSEN (2012); Sood (2010); Whittle, Turner, Al-Alami (2007).

- The prompt publication of the proposal put forth by the *Working Group on the Classification of Sexual Disorders and Sexual Health*, so as to allow for a debate within the trans movement.
- The continued participation of the trans movement in the ICD revision process.

2. DSM-5 publication

After the final draft of the DSM-5 was approved on December 1st 2012 by the American Psychiatric Association's Board of Trustees (APA 2012), the publication of the DSM-5 (APA 2013a) was presented in the context of the American Psychiatric Association's annual meeting, which took place between May 18th-22nd 2013 in San Francisco, U.S.A. (APA 2013b, 2013c). Based on the revision of trans-specific diagnostic categories in the DSM-5 (APA 2013a), as well as fact sheets published on the web (APA 2013d, 2013e), we would like to share the following reflections.

Continued psychopathologization of gender transition processes

As was highlighted in the previous STP communiqué, published in January 2013, the modifications introduced in the DSM-5 don't imply a depsychopathologization of trans expressions, trajectories and identities. They continue to be classified in the DSM-5 under the diagnostic categories of "*Gender Dysphoria*" and "*Transvestic Disorder*" (APA 2013a: 451, 702).

The explanatory text that accompanies the "*Gender Dysphoria*" diagnostic criteria in the DSM-5 differentiates the diagnosis from a "[n]onconformity to gender roles" (APA 2013a: 458), thus identifying as relevant criteria for the application of the diagnosis the presence of a "*clinically significant distress or impairment in social, occupational, or other important areas of functioning*" (criterion B) (APA 2013a: 453). The fact sheet about 'Gender Dysphoria' published on the web emphasizes that "*gender nonconformity is not in itself a mental disorder*" (APA 2013d: 1). In the case of 'Transvestic Disorder', the DSM-5 references the distinction of the diagnostic category from cross-dressing practices, therefore underlining the necessity of complying with criterion B ("*clinically significant distress or impairment in social, occupational, or other important areas of functioning*", APA 2013a: 702).

These nuances are insufficient, in our opinion, given that both diagnostic categories continue to be present in the DSM-5, '*Diagnostic and Statistical Manual of Mental Disorders*', thus perpetuating a conceptualization and treatment of gender diversity as mental disorder.

'Gender Dysphoria'

In relation to the *"Gender Dysphoria"* category (APA 2013a: 451), a certain echoing of critical debates that have emerged in recent years is noticeable. For instance, we can point to the attempt of reducing stigmatizing weight in the category via a change in its title (from *'Gender Identity Disorder'* to *'Gender Dysphoria'*)⁹, in addition to the intention of recognizing gender diversity beyond a binary model by way of the introduction of the phrase *"or some alternative gender different from one's assigned gender"* (APA 2013a: 452) in the diagnostic criteria.

Nevertheless, we must emphasize that the concept of *'Gender Dysphoria'* is problematic, in that it associates gender transition processes with a state of suffering or distress. Furthermore, these diagnostic criteria reference the term *'incongruence'*¹⁰, which, as we mentioned in the section about the ICD revision process, has troublesome connotations.

We consider that the acknowledgment of gender diversity constitutes a relevant aspect of a trans-affirmative clinical practice. However, we disagree with the inclusion of a wide spectrum of gender expressions and identities within a psychopathological model, as occurs in the DSM-5 with the use of the expression *"or some alternative gender"* (APA 2013a: 452).

Similarly, while defending the right of people with a diagnosis related to intersexuality to access trans-specific health care, we find their inclusion within a psychiatric model problematic.

We question the description of supposed developmental paths that is outlined in the accompanying text of the DSM-5's diagnostic criteria, for considering that they don't correspond to a wide diversity of gender trajectories that exist in the present day. Additionally, we find the presumption of a predictable interrelation between gender identity and *'sexual orientation'* especially unsettling¹¹.

Furthermore, we believe that the use of *"natal girl" / "natal boy", "natal female" / "natal male"* terminology (APA 2013a: 453, 455) hinders reading comprehension, since it differs from current practice of naming trans people by referring to their lived gender identity, as opposed to the gender assigned at birth.

Moreover, we observe a contradiction between the recognition of a lack of certainty with regards to the applicability of *'Gender Dysphoria'* diagnostic criteria in different cultural contexts and the presupposition of the existence of *"individuals with gender dysphoria"* and an *"equivalent to gender dysphoria"* in different countries and cultures (APA 2013a: 457)¹².

⁹ *"The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se"* (APA 2013a: 451).

¹⁰ *"A marked incongruence between one's experienced/expressed gender and assigned gender"* (APA 2013a: 452).

¹¹ *"For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex"* (APA 2013a: 455).

¹² *"Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized*

With regards to the usefulness of a diagnostic category in order to facilitate public coverage of trans-specific treatments, we find that the possibility offered by the ICD, as a classification that includes a wide range of health care processes, can be helpful for a coding of trans-specific health care not based on mental disorder or illness, but as a health process that may require medical assistance.

As per the arguments outlined in this section, we strongly disagree with the continuous inclusion of 'Gender Dysphoria' in the DSM-5.

Psychopathologization of gender diversity in childhood

We are concerned about the continued classification of gender diversity in childhood in the DSM-5, under the title of *"Gender Dysphoria in Children"* (APA 2013a: 452).

Similar to our reflection on the category of 'Gender Incongruence of Childhood' proposed for the ICD-11, we question the clinical usefulness of a diagnostic category for children with gender expressions and trajectories which differ from cultural expectations associated with the gender assigned at birth.

In the case of the DSM-5, given its character of *"Diagnostic and Statistical Manual of Mental Disorders"*, we are especially concerned about the risks inherent in a psychopathologization process of gender diversity in children, including the risk of exposure to situations of social discrimination, conversion therapies and other forms of iatrogenic abuse¹³.

Within established diagnostic criteria for *"Gender Dysphoria in Children"* in the DSM-5 and the accompanying text, we note a discrepancy between the recognition of possible identification with *"some alternative gender different from one's assigned gender"*¹⁴ and the assumption of a *"strong rejection"* of *"toys, games and activities"* considered typical of the assigned gender¹⁵ in combination with a *"strong preference"* for those *"stereotypically used or engaged in the other gender"* (APA 2013: 452)¹⁶, thus reproducing a binary imaginary, reducing gender diversity in children, and mirroring the occidental origin of the diagnostic model.

For these reasons, we firmly reject the diagnostic classification of gender diversity in children in the DSM-5.

gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met" (APA 2013a: 457).

¹³ See Bryant (2006); Langer, Martin (2004).

¹⁴ *"A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)"* (APA 2013a: 452).

¹⁵ *"In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities"* (APA 2013a: 452).

¹⁶ *"A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender"* (APA 2013a: 452).

'Transvestic Disorder'

Regarding the category of *"Transvestic Disorder"* (APA 2013a: 702), we note with concern its continued inclusion in the DSM-5 and the amplification of diagnostic criteria through the introduction of the concept of *"autogynephilia"* (APA 2013a: 702)¹⁷ and by the way of not specifying gender and sexual orientation (in contrast to the *"Transvestic Fetishism"* category in the DSM-IV-TR, which limited diagnostic criteria to the *"heterosexual male"*, APA 2000: 574). We also notice that the DSM-5 did not end up introducing the concept of *"[a]utoandrophilia"*, proposed in a previous versions of the category's draft (Knudson, De Cuypere, Bockting 2011: 10). Nevertheless, we oppose both categories ('autogynephilia' and 'autoandrophilia').

We consider the category of 'Transvestic Disorder' to lack in clinical utility and to potentially enable an increased risk in discrimination towards people with gender expressions that differ from established social norms. In order to facilitate counseling for people who would like to have psychological support in relation to gender expressions, sexual practices or experiences of discrimination, we find that it would be of importance to be able to rely on professionals with adequate training in sexual and gender diversity and non-pathologizing perspectives, as well as to have possibilities for contact with activist groups and networks, instead of receiving a stigmatizing diagnosis. Therefore, we strongly reject the inclusion of the category of 'Transvestic Disorder' in the DSM-5.

In conclusion, we would like to emphasize that our demand of a complete removal of trans-specific categories from the DSM continues to be in full force.

3. International Day of Action for Trans Depathologization 2013

Finally, we would like announce once again that the upcoming **International Day of Action for Trans Depathologization** will take place on **Saturday, October 19th 2013**, under the motto *"Stop Pathologizing Gender Diversity in Childhood"*. As in previous years, we invite activist groups and networks throughout the world to actively participate in this international day of mobilization, through organizing a demonstration or other action for trans depathologization.

Coordination Team of STP, International Campaign Stop Trans Pathologization, August 1st, 2013.

www.stp2012.info

¹⁷ "Specify if: (...) ***With autogynephilia:*** *If sexually aroused by thoughts or images of self as female*" (APA 2013a: 702).

References

- Ansara YG, Hegarty P (2011). Cisgenderism in psychology: pathologising and misgendering children from 1999 to 2008. *Psychology & Sexuality*. iFirst, 1-24. doi: 10.1080/19419899.2011.576696.
- APA, American Psychiatric Association (2000). *DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Arlington: American Psychiatric Publishing.
- APA, American Psychiatric Association (2012a). American Psychiatric Association Board of Trustees Approves DSM-5. December 1, 2012. <http://www.psych.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2012%20Releases/12-43-DSM-5-BOT-Vote-News-Release--FINAL--3-.pdf> (retrieved: July 29, 2013).
- APA, American Psychiatric Association (2013a). *DSM-5, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. Arlington: American Psychiatric Publishing.
- APA, American Psychiatric Association (2013b). American Psychiatric Association Releases DSM-5. Publication of diagnostic manual culminates 14-year development process, May 17, 2013. <http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2013%20Releases/13-31-DSM-5-Publication-News-Release.pdf> (retrieved: July 29, 2013)
- APA, American Psychiatric Association (2013c). *DSM-5 Development*. <http://www.dsm5.org/Pages/Default.asp> (retrieved: July 29, 2013).
- APA, American Psychiatric Association (2013d). Gender Dysphoria, 2013. [DSM-5 Fact Sheet]. <http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/DSM-5-Gender-Dysphoria.pdf> (retrieved: July 29, 2013).
- APA, American Psychiatric Association (2013e). Paraphilic Disorders [DSM-5 Fact Sheet]. <http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/DSM-5-Paraphilic-Disorders.pdf> (retrieved: July 29, 2013).
- Beauchamp TL, Childress JF (1999 [1979]). *Principios de Ética Biomédica*. Barcelona: Masson, 1999.
- Bryant K (2006). Making gender identity disorder of childhood: Historical lessons for contemporary debates. *Sexuality Research & Social Policy: A Journal of the NSRC*, 3:23–39. doi:10.1525/srsp.2006.3.3.23.
- Drescher J, Cohen-Kettenis P, Winter S. Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, December 2012;24(6):568-577.
- Drescher J. Controversies in Gender Diagnoses. *LGBT Health* 2013;1(1):9-13. DOI: 10.1089/lgbt.2013.1500. <http://online.liebertpub.com/doi/pdfplus/10.1089/lgbt.2013.1500> (retrieved: July 29, 2013).
- GLSEN, Gay Lesbian Straight Education Network (2012). *Playgrounds and Prejudice: Elementary School Climate in the United States. A Survey of Students and Teachers*. New York: Harris Interactive. <http://www.umass.edu/stonewall/uploads/listWidget/25153/playgrounds%20&%20prej.pdf> (retrieved: July 9, 2013).
- Gómez A (2004). Trascendiendo. *Desacatos, Revista de Antropología Social*, 14-15:199-208. <http://www.ciesas.edu.mx/desacatos/15-16%20Indexado/3%20Testimonio%201.pdf> (retrieved: July 29, 2013). English Version: Gómez A. (2004). *Transcending*, 1-17. <http://www.2spirits.com/TrascendiendoEnglishversion.pdf> (retrieved: July 29, 2013).

Knudson G, De Cuypere G, Bockting W. Second Response of the World Professional Association for Transgender Health to the Proposed Revision of the Diagnosis of Transvestic Disorder for DSM 5. *International Journal of Transgenderism* 2011;13(1):9-12.

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

Sood N (2010). Transgender People's Access to Sexual Health and Rights: A Study of Law and Policy in 12 Asian Countries. ARROW, Asian-Pacific Resource and Research Centre for Women. <http://arrow.org.my/images/publications/ICPD+15/CaseStudies/Transgender%20People%E2%80%99s%20Access%20to%20Sexual%20Health%20and%20Rights.pdf> (retrieved: July 29, 2013).

STP, International Campaign Stop Trans Pathologization (2012). Reflections on the ICD Revision Process from a Depathologization and Human Rights Perspective. http://www.stp2012.info/STP2012_Reflections_ICD.pdf (retrieved: July 29, 2013).

STP, International Campaign Stop Trans Pathologization (2013). Recent Developments related to the DSM and ICD Revision Processes. http://www.stp2012.info/STP_Communique_DSM_ICD.pdf (retrieved: July 29, 2013).

UN, United Nations (1989 [entry into force 1990]). General Assembly. Convention on the Rights of the Child, 1989. <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx> (retrieved: July 29, 2013).

UN, United Nations (2005). Committee on the Rights of the Child. General Comment No. 7 (2005). Implementing child rights in early childhood. <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/GeneralComment7Rev1.pdf> (retrieved: July 29, 2013).

UN, United Nations (2009). Committee on the Rights of the Child. General Comment No. 12 (2009). The right of the child to be heard. <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.doc> (retrieved: July 29, 2013).

UN, United Nations (2011). Committee on the Rights of the Child. General Comment N° 13 (2011). The right of the child to freedom from all forms of violence. http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf (retrieved: July 29, 2013).

UN, United Nations (2012). Human Rights Council. A/HRC/19/L.31. Rights of the Child, March 20, 2012. <http://daccess-dds-ny.un.org/doc/RESOLUTION/LTD/G12/123/37/PDF/G1212337.pdf?OpenElement> (retrieved: July 29, 2013).

UN, United Nations (2013a). Committee on the Rights of the Child. General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, párrafo 1). http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf (retrieved: July 29, 2013).

UN, United Nations (2013b). Committee on the Rights of the Child. General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24). http://www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-15_en.doc (retrieved: July 29, 2013).

UN, United Nations (2013c). Committee on the Rights of the Child. General Comment No. 17 (2013) on the right of the child to rest, leisure, play, recreational activities, cultural life and the arts. http://www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-17_en.doc (retrieved: July 29, 2013).

UN, United Nations (2013d). Human Rights Council. A/HRC/22/L.27. Rights of the child: the right of the child to the enjoyment of the highest attainable standard of health. March 18, 2013. <http://daccess-dds-ny.un.org/doc/RESOLUTION/LTD/G13/121/47/PDF/G1312147.pdf?OpenElement> (retrieved: July 29, 2013).

Vasey P, Bartlett N (2007). What Can the Samoan 'Fa'afafine' Teach us about the Western Concept of Gender Identity Disorder in Childhood? *Perspectives in Biology and Medicine*, 50:481–490.

WHO, World Health Organization (2013a). Revision Timelines. <http://www.who.int/classifications/icd/revision/timeline/en/index.html> (retrieved: July 29, 2013).

WHO, World Health Organization (2013b). ICD-11 Beta Draft. <http://apps.who.int/classifications/icd11/browse/f/en> (retrieved: July 29, 2013).

WHO, World Health Organization (2013c). Field Tests. <http://www.who.int/classifications/icd/revision/fieldtests/en/index.html> (retrieved: July 29, 2013).

Whittle S, Turner L, Al-Alami M (2007). *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*. Manchester: Press for Change, Manchester Metropolitan University. <http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf> (retrieved: July 29, 2013).

WPATH, World Professional Association for Transgender Health (2013). Executive Summary. WPATH Consensus Process regarding Transgender- and Transexual-Related Diagnosis in ICD-11, 31 May 2013. http://www.wpath.org/documents/WPATH%20ICD-11%20Consensus%20Report_Executive%20Summary_7-7-13.pdf (retrieved: July 29, 2013).

Yogyakarta Principles (2007). http://www.yogyakartaprinciples.org/principles_en.pdf (retrieved: July 29, 2013).