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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

AIDEN STOCKMAN; NICOLAS TALBOTT; TAMASYN REEVES; JAQUICE TATE; JOHN DOES 1-2; JANE DOE; and EQUALITY CALIFORNIA,

Plaintiffs,

v.

DONALD J. TRUMP, et al.

Defendants.

CASE NO. 5:17-cv-01799-JGB-KKx

SUPPLEMENTAL DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Hearing

Date: November 20, 2017
Time: 9:00 a.m.
Courtroom: 1

1. I, George R. Brown, M.D., have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I make this declaration based on my own personal knowledge.

3. I offer this declaration as a supplement to my previous declaration submitted in the above-captioned case [Docket No. 27] describing my professional education, experience, and background, including my awareness of the extensive process that led to the adoption of a Department of Defense policy in June 2016 permitting transgender people to serve in the military.

The Categorization of Medical Conditions Related to Gender Identity in the ICD-10 and the Forthcoming ICD-11

4. The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), which is expected to be approved by the World Health Assembly in May 2018. (See Exhibit A, Geoffrey M. Reed et al., "Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 based on current scientific evidence, best clinical practices, and human rights considerations," World Psychiatry 15:3, 205 (October 2016) (hereinafter "Reed").)

5. The ICD-10 was approved in 1990, nearly thirty years ago. The current period between revisions is the longest in the history of the ICD, which has resulted in some portions of the ICD-10 being significantly outdated. In particular, the portions of the ICD-10 relating to gender identity required significant revision in order to reflect advances in the research and the current scientific understanding of gender identity, transgender people, and the medical treatments for medical conditions relating to gender identity and gender dysphoria.

6. In order to provide scientifically and clinically sound recommendations about these needed revisions, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research appointed a

Joint Working Group to develop specific recommendations for how to revise the ICD-10 categories relating to gender identity. The Joint Working Group reviewed available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 categories, in addition to other relevant materials, including what were then proposals for revising the American Psychiatric Association's DSM-5. The Joint Working Group made specific proposals regarding the placement and organization of categories and drafted diagnostic guidelines for the ICD-11 recommended diagnostic categories. I was invited to present my ideas on these matters at a meeting of this group in Oslo, Norway, and I had the opportunity to meet with Mr. Reed personally regarding the revisions.

7. The Joint Working Group recommended retaining diagnoses for gender incongruence (a new term that replaces Transsexualism and Gender Identity Disorder, but applies to the same patients previously diagnosed with these conditions) in order to preserve access to health service for transgender people, but moving these categories out of the ICD-11 chapter on Mental and Behavioral Disorders to the proposed new ICD-11 chapter on Conditions Related to Sexual Health. The Working Group recommended changing the ICD-10 category F64.0 Transsexualism to Gender Incongruence of Adolescence and Adulthood and the ICD-10 F64.2 Gender Identity Disorder of Childhood to Gender Incongruence of Childhood.

8. The main reason for moving and renaming these diagnoses was to reflect current scientific research and knowledge about gender identity and transgender people, which recognizes that being transgender is not a disorder, that transition-related care is a basic aspect of promoting health and well-being for transgender people, and that gender dysphoria is a curable condition that has medical components and should not be limited to a mental health diagnosis.

9. In light of these proposed revisions, it would be inappropriate and inaccurate to rely upon the outdated categorization of transsexualism and other medical conditions related to gender identity in the ICD-10 in any current discussion of these conditions. Further, in the ICD-10 terminology of 1990, it was never the case that clinicians working in this field of medicine considered transsexualism or gender identity disorder a "personality disorder" even though the Subgrouping, Gender Identity Disorders, was listed under the Grouping "Disorders of adult personality and behavior" in the Chapter entitled "Mental and Behavioral Disorders" in ICD-10. This erroneous placement for gender identity disorders will be corrected in ICD-11, where it is made clear that the replacement term, "gender incongruence," is not a personality or behavioral disorder. This important clarification is consistent with my professional opinion and those of the vast majority of researchers and clinicians who work with persons with gender incongruence/gender dysphoria (see Reed).

10. There is no medical or scientific basis for categorizing transsexualism, gender dysphoria or any other medical condition associated with transgender people as a personality or behavioral disorder.

WAIVERS

11. Medical wavier is not an option, and has never been an option, for transgender persons attempting to accede into the military. The new accessions policy articulated by Secretary Carter has not been put into effect, so the pre-June 2016 military policy for transgender persons continues to govern the standards for accession into the military, whether through enlistment, appointment or induction. This policy does not allow medical waivers for persons with clinically active gender dysphoria, or who have been treated for gender dysphoria in the past. In that regard, it treats those with gender dysphoria, a curable condition, differently than those with other curable medical conditions. For example, while an individual may receive an accession waiver for being medically overweight, an

individual cannot receive a waiver for a prior course of treatment for gender dysphoria, irrespective of the success of that treatment.

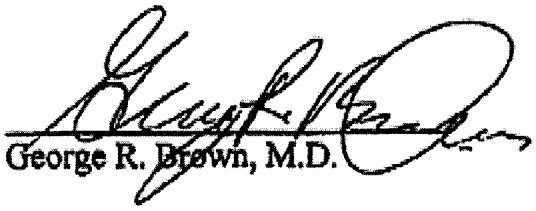
12. The current enlistment policy allows waivers for a variety of medical conditions. However, entry waivers will not be granted for conditions that would disqualify an individual from the possibility of retention. Because being transgender is a disqualifying condition for retention, transgender people cannot obtain medical waivers to enter the military.

13. The enlistment policy treats gender dysphoria differently than other curable conditions. The result of this inconsistency is that transgender personnel are excluded or singled out for disqualification from enlistment, even when they are mentally and physically healthy.

14. In my thirty-two years of working as an active duty military psychiatrist or VHA psychiatrist, I am unaware of any waiver ever being granted for any transgender person seeking to enlist in any branch of the Armed Forces.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 3, 2017



George R. Brown, M.D.

Exhibit A

SPECIAL ARTICLE

Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations

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In the World Health Organization's forthcoming eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), substantial changes have been proposed to the ICD-10 classification of mental and behavioural disorders related to sexuality and gender identity. These concern the following ICD-10 disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders associated with sexual development and orientation. Changes have been proposed based on advances in research and clinical practice, and major shifts in social attitudes and in relevant policies, laws, and human rights standards. This paper describes the main recommended changes, the rationale and evidence considered, and important differences from the DSM-5. An integrated classification of sexual dysfunctions has been proposed for a new chapter on Conditions Related to Sexual Health, overcoming the mind/body separation that is inherent in ICD-10. Gender identity disorders in ICD-10 have been reconceptualized as Gender incongruence, and also proposed to be moved to the new chapter on sexual health. The proposed classification of Paraphilic disorders distinguishes between conditions that are relevant to public health and clinical psychopathology and those that merely reflect private behaviour. ICD-10 categories related to sexual orientation have been recommended for deletion from the ICD-11.

Key words: International Classification of Diseases, ICD-11, sexual health, sexual dysfunctions, transgender, gender dysphoria, gender incongruence, paraphilic disorders, sexual orientation, DSM-5

(World Psychiatry 2016;15:205–221)

The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11). The ICD-11 is expected to be approved by the World Health Assembly in May 2018. The ICD-10 was approved in 1990, making the current period between revisions the longest in the history of the ICD.

In 2007, the WHO Department of Mental Health and Substance Abuse appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, to provide policy guidance and consultation throughout the development of the ICD-11 classification of mental and behavioural disorders[1]. As the revision process advanced, a series of Working Groups in different disorder content areas were also appointed to review available evidence and develop recommendations regarding needed revisions in specific diagnostic groupings[2].

From early in the revision process, it was clear that there were a series of complex and potentially controversial issues associated with the ICD-10 categories related to sexuality and gender identity, including the following disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders associated with sexual development and orientation. During the more than 25 years since the approval of ICD-10, there have been substantial advances in research relevant to these categories, as well as major changes in social attitudes and in relevant policies, laws, and human rights standards.

Due to the complexity of this context and the need to take a broad perspective in order to develop scientifically and clinically sound recommendations that would facilitate access to health services, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research have worked together to propose revisions in these areas. The two WHO departments appointed a joint Working Group on Sexual Disorders and Sexual Health to assist in the development of specific recommendations.

The first task of the Working Group was to review available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 diagnostic categories identified above. These issues were examined within various settings, including primary care and specialist health care settings, as well as social service and forensic contexts. Also considered were human rights issues pertinent to diagnostic classification in each of the areas under the Working Group's purview. The Working Group was also asked to review what were then proposals for the American

Psychiatric Association's DSM-5[3], and to consider the clinical utility of those proposals and their suitability for global implementation in various settings. Finally, the Working Group was asked to prepare specific proposals, including the placement and organization of categories, and to draft diagnostic guidelines for the ICD-11 recommended diagnostic categories, in line with the overall ICD revision requirements[2].

The following sections describe the main recommended changes for the above-mentioned four areas in the ICD-11 as compared to ICD-10. The ICD-10 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders[4], the version intended for use by specialist mental health professionals, is used as the frame of reference for this comparison. The rationale for changes, the evidence considered, and specific comments on differences from DSM-5 are also provided.

PROPOSED CHANGES TO F52 SEXUAL DYSFUNCTIONS, NOT CAUSED BY ORGANIC DISORDER OR DISEASE

The ICD-10 classification of Sexual dysfunctions (F52) is based on a Cartesian separation of "organic" and "non-organic" conditions. Sexual dysfunctions considered "non-organic" are classified in the ICD-10 chapter on Mental and Behavioural Disorders, and most "organic" sexual dysfunctions are classified in the chapter on Diseases of the Genitourinary System. However, substantial evidence has accumulated since ICD-10's publication indicating that the origin and maintenance of sexual dysfunctions frequently involves the interaction of physical and psychological factors[5]. The ICD-10 classification of sexual dysfunctions is therefore not consistent with current, more integrative clinical approaches in sexual health[6-9].

The Working Group on Sexual Disorders and Sexual Health has proposed an integrated classification of sexual dysfunctions for ICD-11 (see Table 1) that is more closely informed by current evidence and best practices, to be included in a new ICD-11 chapter on Conditions Related to Sexual Health[10]. The proposed integrated classification encompasses the sexual dysfunctions listed in the ICD-10 chapter on Mental and Behavioural Disorders and many of those currently found in the chapter on Diseases of the Genitourinary System[11].

In the proposed diagnostic guidelines for ICD-11, sexual response is described as a complex interaction of psychological, interpersonal, social, cultural, physiological and gender-influenced processes. Any of these factors may contribute to the development of sexual dysfunctions[8], which are described as syndromes that comprise the various ways in which people may have difficulty experiencing personally satisfying, non-coercive sexual activities.

The proposed ICD-11 diagnostic guidelines organize Sexual dysfunctions into four main groups: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. In addition, a separate grouping of Sexual pain disorders has been proposed. Where possible, categories in the proposed classification of sexual dysfunctions apply to both men and women, emphasizing commonalities in sexual response[12,13] (e.g., Hypoactive sexual desire dysfunction, Orgasmic dysfunction), without ignoring established sex differences in the nature of these experiences[14]. Men and women exhibit similar central nervous system pathways of activation and deactivation and similar neurotransmitter activity related to sexual desire. Dynamic alterations of sexual response are similarly modulated and reinforced by behaviour, experience and neuroplasticity. Separate sexual dysfunctions categories for men and women are provided where sex differences are related to distinct clinical presentations (e.g., Female sexual arousal dysfunction in women as compared to Erectile dysfunction in men).

The proposed guidelines indicate that, in order to be considered a sexual dysfunction, the problem or difficulty should generally: a) have been persistent or recurrent over a period of at least several months; b) occur frequently, although it may fluctuate in severity; and c) be associated with clinically significant distress. However, in cases where there is an immediate acute cause of the sexual dysfunction (e.g., a radical prostatectomy or injury to the spinal cord in the case of Erectile dysfunction; breast cancer and its treatment in Female sexual arousal dysfunction), it may be appropriate to assign the diagnosis even though the duration requirement has not been met, in order to initiate treatment.

The proposed diagnostic guidelines make clear that there is no normative standard for sexual activity. "Satisfactory" sexual functioning is defined as being satisfying to the individual, i.e. the person is able to participate in sexual activity and in a sexual relationship as desired. If the individual is satisfied with his/her pattern of sexual experience and activity, even if it is different from what may be satisfying to other people or what is considered normative in a given culture or subculture, a sexual dysfunction should not be diagnosed. Unrealistic expectations on the part of a partner, a discrepancy in sexual desire between partners, or inadequate sexual stimulation are not valid bases for a diagnosis of sexual dysfunction.

The proposed ICD-11 classification uses a system of harmonized qualifiers that may be applied across categories to identify the important clinical characteristics of the sexual dysfunctions. A *temporal qualifier* indicates whether the sexual dysfunction is *lifelong*, i.e. the person has always experienced the dysfunction from the time of initiation of relevant sexual activity, or *acquired*, i.e. the onset of the sexual dysfunction has followed a period of time during which the person did not experience it. A *situational qualifier* is used to indicate whether the dysfunction is *generalized*, i.e. the desired response is absent or diminished in all circumstances, including masturbation, or *situational*, i.e. the desired response is absent or diminished in some circumstances but not in others (e.g., with some partners or in response to some stimuli).

An innovative feature of the proposed ICD-11 classification of Sexual dysfunctions and Sexual pain disorders, and an

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments
***Chapter*:** Conditions Related to Sexual Health ***Grouping*:** Sexual dysfunctions	***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Behavioural syndromes associated with physiological disturbances and physical factors ***Subgrouping*:** Sexual dysfunction, not caused by organic disorder or disease ***Chapter*:** Diseases of the Genitourinary System ***Grouping*:** Diseases of male genital organs ***Subgrouping*:** Other disorders of penis ***Grouping*:** Noninflammatory disorders of female genital tract ***Subgrouping*:** Pain and other conditions associated with female genital organs and menstrual cycle	***Grouping*:** Sexual dysfunctions	• In ICD-11, Sexual dysfunctions have been included in a new chapter called Conditions Related to Sexual Health. • ICD-11 Sexual dysfunctions proposals represent an integrated classification, including conditions listed in Mental and Behavioural Disorders chapter in ICD-10 and many of those currently found in Diseases of the Genitourinary System. • In ICD-11, there are four main groupings of sexual dysfunctions: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. There is another separate grouping of Sexual pain disorders. • DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
***Category*:** Hypoactive sexual desire dysfunction	***Category*:** Lack or loss of sexual desire	***Category***: Female sexual interest/arousal disorder; Male hypoactive sexual desire disorder	• In ICD-11, Hypoactive sexual desire dysfunction can be applied to both men and women; In DSM-5, Female sexual interest/arousal disorder is separated from Male hypoactive sexual desire disorder.
Category: *Recommended for deletion*	***Category***: Sexual aversion	***Category***: Not included	• In ICD-11, the ICD-10 category Sexual aversion would be classified under Sexual pain-penetration disorder or under Specific phobia, depending on specific nature of symptoms. • In DSM-5, that category would similarly be classified as Genital-pelvic pain/penetration disorder or under Specific phobia.
Category: Female sexual arousal dysfunction	***Category***: Failure of genital response; Lack of sexual enjoyment	***Category***: Female sexual interest/arousal disorder	• In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • In ICD-11, the psychological component of arousal involved in ICD-10 Lack of sexual enjoyment is also subsumed in women under Female sexual arousal dysfunction.
Category: Erectile dysfunction	***Category***: Failure of genital response; Impotence of organic origin	***Category***: Erectile disorder	• In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • ICD-11 includes "organic" Erectile dysfunctions.
Category: Orgasmic dysfunction	***Category***: Orgasmic dysfunction	***Category***: Female orgasmic disorder	• In ICD-11, Orgasmic dysfunction can be applied to both men and women. • In ICD-11, there is a distinction between subjective experience of orgasm in men and ejaculation.

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5 *(continued)*

Proposed ICD-11	ICD-10	DSM-5	Comments
Category: Early ejaculation	***Category***: Premature ejaculation	***Category***: Premature (early) ejaculation	• Terminology in ICD-11 changed from Premature ejaculation to Early ejaculation.
Category: Delayed ejaculation	***Category***: Orgasmic dysfunction	***Category***: Delayed ejaculation	• DSM-5 does not distinguish between subjective experience of orgasm and ejaculation in men.
Category: Other specified sexual dysfunction	***Category***: Other sexual dysfunction, not caused by organic disorder or disease; Other specified disorders of penis; Other specified conditions associated with female genital organs and menstrual cycle	***Category***: Other specified sexual dysfunction	• DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
Category: Unspecified sexual dysfunction	***Category***: Unspecified sexual dysfunction, not caused by organic disorder or disease; Disorder of penis, unspecified; Unspecified condition associated with female genital organs and menstrual cycle	***Category***: Unspecified sexual dysfunction	• DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
Category: Sexual pain-penetration disorder (in separate grouping of Sexual pain disorders)	***Category***: Nonorganic vaginismus; Vaginismus (organic)	***Category***: Genito-pelvic pain/penetration disorder	• In ICD-11, Sexual pain penetration disorder includes Vaginismus and excludes Dyspareunia and Vulvodynia, which are classified in the Genitourinary chapter. • In DSM-5, Genito-pelvic pain/penetration disorder groups includes Dyspareunia and Vulvodynia if it occurs during penetration attempts or vaginal intercourse.

important one for a system that does not attempt to divide "organic" and "non-organic" dysfunctions, is a system of *etiological qualifiers* that may be applied to these categories. These qualifiers are not mutually exclusive, and as many may be applied as are considered to be relevant and contributory in a particular case. Proposed qualifiers include the following:

- *Associated with disorder or disease classified elsewhere, injury or surgical treatment* (e.g., diabetes mellitus, depressive disorders, hypothyroidism, multiple sclerosis, female genital mutilation, radical prostatectomy)[15-19];
- *Associated with a medication or substance* (e.g., selective serotonin reuptake inhibitors, histamine-2 receptor antagonists, alcohol, opiates, amphetamines)[20,21];
- *Associated with lack of knowledge* (e.g., about the individual's own body, sexual functioning, and sexual response)[22];
- *Associated with psychological or behavioural factors* (e.g., negative attitudes toward sexual activity, adverse past sexual experiences, poor sleep hygiene, overwork)[23,24];
- *Associated with relationship factors* (e.g., relationship conflict, lack of romantic attachment)[25,26];
- *Associated with cultural factors* (e.g., culturally-based inhibitions about the expression of sexual pleasure, the belief that loss of semen can lead to weakness, disease or death)[27,28].

Other changes that have been proposed include the elimination of the ICD-10 category F52.7 Excessive sexual drive from the classification of Sexual dysfunctions. The ICD-10 category F52.0 Loss or lack of sexual desire is more specifically categorized in ICD-11 as Hypoactive sexual desire dysfunction in women and men, Female sexual arousal dysfunction in women, or Erectile dysfunction in men. The ICD-10 category F52.10 Sexual aversion is classified in ICD-11 under Sexual pain-penetration disorder or under the grouping of Anxiety and fear-related disorders if it is used to describe a phobic response. The ICD-10 category F52.11 Lack of sexual enjoyment, which the ICD-10 indicates is more common in women, is captured primarily in the ICD-11 under Female sexual arousal dysfunction. Other possible reasons for lack of sexual enjoyment, including hypohedonic orgasm and painful orgasm[29], would be classified under Other specified sexual dysfunctions. The ICD-10 category F52.2 Failure of genital response is separated into two categories: Female sexual arousal dysfunction in women, and Erectile dysfunction in men.

Comparison with DSM-5

The proposed classification of sexual dysfunctions in ICD-11 is different from the DSM-5 in its attempt to integrate

dysfunctions that may have a range of etiological or contributory dimensions. The DSM-5 acknowledges that an array of factors may be relevant to etiology and treatment and may contribute to sexual dysfunctions; these include partner, relationship, individual vulnerability, cultural, religious, and medical factors. At the same time, the DSM-5 indicates that, if a sexual dysfunction is caused by a nonsexual medical disorder, the effects of a substance or medication, or a medical condition, a diagnosis of Sexual dysfunction would not be assigned. This is logical given the DSM-5's purpose as a classification of mental and behavioural disorders (even though it differs from the approach that DSM-5 has taken to Sleep-wake disorders and Neurocognitive disorders). Because ICD-11 is a classification of all health conditions, it provides the possibility for greater integration. The proposed ICD-11 classification allows for assigning a Sexual dysfunction diagnosis in situations in which this is an independent focus of treatment, regardless of presumed etiology. The presence of a variety of contributory factors may be recorded using the etiological qualifiers.

The DSM-5 has combined dysfunctions of sexual desire and sexual arousal in women in the category Female sexual interest/arousal disorder[30], which has proved to be quite controversial[31-35]. In contrast, the proposed ICD-11 category Hypoactive sexual desire dysfunction can be applied to both men and women, while Female sexual arousal dysfunction is classified separately. The separation of desire and arousal in women into distinct dysfunctions is supported by several lines of evidence, including genetic evidence from twin studies[36], studies of specific single nucleotide polymorphisms and the use of serotonergic antidepressant medications[37,38], and neuroimaging studies[39]. There is also evidence that Hypoactive desire disorder in women and men respond to similar treatments[40], and that these are different from treatments that are effective for Female sexual arousal disorder[41-43]. Although there is significant comorbidity between desire and arousal dysfunction, the overlap of these conditions does not mean that they are one and the same; research suggests that management should be targeted toward their distinct features[44].

The proposed classification of sexual pain in ICD-11 provides the possibility of identifying specific types of pain syndromes without excluding those in which another medical condition is considered to be contributory. The DSM-5 category Genito-pelvic pain/penetration disorder includes vaginismus, dyspareunia and vulvodynia not completely attributable to other medical conditions. A similar category of Sexual pain-penetration disorder has been proposed for ICD-11, but it does not include dyspareunia and vulvodynia, which have been retained as separate categories in the ICD-11 genitourinary chapter. These syndromes are characterized by different etiologies, occur in different populations, and have distinct treatment approaches[45-47].

Finally, the DSM-IV-TR category Male orgasmic disorder has been replaced in DSM-5 by Delayed ejaculation. This decision seems to have been largely based on a Medline search that indicated infrequent usage of terminology including orgasm as opposed to terminology specifying ejaculation for male disorders[48]. Another rationale for DSM-5 to modify the term was the small number of cases of male orgasmic disorder seen in clinical practice[49]. However, this was not only a modification of terminology but rather the lumping of two separate phenomena into a single category. The proposed ICD-11 classification of Sexual dysfunctions emphasizes the subjective experience of orgasm and separates it from the ejaculatory phenomenon, consistent with available research[50].

PROPOSED CHANGES TO F64 GENDER IDENTITY DISORDERS

Over the past several years, a range of civil society organizations as well as the governments of several Member States and the European Union Parliament have urged the WHO to remove categories related to transgender identity from its classification of mental disorders in the ICD-11[51-53].

One impetus for this advocacy has been an objection to the stigmatization that accompanies the designation of any condition as a mental disorder in many cultures and countries. The WHO Department of Mental Health and Substance Abuse is committed to a variety of efforts to reduce the stigmatization of mental disorders[54]. However, the stigmatization of mental disorders *per se* would not be considered a sufficient reason to eliminate or move a mental disorder category. The conditions listed in the ICD Mental and Behavioural Disorders chapter are intended to assist in the identification of people who need mental health services and in the selection of appropriate treatments[1], in fulfillment of WHO's public health objectives.

Nevertheless, there is substantial evidence that the current nexus of stigmatization of transgender people and of mental disorders has contributed to a doubly burdensome situation for this population, which raises legitimate questions about the extent to which the conceptualization of transgender identity as a mental disorder supports WHO's constitutional objective of "the attainment by all peoples of the highest possible level of health"[55]. Stigma associated with the intersection of transgender status and mental disorders appears to have contributed to precarious legal status, human rights violations, and barriers to appropriate health care in this population[56-58].

The WHO's 2015 report on *Sexual health, human rights, and the law*[58] indicates that, in spite of recent progress, there are still very few non-discriminatory, appropriate health services available and accessible to transgender people. Health professionals often do not have the necessary competence to provide services to this population, due to a lack of appropriate professional training and relevant health system standards[59-61]. Limited access to accurate information and appropriate health services can contribute to a variety of negative behavioural and mental health outcomes among transgender people, including increased HIV-related risk behaviour, anxiety, depression, substance abuse, and suicide[62-65]. Additionally,

Table 2 Classification of conditions related to gender identity in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[71,72]
Chapter: Conditions Related to Sexual Health ***Grouping***: Gender incongruence	***Chapter***: Mental and Behavioural Disorders ***Grouping***: Disorders of adult personality and behaviour ***Subgrouping***: Gender identity disorders	***Grouping***: Gender dysphoria	• ICD-11 does not classify Gender incongruence as a mental and behavioural disorder; Gender dysphoria is listed as a mental disorder in DSM-5. • ICD-11's primary focus is experience of incongruence between experienced gender and assigned sex; DSM-5 emphasizes distress related to gender identity through name of category and criteria.
Category: Gender incongruence of adolescence and adulthood	***Category***: Transsexualism	***Category***: Gender dysphoria in adolescents and adults	• ICD-11 contains four broad essential features and two are required for diagnosis; DSM-5 contains six criteria and two are required for diagnosis. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of several months; DSM-5 requires six months.
Recommended for deletion	***Category***: Dual-role transvestism	*Not included*	• Recommended for deletion from ICD-11 due to lack of public health or clinical relevance (not in DSM-5).
Category: Gender incongruence of childhood	***Category***: Gender identity disorder of childhood	***Category***: Gender dysphoria in children	• ICD-11 contains three essential features, all of which are required for diagnosis; DSM-5 contains eight diagnostic criteria, six of which must be present. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of two years, suggesting that the diagnosis cannot be made before approximately age 5; DSM-5 requires six months and does not set a lower age limit.
Recommended for deletion	***Category***: Other gender identity disorders	***Category***: Other specified gender dysphoria	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.
Recommended for deletion	***Category***: Gender identity disorder, unspecified	***Category***: Unspecified gender dysphoria	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.

many transgender people self-administer hormones of dubious quality obtained through illicit markets or online without medical supervision[66,67], with potentially serious health consequences[68-70]. For example, in a recent study of 250 transgender people in Mexico City, nearly three-quarters of participants had used hormones, and nearly half of these had begun using them without medical supervision[71].

In spite of WHO's concerted advocacy for mental health parity[54], a primary mental disorder diagnosis can exacerbate problems for transgender people in accessing health services, particularly those that are not considered to be mental health services. Even in countries that recognize the need for transgender-related health services and where professionals with relevant expertise are relatively available, private and public insurers often specifically exclude coverage for these services[58]. Classification as a mental disorder has also contributed to the perception that transgender people must be treated by psychiatric specialists, further restricting access to services that could reasonably be provided at other levels of care.

In most countries, the provision of health services requires the diagnosis of a health condition that is specifically related to those services. If no diagnosis were available to identify transgender people who were seeking related health services, these services would likely become even less available than they are now[72,73]. Thus, the Working Group on Sexual Disorders and Sexual Health has recommended retaining gender incongruence diagnoses in the ICD-11 to preserve access to health services, but moving these categories out of the ICD-11 chapter on Mental and Behavioural Disorders (see Table 2). After consideration of a variety of placement options[72], these

categories have been provisionally included in the proposed new ICD-11 chapter on Conditions Related to Sexual Health.

The Working Group has recommended reconceptualizing the ICD-10 category F64.0 Transsexualism as Gender incongruence of adolescence and adulthood[72] and the ICD-10 category F64.2 Gender identity disorder of childhood as Gender incongruence of childhood[73]. The proposed diagnostic requirements for Gender incongruence of adolescence and adulthood include the continuous presence for at least several months of at least two of the following features: a) a strong dislike or discomfort with primary or secondary sex characteristics due to their incongruity with the experienced gender; b) a strong desire to be rid of some or all of one's primary or secondary sex characteristics (or, in adolescence, anticipated secondary sex characteristics); c) a strong desire to have the primary or secondary characteristics of the experienced gender; and d) a strong desire to be treated (to live and be accepted as) a person of the experienced gender. As in the ICD-10, the diagnosis of Gender incongruence of adolescence and adulthood cannot be assigned before the onset of puberty. The duration requirement is reduced from two years in ICD-10 to several months in ICD-11.

The ICD-11 abandons ICD-10 terms such as "opposite sex" and "anatomic sex" in defining the condition, using more contemporary and less binary terms such as "experienced gender" and "assigned sex". Unlike ICD-10, the proposed ICD-11 diagnostic guidelines do not implicitly presume that all individuals seek or desire full transition services to the "opposite" gender. The proposed guidelines also explicitly pay attention to the anticipated development of secondary sex characteristics in young adolescents who have not yet reached the last physical stages of puberty, an issue that is not addressed in ICD-10.

The proposed ICD-11 diagnostic requirements for Gender incongruence of childhood are considerably stricter than those of ICD-10, in order to avoid as much as possible the diagnosis of children who are merely gender variant. All three of the following essential features must be present: a) a strong desire to be, or an insistence that the child is, of a different gender; b) a strong dislike of the child's own sexual anatomy or anticipated secondary sex characteristics, or a strong desire to have the sexual anatomy or anticipated secondary sex characteristics of the desired gender; and c) make believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The third essential feature is not meaningful without the other two being present; in their absence it is merely a description of gender variant behaviour. These characteristics must have been present for at least two years in a prepubertal child, effectively meaning that the diagnosis cannot be assigned prior to the age of approximately 5 years. The ICD-10 does not mention a specific duration requirement or a minimum age at which it is appropriate to assign the diagnosis.

The proposed diagnostic guidelines for both Gender incongruence of adolescence and adulthood and Gender incongruence of childhood indicate explicitly that gender variant behaviour and preferences alone are not sufficient for making a diagnosis; some form of experienced anatomic incongruence is also necessary. Importantly, the diagnostic guidelines for both categories indicate that gender incongruence may be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, particularly in disapproving social environments and where protective laws and policies are absent, but that neither distress nor functional impairment is a diagnostic requirement.

The area of transgender health is characterized by calls for change in health system responses[58,74,75], by rapid change in social attitudes in some countries, and by controversy. As a part of this work, the Working Group on Sexual Disorders and Sexual Health received proposals and opinions from a wide range of civil societies, professional organizations, and other interested parties[72,73]. The most controversial issue has been the question of whether the childhood diagnostic category should be retained[73]. The main argument advanced against retaining the category is that stigmatization associated with being diagnosed with *any* health condition – not just a mental disorder diagnosis – is potentially harmful to children who will in any case not be receiving medical interventions before puberty[76]. A more substantive critique is that, if it is the case that the problems of extremely gender-variant children arise primarily from hostile social reactions and victimization, assigning a diagnosis to the child amounts to blaming the victim[77]. This latter concern suggests a need for further research as well as a broader social conversation. The Working Group has recommended retaining the category based on the rationale that it will preserve access to treatment for this vulnerable and already stigmatized group. Treatment most often consists of specialized supportive mental health services as well as family and social (e.g., school) interventions[73], while treatments aimed at suppressing gender-variant behaviours in children are increasingly viewed as unethical.

The diagnosis also serves to alert health professionals that a transgender identity in childhood often does not develop seamlessly into an adult transgender identity. Available research instead indicates that the majority of children diagnosed with DSM-IV Gender identity disorder of childhood, which was not as strict in its requirements as those proposed for ICD-11, grow up to be cisgender (non-transgender) adults with a homosexual orientation[78-80]. In spite of the claims of some clinicians to be able to distinguish between children whose transgender identity is likely to persist into adolescence and adulthood and those likely to be gay or lesbian, there is considerable overlap between these groups in all predictors examined[80], and no valid method of making a prediction at an individual level has been published in the scientific literature. Therefore, while medical interventions are not currently recommended for prepubertal gender incongruent children, psychosocial interventions need to be undertaken with caution and based on considerable expertise so as not to limit later choices[59,81,82]. The inclusion of the category in the ICD-11 is intended to provide better opportunities for much-needed education of health professionals, the development of stand-

ards and pathways of care to help guide clinicians and family members, including adequate informed consent procedures, and future research efforts.

Finally, the ICD-10 category F64.1 Dual-role transvestism – occasionally dressing in clothing typical of another gender in order to "enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change"[4] or accompanying sexual arousal – has been recommended for deletion from the ICD-11, due to its lack of public health or clinical relevance.

Comparison with DSM-5

The most important difference between the proposals for ICD-11 and the DSM-5 is that the latter has retained the categories related to gender identity as a part of its classification of mental disorders. Both childhood and adult forms of Gender identity disorder in DSM-IV have been renamed in DSM-5 as Gender dysphoria, defined by "marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months' duration" and "clinically significant distress or impairment in social, school, or other important areas of functioning"[3]. Both the name of the DSM-5 condition – dysphoria – and the diagnostic criteria, therefore, emphasize distress and dysfunction as integral aspects of the condition. They are also the central rationale for classifying these conditions as mental disorders; without distress or dysfunction, gender dysphoria would not fulfill the requirements of DSM-5's own definition of a mental disorder.

In contrast, the proposal for ICD-11 is to include child and adult Gender incongruence categories in another chapter that explicitly integrates medical and psychological perspectives, Conditions Related to Sexual Health. The proposed ICD-11 diagnostic guidelines indicate that distress and dysfunction, although not necessary for a diagnosis of Gender incongruence, may occur in disapproving social environments and that individuals with gender incongruence are at increased risk for psychological distress, psychiatric symptoms, social isolation, school drop-out, loss of employment, homelessness, disrupted interpersonal relationships, physical injuries, social rejection, stigmatization, victimization, and violence. At the same time, particularly in countries with progressive laws and policies, young transgender people living in supportive environments still seek health services, even in the absence of distress or impairment. The ICD-11 approach provides for this.

A challenge to DSM-5 conceptualization of Gender dysphoria is, therefore, the question of whether distress and dysfunction related to the social consequences of gender variance (e.g., stigmatization, violence) can be distinguished from distress related to transgender identity itself[83,84]. A recent study of 250 transgender adults receiving services at the only publicly funded clinic in Mexico City providing comprehensive services for transgender people[71] found that distress and dysfunction associated with emerging transgender identity were very common, but not universal. However, more than three-quarters of participants reported having experienced social rejection and nearly two-thirds had experienced violence related to their gender identity during childhood or adolescence. Distress and dysfunction were more strongly predicted by experiences of social rejection and violence than by features related to gender incongruence. These data provide further support for ICD-11's conceptualization and the removal of gender incongruence from the classification of mental disorders.

Finally, there are several technical differences between the proposals for ICD-11 and DSM-5 in relation to these categories. The most substantive is that the DSM-5 diagnosis of Gender dysphoria of childhood requires a duration of only six months, in contrast to two years in the ICD-11 proposal, and does not specify a lower age limit at which the diagnosis can be applied.

PROPOSED CHANGES TO F65 DISORDERS OF SEXUAL PREFERENCE

From WHO's perspective, there is an important distinction between conditions that are relevant to public health and indicate the need for health services versus those that are simply descriptions of private behaviour without appreciable public health impact and for which treatment is neither indicated nor sought. This distinction is based on the ICD's central function as a global public health tool that provides the framework for international public health surveillance and health reporting. It is also related to the increasing use of the ICD over the past several decades by WHO Member States to structure clinical care and define eligibility for subsidized health services[1]. The regulation of private behaviour without health consequences to the individual or to others may be considered in different societies to be a matter for criminal law, religious proscription, or public morality, but is not a legitimate focus of public health or of health classification.

This requirement is particularly pertinent to the classification of atypical sexual preferences commonly referred to as paraphilias. The Working Group on Sexual Disorders and Sexual Health noted that the diagnostic guidelines provided for ICD-10's classification of Disorders of sexual preference often merely describe the sexual behaviour involved. For example, the ICD-10 diagnostic guidelines define F65.1 Fetishistic transvestism as "the wearing of clothes of the opposite sex principally to obtain sexual excitement"[4], without requiring any sort of distress or dysfunction and without reference to the public health or clinical relevance of this behaviour. This is at odds with ICD-10's general guidance for what constitutes a mental disorder and contradicts ICD-10's own statement that "social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder"[4]. According to this principle, specific patterns of sexual arousal that are merely relatively unusual[85,86], but are not associated with distress,

dysfunction or harm to the individual or to others[87,88], are not mental disorders. Labeling them as such does not contribute meaningfully to public health surveillance or to the design of health services, and may create harm to individuals so labeled[89]. Thus, a major consideration for the recommended revisions for ICD-11 in this area was whether an atypical sexual arousal pattern represented a condition of public health significance and clinical importance.

The Working Group recommended that Disorders of sexual preference be renamed as Paraphilic disorders to reflect the terminology used in the current scientific literature and in clinical practice[90]. The Group proposed that the paraphilic disorders included in ICD-11 consist primarily of patterns of atypical sexual arousal that focus on non-consenting others, as these conditions could be considered to have public health implications (see Table 3). The core proposed diagnostic requirements for a Paraphilic disorder in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal – as manifested by persistent sexual thoughts, fantasies, urges, or behaviours – that involves others whose age or status renders them unwilling or unable to consent (e.g., pre-pubertal children, an unsuspecting individual being viewed through a window, an animal); and b) that the individual has acted on these thoughts, fantasies or urges or is markedly distressed by them. There is no requirement in the proposed ICD-11 diagnostic guidelines that the relevant arousal pattern be exclusive or preferential.

This conceptualization has resulted in the recommendation to retain three ICD-10 categories in this section, each labeled specifically as a disorder rather than simply naming or describing the behaviour involved. These include Exhibitionistic disorder, Voyeuristic disorder, and Pedophilic disorder. In addition, two new named categories have been proposed: Coercive sexual sadism disorder and Frotteuristic disorder.

Coercive sexual sadism disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. This arousal pattern has been found to be prevalent among sex offenders treated in forensic institutions[92-96] and among individuals who have committed sexually motivated homicides[97]. The new proposed nomenclature of Coercive sexual sadism disorder was selected to clearly distinguish this disorder from consensual sadomasochistic behaviours that do not involve substantial harm or risk.

Frotteuristic disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person in public places. Frotteurism has been found to be among the most common of paraphilic disorders[98-102] and is a significant problem in some countries[103]. It was also included in DSM-IV and has been retained in DSM-5.

In addition, the category Other paraphilic disorder involving non-consenting individuals is proposed for use when the other diagnostic requirements for a paraphilic disorder are met but the specific pattern of sexual arousal does not fit into any of the available named categories and is not sufficiently common or well researched to be included as a named category (e.g., arousal patterns involving corpses or animals).

Based on the concerns described above, the Working Group proposed that three named ICD-10 categories – F65.0 Fetishism, F65.1 Fetishistic transvestism, and F65.5 Sadomasochism – be removed from the classification. Indeed, several countries (Denmark, Sweden, Norway and Finland) have already removed these categories from their national lists of accepted ICD-10 diagnoses, in response to similar concerns[104]. Instead, the proposed additional category Other paraphilic disorder involving solitary behaviour or consenting individuals may be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death (e.g., asphyxophilia, or achieving sexual arousal by restriction of breathing).

One additional requirement in the proposed diagnostic guidelines is that, when a diagnosis of Other paraphilic disorder involving solitary behaviour or consenting individuals is assigned based on distress, the distress should not be entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society). In these cases, codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services may be considered. These are non-disease categories that indicate reasons for clinical encounters and include Counselling related to sexual knowledge and sexual attitude, Counselling related to sexual behaviour and sexual relationships of the patient, and Counselling related to sexual behaviour and sexual relationship of the couple. These categories recognize the need for health services, including mental health services, that may be legitimately provided in the absence of diagnosable mental disorders[11].

The proposed diagnostic guidelines make clear that the mere occurrence or a history of specific sexual behaviours is insufficient to establish a diagnosis of a Paraphilic disorder. Rather, these sexual behaviours must reflect a sustained, focused, and intense pattern of paraphilic sexual arousal. When this is not the case, other causes of the sexual behaviour need to be considered. For example, many sexual crimes involving non-consenting individuals reflect actions or behaviours that may be transient or occur impulsively or opportunistically rather than reflecting either a persistent pattern of sexual arousal or any underlying mental disorder. However, sexual behaviours involving non-consenting individuals may also occur in the context of some mental and behavioural disorders, such as manic episodes or dementia, or in the context of substance intoxication. These do not satisfy the definitional requirements of a Paraphilic disorder.

The Working Group on Sexual Disorders and Sexual Health has also recommended that the proposed ICD-11 grouping of Paraphilic disorders be retained within the chapter on Mental and Behavioural Disorders rather than being moved to the proposed new chapter on Conditions Related to Sexual Health, for two main reasons. First, the assessment and treatment of Paraphilic disorders, which often takes place in forensic con-

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[90]
Chapter: Mental and Behavioural Disorders ***Grouping***: Paraphilic disorders	***Chapter***: Mental and Behavioural Disorders ***Grouping***: Disorders of adult personality and behaviour ***Subgrouping***: Disorders of sexual preference	***Grouping***: Paraphilic disorders	• ICD-11 name changed to be consistent with current scientific literature and clinical practice; brings it in line with DSM-5. • ICD-11 distinguishes between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. • Requirements for named Paraphilic disorders in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal that involves others whose age or status renders them unwilling or unable to consent; and b) that the individual has acted on the arousal patterns or is markedly distressed by it.
Category: Exhibitionistic disorder	***Category***: Exhibitionism	***Category***: Exhibitionistic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Voyeuristic disorder	***Category***: Voyeurism	***Category***: Voyeuristic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Pedophilic disorder	***Category***: Paedophilic disorder	***Category***: Pedophilic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders. • In DSM-5, diagnosis may be assigned based on the presence of "interpersonal difficulty" due to the arousal pattern, in the absence of action, distress, or functional impairment. • DSM-5 includes a variety of specifiers, which have been criticized for lack of consistency and questionable validity[91].
Category: Coercive sexual sadism disorder	*Not included*	*Not included*	• Defined by sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. • Not equivalent to DSM-5 Sexual sadism disorder or ICD-10 Sadomasochism, which do not distinguish between arousal patterns involving consenting and non-consenting others.
Category: Frotteuristic disorder	*Not included*	***Category***: Frotteuristic disorder	• DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Recommended for deletion	***Category***: Sadomasochism	***Category***: Sexual masochism disorder	• If consensual behaviour is involved, may be classified as in ICD-11 as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death. • If arousal pattern focuses on the infliction of suffering on non-consenting individuals, may be classified in ICD-11 as Coercive sexual sadism disorder.
Not included	*Combined with Sexual masochism*	***Category***: Sexual sadism disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5 *(continued)*

Proposed ICD-11	ICD-10	DSM-5	Comments[90]
Recommended for deletion	***Category***: Fetishism	***Category***: Fetishistic disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
Recommended for deletion	***Category***: Fetishistic transvestism	***Category***: Transvestic disorder	• In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
Recommended for deletion	***Category***: Multiple disorders of sexual preference	*Not included*	• This ICD-10 category was not considered to be clinically informative. Multiple paraphilic disorder diagnoses may be assigned in both ICD-11 and DSM-5.
Category: Other paraphilic disorder involving non-consenting individuals	*Not included*	*Not included*	• May be used when the diagnostic requirements for a Paraphilic disorder are met but the specific pattern of sexual arousal does not fit into available named categories (e.g., arousal patterns involving corpses or animals).
***Category*: Other paraphilic disorder involving solitary behaviour or consenting individuals	*Not included*	*Not included*	• May be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death.
Recommended for deletion	***Category***: Other disorders of sexual preference	***Category***: Other specified paraphilic disorder	• Replaced in ICD-11 by above two "Other paraphilic disorder" categories, which specify whether arousal pattern involves: a) non-consenting individuals; or b) consenting individuals or solitary behaviour.
Recommended for deletion	***Category***: Disorder of sexual preference, unspecified	***Category***: Unspecified paraphilic disorder	• Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only relatively unusual patterns of sexual arousal that are not associated with distress, dysfunction, or harm to the individual or to others.

texts, requires specialized mental health expertise. Evidence-based treatments for Paraphilic disorders are almost entirely psychological and psychiatric in nature and require substantial mental health expertise to administer. When adjunctive somatic treatments are used (e.g., anti-androgen drugs), they are controversial and legally and clinically complex and must be administered within a psychiatric framework.

Second, a substantial portion of the assessment and treatment of Paraphilic disorders relates to the civil commitment, mitigation, and treatment of specific classes of sex offenders. This is a complex and controversial legal area that must be considered in defining how Paraphilic disorders should be classified. In many countries – including the US, Germany, the UK, Canada, and other countries whose legal systems are based on the British or German systems – there are laws that allow for the civil commitment and preventive detention of certain sexual offenders who are sometimes termed sexually violent predators. These laws permit involuntary commitment of such individuals to psychiatric facilities after they have completed mandatory prison sentences, to allow for continued treatment and minimization of risk to the community where these offenders are to be released.

In countries where the constitutionality of such laws has been challenged, they have been upheld[105]. However, crucial to the finding of constitutionality has been the determination by relevant courts that a risk of dangerousness by itself is not sufficient grounds for civil commitment under such statutes. Rather, the constitutional requirement specifically rests on a finding of the presence of a mental disorder as the basis for civil commitment because it "narrows the class of persons eligible for confinement to those who are unable to control their dangerousness"[106].

Although there are continuing controversies about the application of these laws in many countries[107,108], the Working Group on Sexual Disorders and Sexual Health did not consider that moving Paraphilic disorders out of the Mental and Behavioural Disorders chapter would be an appropriate or helpful way to address these concerns.

Comparison with DSM-5

The changes proposed for Paraphilic disorders in ICD-11 represent a major departure from ICD-10, which was developed during the late 1980s. In many ways, these changes align the ICD-11 more closely with the DSM-5. At the same time, there are substantive differences between the two systems. Sexual masochism disorder, Fetishistic disorder, and Transvestic disorder are included as named mental disorders in DSM-

5, while in ICD-11 these phenomena can be diagnosed under Other paraphilic disorder involving solitary behaviour or consenting individuals only if they are associated with significant distress or significant risk of injury or death.

The duration requirement proposed for Paraphilic disorders in ICD-11 is more flexible than the six-month requirement in DSM-5, which does not appear to have specific empirical support[109]. The ICD-11 guidelines require a clinical judgment that the arousal pattern is sustained, focused, and intense, making clear that a single instance of behaviour or criminal act does not meet this requirement. Functional impairment is included relatively automatically in diagnostic criteria for DSM-5, but has not been included as a part of the proposed ICD-11 diagnostic guidelines for Paraphilic disorders, in keeping with the general principle for ICD-11 Mental and Behavioural Disorders that impairment should only be used when necessary to distinguish a disorder from normality[1].

PROPOSED CHANGES TO F66 PSYCHOLOGICAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH SEXUAL DEVELOPMENT AND ORIENTATION

The ICD-10 explicitly states that "sexual orientation by itself is not to be considered a disorder"[4]. Nevertheless, the ICD-10 grouping of Psychological and behavioural disorders associated with sexual development and orientation suggests that there do exist mental disorders uniquely linked to sexual orientation. These categories include F66.0 Sexual maturation disorder, F66.1 Egodystonic sexual orientation, and F66.2 Sexual relationship disorder (see Table 4).

The Working Group on Sexual Disorders and Sexual Health emphasized that, although the ICD-10 F66 categories mention gender identity in their definitions, historically they emerged from concerns related to sexual orientation[89]. Over the last half century, international classification systems of mental disorders, including the ICD and the DSM, but also various national and regional classifications, have gradually removed diagnostic categories that defined homosexuality *per se* as a mental disorder. This reflects emerging human rights standards[56,110], the recognition that homosexual behaviour is a widely prevalent aspect of human behaviour[111], and the lack of empirical evidence to support pathologization and medicalization of variations in sexual orientation expression[112,113].

As noted earlier, the ICD-10 also indicates that "social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder"[4]. The Working Group viewed this exclusion as essential to the consideration of diagnostic categories linked to sexual orientation[89]. Given that expression of same-sex orientation continues to be heavily stigmatized in parts of the world[56,110], psychological and behavioural symptoms seen in non-heterosexual individuals may be products of persistently hostile social responses rather than expressions of inherent psychopathology. This perspective is supported by robust empirical evidence from international studies[114-116]. Violence, stigma, exclusion and discrimination linked to same-sex orientations is a worldwide phenomenon and has been documented as especially vicious, often showing a high degree of brutality[117]. In some countries, criminal law is still applied to consensual same-sex sexual activity, though international, regional and national human rights bodies have explicitly called for States to end this practice[56]. Thus, the Working Group concluded that, if a disease label is to be attached to a social condition, it is essential that the condition have demonstrable public health and clinical utility, for example by identifying a legitimate mental health need.

The core diagnostic features of F66.0 Sexual maturation disorder in the ICD-10 are: a) uncertainty about one's gender identity or sexual orientation and b) distress *about the uncertainty* rather than about the particular gender identity or sexual orientation. Research has repeatedly demonstrated that same-sex sexual orientation emerges over time[118], with the process typically beginning in late childhood or early adolescence. Often there is a substantial level of anti-gay stigma in the individual's social environment that creates stress for the individual. As distress arising from stigma cannot be considered as indicative of a mental disorder under the ICD-10 social conflict exclusion, the Working Group considered that this category conflates normative developmental patterns observed in gay, lesbian, bisexual, and transgender people with psychopathological processes.

The concept of egodystonic homosexuality (F66.1 Egodystonic sexual orientation in ICD-10) first entered mental disorders classifications in DSM-III, as part of a negotiation related to removing homosexuality *per se* from that diagnostic system[119]. The compromise was that, while homosexuality itself might not be a disorder, homosexuality could still provide the basis for a psychiatric diagnosis, but only if the individual was distressed about it. This construction was dropped from American Psychiatric Association's classification in 1987[113]. In what appears to have been a parallel process in the subsequent revisions leading to ICD-10, the concept of Egodystonic sexual orientation was incorporated in the ICD-10, approved in 1990, when the ICD-9 diagnostic category for homosexuality *per se* was removed. According to the ICD-10, it is theoretically possible to apply this category to individuals with a heterosexual orientation who wish it were otherwise, but is hard to see this as anything other than an attempt to deflect criticism regarding the purpose of the category[120].

Lesbian, gay, and bisexual individuals often report higher levels of distress than their heterosexual counterparts in international surveys, but this has been linked strongly to experiences of social rejection and stigmatization[114-116]. Because distress related to social adversity cannot be considered as indicative of a mental disorder, any more than can distress related to other socially stigmatized conditions such as poverty or physical illness, the Working Group considered the existence of this distress as lacking in evidentiary value.

F66.2 Sexual relationship disorder in ICD-10 describes a situation in which the individual's sexual orientation (or gender

Table 4 Classification of disorders related to sexual orientation in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments[89]
Recommended for deletion	***Chapter*:** Mental and Behavioural Disorders ***Grouping*:** Disorders of adult personality and behaviour ***Subgrouping*:** Psychological and behavioural disorders associated with sexual development and orientation	*Not included*	• All categories in this ICD-10 grouping have been recommended for deletion. • These categories or their equivalents are not included in DSM-5, and were not included in DSM-IV. • No scientific interest in these conditions since ICD-10 was published. • No evidence-based treatments. • Working Group determined that these categories confound responses to adverse social circumstances, normal developmental patterns, and psychopathology. • If requirements for depression, anxiety, or another disorder are met, that diagnosis should be used. These diagnoses do not depend on thematic content of associated concerns. • Otherwise, Counselling related to sexuality codes from ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services are more appropriate.
Recommended for deletion	***Category*:** Sexual maturation disorder	*Not included*	• ICD-10 defines category based on uncertainty about gender identity or sexual orientation, which causes anxiety or depression.
Recommended for deletion	***Category***: Egodystonic sexual orientation	*Not included*	• According to ICD-10, should be used when the gender identity or sexual preference is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders.
Recommended for deletion	***Category***: Sexual relationship disorder	*Not included*	• According to ICD-10, should be used when the gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner. • Difficulties in intimate relationships are common, occur for many reasons, and are dyadic. Working Group concluded that there was no justification for category based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.
Recommended for deletion	***Category***: Other psychosexual development disorder	*Not included*	• This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
Recommended for deletion	***Category***: Psychosexual development disorder, unspecified	*Not included*	• This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
Recommended for deletion	***Qualifiers*:** *(May be applied to all categories in grouping)* • *Heterosexual* • *Homosexual* • *Bisexual* • *Other, including prepubertal*	*Not included*	• These categories specify sexual orientation of individual receiving any of the above ICD-10 diagnoses, which are recommended for deletion.

identity) has created a disturbance in a primary sexual relationship. Difficulties in intimate relationships are common, occur for many reasons, and are, by their nature, dyadic. The Working Group concluded that there was no justification for creating a mental disorder category specifically based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.

The Working Group's review concluded that gay, lesbian, and bisexual people receive mental health services for the same reasons that heterosexual people do, and also could find no evidence that concerns about sexual orientation that accompany other mental disorders such as depression or anxiety require different methods of treatment[121]. Further, there are no evidence-based practices related to the F66 categories, and therapeutic attempts to change sexual orientation are considered to be outside the scope of ethical practice[122]. There is also a risk that misattributing symptoms of other mental disorders to conflicts about sexual orientation may interfere with appropriate treatment selection[89].

Moreover, the F66 categories have attracted no scientific interest since the ICD-10 was published. The Working Group conducted a search of Medline, Web of Science, and PsycINFO, and failed to find a single reference to Sexual maturation disorder or Sexual relationship disorder. The last peer-reviewed, indexed reference to "egodystonic homosexuality" was published more than two decades ago. The F66 categories do not

contribute meaningfully to public health surveillance, are not routinely reported by any country, and are not used in WHO's calculation of disease burden. At the same time, they selectively target individuals with same-sex orientation or gender nonconformity, with no apparent justification. Individuals with needs for information or who experience distress specifically related to sexual orientation that is not diagnosable as another disorder (e.g., Adjustment disorder) can still receive services through the use of codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services described earlier in this paper.

The Working Group has therefore proposed the elimination of the entire grouping of F66 disorders from the ICD-11.

Comparison with DSM-5

The proposed changes for ICD-11 in this area bring it in line with DSM-5. No equivalent to any of the ICD-10 F66 categories is included in DSM-5 or was included in DSM-IV.

CONCLUSIONS

In the more than quarter century since the approval of the ICD-10, there have been substantial gains in scientific, clinical, social, and human rights understandings relevant to diagnostic categories related to sexuality and gender identity. These different streams of evidence have been considered in the development of a set of proposals for ICD-11 that departs markedly from the descriptions of categories related to sexuality and gender identity in the ICD-10. The inclusion of mental and behavioural disorders alongside all other diagnostic entities in health care is a central feature of the ICD, and has uniquely positioned the current revision effort to contemplate a broader and more integrative set of classification options with respect to these categories.

The ICD-10 classification of Sexual dysfunctions was substantially outdated in its view of psychological and physical causes of sexual dysfunction as separable and separate, making it inconsistent with current evidence regarding the etiology and treatment of these conditions. For the ICD-11, an innovative, integrated system has been proposed, including a set of qualifiers to indicate the range of factors that the clinician considers to be contributory. It must be emphasized that the WHO does not consider the ICD-11 chapters to constitute scope of practice boundaries between medical specialties, but intends and expects that psychiatrists and other mental health professionals with appropriate training will continue to engage in the treatment of these common and costly conditions and that the reformulated classification of these conditions will encourage broader availability of treatment.

The role of psychiatry in many countries is likely to evolve in substantive ways with respect to the evaluation and treatment of Gender incongruence, proposed to replace Gender identity disorders in the ICD-10. The best health care services for transgender people are by definition multidisciplinary[59]. But psychiatrists in some countries have been unfortunately positioned as gatekeepers to enforce elaborate and burdensome requirements in order to access these services[83], ostensibly in order to verify that transgender people are certain about their decision to seek health services to make their bodies align with their experienced identity. However, in the recent Mexican study described above[71], the average delay between reported awareness of transgender identity and initiation of hormones – by far the most common treatment received – was found to be more than 12 years, and nearly half of participants had initiated hormones without medical supervision, exposing themselves to serious health risks. While these figures are not broadly generalizable, they are likely more reflective of the situation in most of the world than those reported in available studies from the US or Western Europe, given that more that 80% of the global population lives in low- and middle-income countries. Psychiatrists and other mental health professionals have a major role to play in improving the health status of this often mistreated population[58,74,75].

With respect to the classification of Paraphilic disorders, the Working Group on Sexual Disorders and Sexual Health has attempted to grapple with thorny issues related to how best to distinguish between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. At the same time, proposals in this area affirm the status of persistent and intense sexual arousal patterns focusing on individuals who do not or cannot consent as psychiatric in their nature and management[90]. In contrast, the Working Group concluded that there are no legitimate public health or clinical objectives served by mental disorder categories uniquely linked to sexual orientation[89].

In summary, the Working Group on Sexual Disorders and Sexual Health has proposed changes in the classification of these conditions that it considers to be: a) more reflective of current scientific evidence and best practices; b) more responsive to the needs, experience, and human rights of vulnerable populations; and c) more supportive of the provision of accessible and high-quality health care services. Proposed diagnostic guidelines for the disorders described in this paper will be made available for review and comment by members of WHO's Global Clinical Practice Network (http://gcp.network)[123], and subsequently for public review prior to finalization of the ICD-11. We hope that this paper will serve to encourage further scientific and professional discussion.

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