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Response to the proposed psychiatric diagnosis of 'gender dysphoria' and the Report of the American Psychiatric Association Task Force on the Treatment of 'Gender Identity Disorder'

We, the undersigned, wish to express our concerns regarding both the proposed psychiatric diagnosis of 'gender dysphoria' and the Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. The Report was published online on July 2nd, 2012 in *Archives of Sexual Behavior*. The Task Force was "...charged by the Board of Trustees 'to perform a critical review of the literature on the treatment of 'gender identity disorder (GID)' at different ages and to present a report to the Board of Trustees'" (Byne, et al., 2012, p. 760). The report also included "...an opinion as to whether or not there is sufficient credible literature to take the next step and develop treatment recommendations'" (Byne, et al., 2012, p. 760).

Our primary concerns with this document include:

- The Task Force's exclusion of and disregard for psychological literature and multiple professional organisations that recommend against psychiatric gender diagnoses
- The past role of some Task Force members in promoting discriminatory and unethical practices
- The pathologising of 'distress' typically caused by social exclusion or by body 'dysphoria' that is prolonged by delayed or denied access to medical gender affirmation services
- Failure to provide biomedical rather than psychiatric pathways for access to gender-affirming hormones and surgery
- Ethnocentric and discriminatory views of people's gender self-designations
- The legislative human rights and professional ethics violations attendant to these views

Considering these concerns, we believe the Task Force's statement does not adhere to medical ethical standards, such as the principle of non-maleficence or '*primum non nocere*' ('*first, do not harm*').

We wish to highlight the following points and concerns:

- 1) The Task Force's literature review ignored statements by professional organizations and an extensive psychological literature that contest the 'GID' diagnosis, thus rendering the Task Force's claims of 'consensus' factually inaccurate. Therefore, any recommendations based on this report are incomplete and inadequate.
 - a. **Many authors in the peer-reviewed psychological literature disagree with the Task Force's 'consensus'** that people's gender identities and expressions should be treated as psychiatric disorders (e.g., Ansara & Hegarty, 2012; Blumer, Green, Knowles, & Williams, 2012; Bockting, 2009; Bryant, 2006; Bryant, 2008; Chen-Hayes, 2001; Hegarty, 2009; Hill, Rozansky, Carfagnini, & Willoughby, 2005; Langer & Martin, 2004; Raj, 2008; Roen, 2011; Vanderburgh, 2009; Vasey & Bartlett, 2007; Winter, 2006; Winters, 2008). The Task Force's exclusion of psychological literature that challenges its pathologising views is ethically and scientifically problematic, raising questions about the Task Force's

credibility.

- b. The Task Force used stigmatizing ‘GID’ language throughout the document. Proposed revisions to the current *DSM-TR-IV* terminology advocate changing ‘gender identity disorder’ to ‘gender dysphoria’ based on claims that current ‘GID’ terminology is stigmatising (Vance, et al., 2010), though ‘gender dysphoria’ can be equally stigmatising in that it treats key aspects of gender affirmation as psychopathology (as explained elsewhere in this document). Multiple sources confirm that stigmatising language contributes to people’s reasons for seeking or not seeking mental health services (Ansara & Hegarty, 2012; British Psychological Society, 2011; WPATH Board of Directors, 2010). Therefore, we disagree with the Task Force’s claims that “...most of the issues pertaining to gender variance (GV) that lead individuals (or their parents in the case of minors) to seek mental health services would remain the same regardless of any changes in DSM nomenclature or diagnostic criteria” and that “[a]ny such changes to the DSM should, therefore, have minimal impact on the utility of the Task Force Report” (Byne, et al., 2012, p. 760).
- c. Several key professional organisations and transgender advocacy groups have published policy statements that challenge the pathologising ‘GID’ approach for being likely to increase prejudice, stigma, and discrimination, including:

The British Psychological Society (BPS) - BPS has highlighted researchers’ agreement that the GID diagnosis is “...plagued by problems of reliability, validity, prognostic value, and co-morbidity” and that “...clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation.” This document is located [here](#).

The World Professional Association for Trans Health (WPATH; formerly HBGDA) – WPATH is internationally recognised as the leading professional authority on transgender health, and the organisation publishes standards of practice for transgender medical and mental health services. In 2010, the WPATH Board of Directors issued a ‘de-pathologisation’ statement advocating for an end to the ‘GID’ model of gender variance as psychiatric disorder and called on professionals to embrace human diversity:

“The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide. The expression of gender characteristics, **including identities**, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. **The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalisation and exclusion, and increasing risks to mental and physical well-being**” (WPATH Board of Directors, 2010, our emphasis). This statement is located [here](#).

TransgenderAsia – TransgenderAsia notes that global pressure is growing to depathologise people who self-designate their own genders. The Society for Transsexual Women of the Philippines ([STRAP](#)), [International Congress on Gender Identity and Human Rights](#), [Cuban Multidisciplinary Society for Sexuality Studies](#), [Asia-Pacific Transgender Network](#), [Global](#)

[Fund for MSM and HIV](#), National Board of Health and Welfare in Sweden, and Ministry of Health in France make up just some of the organisations and governments that have all joined TransgenderAsia's "call for the removal of gender identity variance from psychiatric diagnostic manuals" (see this call [here](#)). The Task Force's exclusion of this global chorus from their report undermines the report's validity.

Press for Change – Press for Change is the United Kingdom's (UK) transgender civil rights organisation responsible for the passage of the Gender Recognition Act. The Engendered Penalties report (Whittle, Turner, & Al-Alami, 2007) produced by Press for Change documented health care discrimination, service denials and delays faced by people with self-designated genders. Similarly, empirical studies in both the UK and United States found that the belief promoted by the 'GID' model that people have or should have the same gender designation as that associated with their birth-assigned sex designation was strongly linked to negative attitudes toward 'transgender' people and an opposition to their civil rights (Norton & Herek, 2012; Tee & Hegarty, 2006).

The American Psychological Association - In 2008, the American Psychological Association adopted a Policy Statement on Transgender, Gender Identity, and Gender Expression Non-Discrimination. This Policy Statement called for "...psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals" (This statement is located [here](#)). The Task Force's treatment recommendations based on a 'GID' model perpetuates precisely the kind of discrimination that the American Psychological Association policy statement seeks to prevent.

- 2) The 'GID' model utilized in the Task Force's report is ethnocentric in that it disregards evidence from many societies and contexts in which people's gender self-designations are not treated as problematic. The 'GID' model attempts to dictate gender norms in a way that marginalizes and excludes cross-cultural viewpoints. The Report also promotes a pathologising view of people's reasonable responses, like 'distress,' to societal inequities and medical access barriers instead of recognising and challenging the inequities responsible for their distress. This concern is in response to the following statement from their report:

"The Task Force could not reach a consensus regarding the question of whether or not persistent cross-gender identification sufficient to motivate an individual to seek sex reassignment, per se, is a form of psychopathology in the absence of clinically significant distress or impairment..." (p 761).

- a. When people recognise that their bodies are not meeting their functional needs and pursue action to realise that need (e.g. by pursuing options for hormones or surgery), this process demonstrates insight and the desire for personal comfort—this kind of recognition manifested as 'distress' is a clear sign of psychological wellbeing, and *not* pathology (Rapley, Moncrieff, & Dillon, 2011). To give a comparative example, when individuals question their sexual orientation, the discomfort associated with realizing that their relationships and sexual expression are not meeting their needs is considered a healthy and vital part of the 'coming out' process (e.g. Cass, 1979). A key difference between these experiences, however, is that the person experiencing sexuality-related distress is not restricted from access to remedies to their distress by mental health professionals.
- b. Considering, again, the American Psychological Association's recommendation for "...psychologists to take a leadership role in working against discrimination towards transgender and gender variant

individuals,” we urge mental health practitioners who wish to promote the mental health and well-being of people seeking gender affirmation to aid and support them in seeking medical resources without delay or restriction. In solidarity with this call from the American Psychological Association, we are also bringing attention to the discriminatory nature of denying access to medical resources for people who meet the legal standards of mental competency applied to other people seeking medical services. Extensive research evidence shows that the single most important determinant of positive therapeutic outcomes in mental health is not treatment method, but warmth, empathy, and the therapeutic relationship (e.g. Lambert, 2001). These key therapeutic concepts are severely compromised when mental health practitioners are complicit in maintaining barriers to medical resources. WPATH’s (2011) latest guidelines have stated that “Psychotherapy is **not** an absolute requirement for hormone therapy and surgery” (p. 28, our emphasis). WPATH made this statement because of the psychological harm that can result from the delays presented by requiring a set number of psychotherapy sessions before granting access to medical services for gender affirmation.

- c. The British Psychological Society has publicly urged the American Psychiatric Association to consider “...a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience” and the fact that strongly evidenced causal factors include “psychosocial factors such as poverty, unemployment and trauma.” (This document is located [here](#)).
- d. The American Psychological Association has suggested that working to promote the health and well-being of people with self-designated genders requires “...legal and social recognition of transgender individuals **consistent with their gender identity and expression**” (our emphasis; this document is located [here](#)). In spite of this, the Task Force engages in cisgenderism—“discriminatory ideology that delegitimises people’s own designations of their genders” ([AnsaraOnline](#), 2012, retrieved on August 2, 2012). Cisgenderism contributes to clients’ experiences of distress. Instances of cisgenderism can be identified in communications, such as in language that *misgenders* people by invalidating how they designate their own genders and pathologises individuals whose self-designated genders differ from those they were assigned ([Ansara & Hegarty, 2012](#)). For example, the Task Force considers children who self-designate themselves as girls as “boys with GID” (Byne, et al., p. 772), thus **misgendering** these girls.
- e. In 2006, Dr. Sam Winter, a current board member of WPATH, addressed the topic of ‘distress’ at Transgender Pre-Conference at the 2006 ILGA World Conference in Geneva:

“...transgenderism is not per se a mental disorder. [...] where trans [sic] people do enjoy acceptance, particularly from those important to them and in their early lives, they also enjoy good mental health in adulthood...there is no Gender Identity Disorder, except the inability or unwillingness...to accept trans-people [sic]...research clearly suggests that, where this view is held, the [discrimination] that trans-people already face is usually even more intense. The psychiatric pathologisation of transgenderism may indeed be enhancing the access of trans-people in the developed [sic] world to subsidised medical care. **But trans-people [sic] worldwide, with different needs, different priorities, are paying the price**” (Winter, 2006, pp 4-5). This document is located [here](#).
- f. We acknowledge that the Task Force’s concern about psychiatric diagnosis has to do with what is considered ‘medically necessary’ for the purposes of obtaining health coverage for ‘GID-related care.’ However, many people in the US and other nations are denied coverage due to ‘transgender’ exclusion

clauses in health insurance policies because of the GID diagnosis itself. Similar exclusions are likely to be caused by the 'Gender Dysphoria' psychiatric diagnosis proposed elsewhere. Meanwhile, international examples may provide the United States with a model for removal of the diagnosis without sacrificing access to care. **For example, France's Ministry of Health removed 'GID' from its list of mental disorders and continues to offer medical services for gender affirmation** (see a news article on this topic [here](#)).

3) Pathologising human expressions, identities, and experiences harms civil rights and violates international human rights standards.

a. According to Principle 19 of the [Yogyakarta Principles](#), international human rights law on sexual orientation and gender identity, people of all ages have the right to express their designated gender:

“Everyone has the right to freedom of opinion and expression, regardless of sexual orientation or gender identity. This includes the expression of identity or personhood through speech, deportment, dress, bodily characteristics, choice of name, or any other means, as well as the freedom to seek, receive and impart information and ideas of all kinds, including with regard to human rights, sexual orientation and gender identity, through any medium and regardless of frontiers.” (p. 24)

b. Although views may have changed to date, we find it troubling that some members of the American Psychiatric Association Task Force have advocated for reparative therapy—also termed ‘behavioural reorientation’—in the past (e.g. Bradley in Zucker & Bradley, 1995; Green, 1987). Reparative therapy aimed at making children’s gender identities or expressions conform to their assigned genders is a harmful practice that is a clear violation of international human rights. For example, Failure of the Task Force to condemn reparative therapy contrasts with current ethical standards of practice. WPATH’s (2011) latest Standards of Care explicitly stated that reparative therapy violates professional ethics:

“Treatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.” (p. 16)

c. We reject the discriminatory claim in the report that “Children have limited capacity to participate in decision making regarding their own treatment” (Byne, 2012, p. 762) since recent findings from researchers using participatory methods have found that children can be erudite and helpful co-researchers whose own input and experiences are vital to the success of health interventions (e.g., Bergström, Jonsson, & Shanahan, 2010; Conroy & Harcourt, 2009).

d. Furthermore, the United Nations Convention on the Rights of the Child (UNCRC, 1989) guarantees all children the right to unrestricted freedom of play and expression, both of which are pathologised by the GID model used in the Task Force’s report reflecting current DSM-IV-TR diagnoses (American Psychiatric Association, 2000). Both of these rights are also pathologised in the diagnoses proposed for DSM-5 (to be published in 2012; see American Psychological Association, 2010).

e. In order to secure equal legal rights for intersex people, the Task Force should have used terminology that promotes equal treatment. For example, the Task Force instead suggests a pathologising view of intersex people’s bodies by using the terms 'disorders of sex development' or 'DSD syndrome.' *Intersex* is

currently the term most widely preferred by people whose bodies are not strictly ‘female’ or ‘male.’ (See more on this topic [here](#))

- 4) Several members of the Task Force have previously engaged in research that promotes discriminatory and pathologising views of the people affected by such research (e.g., Susan Bradley, Richard Green, Heino Meyer-Bahlburg). These problematic figures have been given authority even as the Task Force has excluded membership from diverse perspectives held by those whose lives the treatment recommendations are most likely to harm.
 - a. Research has identified that several Task Force members have published highly cisgenderist research in the past (e.g., Susan Bradley, Richard Green, Heino Meyer-Bahlburg). Some members (e.g., Susan Bradley) make up an “invisible college” of gender researchers whose sphere of influence is linked through a network of collaborating authors ([Ansara & Hegarty, 2012](#)). Importantly, this research found that this invisible college has produced some of the most cisgenderist articles in the literature on people with self-designated genders. Articles by certain members on the American Psychiatric Association Task Force were more pathologising in their language and misgendered their clients or research participants more often than others outside their invisible college ([Ansara & Hegarty, 2012](#)).
 - b. The exclusion of a variety of people with self-designated genders from the task force further discredits the legitimacy of ‘consensus’ on treatment guidelines. This comprises the inclusion of voices from all age groups and nations of people affected. The Task Force needs to acknowledge and make efforts to change the fact that the literature from which they draw their recommendations are limited to sampling clinical populations and ignores cross-cultural perspectives from societies where people with self-designated genders have been traditionally accepted and not pathologised

The three aims of this campaign are:

- 1) **TO demand that the American Psychiatric Association Task Force retract their factually inaccurate claims about ‘consensus’, when no such consensus exists** in the literature or elsewhere. This includes selectively quoting policy statements (e.g. WPATH) while ignoring information in these statements that contrasts with the Task Force’s approach. **Genuine consensus will require consultation in non-clinical settings with a wide variety of people whose genders have been delegitimised by others** (e.g. people who seek or have sought gender affirmation in social, legal, and/or medical arenas, such as those typically labelled as ‘trans, intersex, ‘genderqueer’, etc.) and about whom they are proposing treatment guidelines, instead of relying on a skewed sample from primarily clinical and US-centric experiences.
- 2) **TO demand that psychiatrists, psychologists, and other medical and mental health professionals working with people whose genders are self-designated use reputable and established psychological guidelines** that stress the need to avoid pathologising or invalidating people’s gender identities or expressions, regardless of their age (e.g., American Psychological Association, 2008; WPATH, 2010). This means not psychopathologising any aspect of gender affirmation, including the distress people experience when their bodies do not meet their gender-related needs.
- 3) **FOR the complete removal of GID and other psychiatric diagnoses that pathologise people’s gender identities and expressions from the DSM (this includes the DSM V’s proposed ‘Gender Dysphoria’) and the transfer with no gaps in services to the alternative of ensuring medical services for gender affirmation available through biomedical pathways.** We call for APA to provide biomedical rather than psychiatric pathways for access to gender-affirming hormones and surgery. Any psychiatric guidelines must

accept the American Psychological Association's ethical mandate to take a "leadership role in working against discrimination towards transgender and gender variant individuals" which includes a call to "...to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals" and to recognise people's self-designated genders as legitimate (American Psychological Association, 2008). This means psychiatrists, psychologists, and other medical and mental health professionals should describe people using gender language they prefer, not merely using de-gendered biological language or descriptions based on perceived surgical or anatomical attributes.

Nearly 40 years ago, The American Psychiatric Association depathologised homosexuality and removed it from the DSM, recognising that this diagnosis perpetuated discrimination based on sexual orientation. We agree with WPATH (2010), BPS (2011), and 'the global call' ([TransgenderAsia](#)) that we need to similarly depathologise all people's own gender designations and expressions. Instead of treating people's minoritised genders as problematic, we urge the American Psychiatric Association to address the social causes of individual distress or impairment that include widespread discrimination, harassment, violence, and denials or delays in medical and legal gender affirmation services (American Psychological Association, 2008).

Should the American Psychiatric Association continue to ignore facts and promote cisgenderist ideology that is likely to increase this discrimination, we will heed the American Psychological Association's (2008) call to be leaders against discrimination by boycotting all uses of the DSM related to people's own gender designations and gender expression (including 'gender dysphoria'). We urge other professionals to join this effort to promote ethical and just practices.

To be added as a signatory to this document, please select 'sign APA Response Letter 2012' in the Service Requested drop-down menu and provide your name, location, degrees, affiliations, and/or awards in the form [here](#).

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