

BEST PRACTICES GUIDE TO TRANS HEALTH CARE IN THE NATIONAL HEALTH SYSTEM

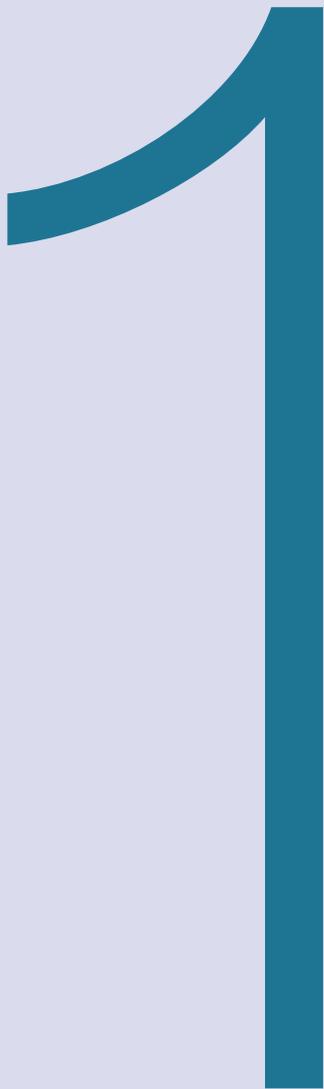


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INTRODUCTION



This is a proposal to improve the health care provided to trans persons by the Spanish public health system, and is intended not only for the general public but especially for professionals and policy-makers working in the government's public health care system. The objective of this document is to furnish analytical tools and reference points for developing alternative non-pathologizing trans health care protocols that have local and international applicability.

This document is structured in two parts: first, we have attempted to describe the problematic aspects of the current health care system for trans people and make a critical analysis of it; and second, the heart of our work, we have developed the Best Practices Guide to trans persons' health care. We expect that the Guide will be further enriched through an open and non-exclusionary collaboration that takes as indispensable the perspectives and experiences of the trans community.

This material has been reviewed and published by the Spanish Network for Depathologization of Trans Identities--a consortium of activists, collectives, social movements and researchers who initiated the historic struggle to depathologize trans identities. Its publication coincides with the events of Trans October 2010, an unprecedented series of international activities and demonstrations that will be mounted this year in more than fifty cities around the world.

We're grateful for the countless and selfless contributions we've received in the course of preparing this document, and we reaffirm our dedication to advancing new perspectives and continuing to fight tirelessly against the violence, stigmatization and marginalization to which we've been subjected.



THE CONTEXT:
THE STATUS OF PATHOLOGIZATION
OF TRANSSEXUALITY IN SPAIN TODAY,
AND CRITICAL REFLECTIONS



2.1 INTRODUCTION

Since 1980 transsexuality has been classified as a mental disorder. At present, the mental illness manuals DSM-IV-TR (published by the American Psychiatric Association/APA) and the ICD-10 (published by the World Health Organization/WHO) characterize transsexuality as “Gender Identity Disorder.”

The debate regarding the de-listing or depathologization of transsexuality has assumed great importance in GLBT activism during recent years and has increasingly attracted the attention of numerous health care professionals—particularly psychiatrists, psychologists and psychotherapists—from all over the world.

Before delving further into the subject, it’s important to clarify a question of terminology. Throughout this document, we preferentially employ the term “trans” rather than “transsexual” in order to include transsexuals, transgender persons and crossdressers without needing to elaborate further on the great diversity that exists within the trans community. That is, the word “trans” is not simply a synonym for “transsexual” (a term that originates from medicine), but is rather a usage proposed by the trans movement for the purpose of distancing ourselves from medical hegemony and changing the paradigm through which transsexuality is understood. In this sense, “trans” refers to any person who expresses a gender identity different from the one assigned at birth on the basis of sex, regardless of whether the individual has modified his or her body or has been given a diagnosis of gender identity disorder.

In order to describe the problems with today’s trans health care, it’s first necessary to describe explicitly how gender identity disorder is diagnosed, what is the existing treatment of trans people within the national health care system, and what is the current status of activism that advocates for trans depathologization. After that, we will put forth proposals for creating new treatment models.

The Origin of Pathologization

The endocrinologist Harry Benjamin in 1954 was one of the first people to use the word “transsexualism” and developed the first criteria for its diagnosis (Benjamin, 1966). In 1979 the Harry Benjamin International Gender Dysphoria Association/HBIGDA (now the World Professional Association for Transgender Health/WPATH) established an official protocol for gender reassignment treatments called the Standards of Care (SOC) for Gender Identity Disorders. This protocol, which followed Benjamin’s diagnostic guidelines and criteria, prescribed in detail the psychiatric, hormonal and surgical treatment of trans people. At present, the most recent version of the SOC requires a period of consultation during which a medical professional ascertains whether a patient is experiencing gender identity disorder as opposed to a different type of mental pathology.

In the course of the 1970s and 1980s, many European countries adopted this model, and through its gradual implementation developed and perfected specialized clinics to diagnose and monitor trans people through the psychiatric departments of selected public hospitals.

The listing of transsexuality as a mental disorder implies that trans people should submit to a psychiatric evaluation in order to obtain hormonal or surgical treatment. In the Spanish case, for example, among other requirements it’s necessary to present a certificate of diagnosis of gender identity dysphoria signed by a physician, psychologist or clinician in order to obtain a change of name and/or sex on identification documents¹.

At the present time the DSM is being revised and it’s expected that the new version will be released in May 2013. The revision of the DSM is of fundamental importance because it will define the medical approach to trans people’s health care treatment in the future and will also influence the content of the ICD of the WHO. At the same time as the DSM and ICD manuals are being revised, work is in progress on a new version of the Standards of Care of WPATH, with publication anticipated in 2011².

The existing version of the Standards of Care has attracted numerous criticisms, including its adherence to a pathologizing approach to trans identities, its reliance on a process of external assessment, its focus on just one three-part transition strategy, and its requirement of a real life test as one of its diagnostic elements.

One of the areas of interest of the Spanish Network for Depathologization of Trans Identities is the development of proposals for making changes in the protocols of the government clinics specializing in trans health care.

This Best Practices Guide has been developed taking the health care system for trans persons in the contemporary Spain as a given, while incidentally proposing features that can be utilized in non-pathologizing models elsewhere in the world.

1 This is the wording of Law 3/2007 of March 15, 2010 (also called the “Gender Identity Law”) that governs the correction of persons’ sex designation in the official government registry.

2 Historically, there has been a close relationship among the revision processes of the DSM, ICD and SOC (see Matte, Devor, Vladicka 2009).

The Treatment of Transsexuality in the Spanish Public Health System

With regard to the medical situation for trans people in Spain, in 2008 the Department of Health decided to manage trans health care coverage through separate clinics instead of including trans health treatment in the general schedule of services provided by the national health system, creating thereby geographic gaps in access to treatment throughout the country. This approach resulted in the establishment of the so-called Gender Identity Disorder Clinics (UTIGs) staffed by psychiatrists and psychologists, endocrinologists and surgeons, and in some cases other specialists such as speech therapists, depending on the individual clinic (although not every type of specialist, particularly surgeons, is ordinarily available in each clinic), where the coordinated treatments trans people underwent could be systematically monitored. In the clinics, gender identity disorder was diagnosed, hormones were prescribed, and a limited number of surgeries was performed each year, more or less following the recommended procedures of the Standards of Care (SOC)³. In Spain, UTIGs are now found in Andalucía, Catalonia, Asturias, Madrid, Extremadura, the Balaeric Islands and the Basque Country, with additional clinics planned for the Canary Islands and Galicia. At present, several of these clinics have been designated as national models, including the Hospital Clinic in Barcelona, La Paz-Ramón y Cajal in Madrid, and the Hospital Carlos Haya in Málaga.

Depathologization Activism

The movement against pathologizing transsexuality is of recent origin and takes many of its cues from the anti-psychiatry movement that recast the concept of mental illness in the process of fighting for the closure of mental asylums.

Advocating for the depathologization of trans identities involves more than simply removing the disorder from the psychiatric manuals; it also involves, above all, the insistence that in the course of the medical treatments they require, trans people be viewed as active participants with the ability to make decisions for themselves, with autonomy over and responsibility for their own bodies, and capable of speaking with authority about their own lives—things that until now have been the exclusive province of the physicians.

Although a few small protests had taken place earlier, the active movement against pathologization in Spain began on October 7, 2007 in the wake of three simultaneous demonstrations held in Madrid, Barcelona and Paris. Since that time, a network of activists and allied groups has grown throughout Spain, and today it operates under the name of the Spanish Network for Depathologization of Trans Identities. Building on this network, the first steps were taken in 2009 toward an international mobilization with the Stop Trans Pathologization-2012 Campaign (STP-2012)⁴. The resulting international mobilization has had the objective

3 See Gómez Gil, Esteva de Antonio (2006a).

4 The year 2012 was chosen because it was initially expected the new DSM-V would be published then, and it was a means of setting an end point for the STP campaign. However, a few months ago, the APA let it be known that the new DSM-V would not be released until May 2013, a delay attributable to the pressures brought to bear on the authors of the new volume.

of demanding the depathologization of trans identities in the next version of the DSM, and assuring medical coverage of hormonal and surgical treatments for trans people who request them. The STP-2012 Campaign has met with a very strong positive response on the part of trans activists all over the world; on next October 23, 2010⁵ events will take place in more than 50 cities in Asia, Africa, the Americas, and Europe (14 of them in Spain) to observe a worldwide day of protest against gender identity disorder.

Transsexuality—a Western Invention

“Transsexuality” is a term invented by U.S. medicine in the 1950s as a way to categorize and label the life trajectories of those persons born with men’s bodies but who lived as women, and those born with women’s bodies but who lived as men. As a result, writing on transsexuality in Europe and the United States constantly framed it in the medico- scientific context of illness and suffering, although care and treatment were also undeniably of concern.

In recent years, public awareness has grown that before medical categories were invented to explain trans phenomena, identities very similar to what we today call trans existed in other cultures and were not considered problematic; on the contrary, they were viewed in a positive light. Among these identities we can point to the hijra in India, the muxé in the Zapotec culture of Mexico, the two-spirit Native Americans, the fa’afafines of Polynesia and the takatapuis of the Maori culture of New Zealand, among others.

The fact is today we recognize that the scientific model developed in the West with regard to sexuality, the body and gender has had a negative impact on sexual and gender diversity in many cultures. The study of anthropology has shown us that pathologization functions as an imperialistic colonizing mechanism that spreads the message that trans people in the West are treated with respect and that some countries even take responsibility for their hormonal and surgical treatment⁶. This idea, though it may appear progressive, reveals little awareness in the West of the existence of other cultures and alternative ways of understanding trans issues, and it does nothing to negate the fact that trans people in many Western countries suffer extreme violence. Nonetheless, we absolutely must pay heed to those places so often ignored--places where people survive and resist the pathologizing model and from whom we have much to learn. In the end, the campaign for the depathologization of transsexuality is a political movement that strives to reduce the impact of culture and oppressive gender norms on the construction of one’s own body and identity.

2.2 DEVELOPING AN ALTERNATIVE PROPOSAL

The proposed guide we will describe below is organized keeping in mind on one hand the importance of recognizing trans people’s gender identity as non-pathological, while on the other hand finding a means to satisfy the need for health services by trans people.

5 See the official website of the STP-2012 Campaign: (<http://www.stp2012.info>).

6 For a more detailed analysis of the way in which the Western medical model was exported, see Balzer (2010).

The Paradigm of Illness vs. the Paradigm of Human Rights

In recent years a view of human rights has emerged that recognizes people's free expression of gender as a fundamental human right. This has been reflected in numerous documents and reports, most notably the Yogyakarta Principles (2007) and the report published in July 2009⁷. "Human Rights and Gender Identity" by Thomas Hamarberg, Commissioner of Human Rights of the Council of Europe. It follows from these international declarations that continuing to regard trans identities as mental or organic illnesses leads to compromising people's human rights.

As we mentioned in the introduction, the DSM and the ICD are currently being revised and new versions are expected in 2013 and 2015, respectively. In February 2010 the APA released a draft of the future DSM-V that indicated that pathologization of trans identities would continue. It was proposed in that draft to alter the term Gender Identity Disorder (GID), replacing it with "Gender Incongruence," while also expanding the diagnostic category of gender identity disorder in children and adolescents, as well as that of transvestic fetishism, among others⁸. In response to the draft, the STP-2012 Campaign in April 2010 publicized a demand for depathologization⁹ addressed to the APA. In addition to the justifications we cite in the second portion of this document, our demand argued even more fundamentally that free gender expression is a basic human right and that pathologization is a means of stigmatizing trans people.

At present, our greatest efforts are directed toward the APA because the publication of the next version of the DSM precedes that of the ICD, and the linkage between the two documents clearly indicates the influence U.S. psychiatry has had over the thinking of the World Health Organization.

Attempts have been made in certain countries to put an end to the pathologization of transsexuality by modifying their individual (i.e., national) listings of diseases. This has been the case in France, where the change has been very controversial. French trans activism, which has greatly inspired Spanish activism, has in recent years demanded that trans identities no longer be a concern of the field of psychiatry. In February 2010 the French Ministry of Health took a step in that direction by moving gender identity disorders from the section of psychiatric illnesses where it had been listed (ALD-23) to a different classification (ALD-31) of illnesses of undetermined cause¹⁰. This action removed trans identities from the purview of psychiatry but did not depathologize them, since transsexuality continued to be regarded as an illness. In order to avoid the kind of reclassification that continues placing transsexuality in a rubric of disorder, the international trans movement has recently decided to stop using the term "psychiatrizing" and replace it with "pathologizing" in order to signify that transsexuality, besides not being a mental illness, also does not have an organic cause.

7 For an in-depth analysis of the human rights perspective as applied to gender identity, see Suess (2010).

8 For more information read the STP-2012 press release (2010).

9 For more information see the STP-2012 demand to the APA (2010).

10 For more information see OUTRANS, 2010: <http://www.outrans.org/spip.php?article94>

Trans-specific Health Rights

Nowadays it might be ventured that, with the exception of the very conservative few, no one in the trans community believes that the gender identity of trans people in itself implies a mental disorder. On the other hand, a full consensus does exist about the best available strategy today to insure that trans people have access to hormones and surgery. The promotion of this strategy must be understood in the context of the Spanish example, which is that the exploration of alternative policy proposals and their articulation to the public is a fairly recent undertaking. Currently, the most important work lies in finding a way to escape the pathologizing model without sacrificing access to medical treatment. In one of its most recent international press releases, STP-2012 explains:

“We demand access to quality trans-specific health care, publicly-covered and unrestricted by psychiatric requirements. In order to guarantee these rights, we propose adding a non-pathologizing statement to the gender reassignment process in the ICD, specifying that it represents health care treatment that is unrelated to any illness that requires medical treatment.”

Thus we can appreciate the complexity of the demand to integrate the body modification treatments needed by some trans people into the national health care system. To elaborate further, our objective consists of four distinct demands.

The first of these has to do with transforming the health care model for trans people by exchanging the present judgmental model for one of autonomy and informed consent. Second is our support for the concept that body modification for trans people, when they request it, is a public health matter and should be covered by the public health system. Third is our belief that we should have a system that permits body modification without a diagnosis of illness. And fourth is that we must improve medical knowledge (regarding the side-effects of hormone treatment, perfecting surgical techniques, etc.) in order to guarantee that trans people have access to the best quality health care available. At present, the most promising consensus is the idea of creating a new non-pathologizing category or term for use in the ICD classification that implies no need to diagnose illness while at the same time guaranteeing necessary medical coverage.

The most important complication related to the issue of health care is that every nation structures its health and social welfare systems differently, thus posing the challenge of making proposals that can be of relevance to the existing diversity of models at the international level.

Focusing for the moment just on the situation in Spain, we have to emphasize that we see definite signs of movement toward a position of depathologization. On March 15, 2010, the Chamber of Deputies responded to an inquiry posed by Deputy Joan Herrera of the parliamentary group ERC-IU-ICV at the request of the Spanish Network for Depathologization of Trans Identities. The inquiry dealt with the government’s position regarding the listing of transsexuality as a mental illness. The government’s response was that “we agree with the need to de-list transsexuality as a mental disorder.”¹¹ This indicates to us that the depatholo-

11 News from STP 2012: http://stp2012.info/es/es/noticias#comunicado_7_abril

gization debate has found a place on the agenda of the politicians and by extension, on the agenda of the present government.

Although the government has not yet corrected the March 15th law 3/2007, which reinforces a pathologizing viewpoint by requiring its citizens to have a gender dysphoria diagnosis before they can change their name or gender designation on official documents, it has begun the process of addressing the trans health issue. The most recent development is that in June 2010 the Ministry of Health established a commission for the purpose of creating the first protocol for transsexual treatment in the national health care system.

With the Best Practices Guide that we present below, we wish to contribute tools to foster a change in the trans health care model from a depathologizing perspective.

3

BEST PRACTICES GUIDE TO
TRANS HEALTH CARE IN THE
NATIONAL HEALTH SYSTEM



3.1 WHY A BEST PRACTICES GUIDE?

The purpose of this Best Practices Guide for trans health care in the national health system is to align trans health medical practice with the diversity paradigm that informs today's understanding of trans identities. This guide seeks to serve as a tool to inspire better health care procedures for trans people in the future.

Current approaches to trans health care take place within the general framework of the Standards of Care (SOC) which are based on the diagnostic protocols contained in the DSM-IV-TR and the ICD. The SOC is presently the international reference document that has encouraged most medical institutions to deal with the issue of transsexuality. Even so, its content has been questioned many times, as much by trans people as by health care professionals¹². In view of the lack of institutional leadership--as much at the national as the international level--to modernize medical practice¹³ and overturn the traditional paradigm with its undesirable side-effects, we are taking the initiative to propose this guide which arises out of a dialogue with trans people and health professionals who specialize in caring for trans people.

This document is structured around seven fundamental axes, each of which points toward a specific change in the traditional model of health care. We will let the practices of the Gender

12 For more information about the criticisms of this model, see Missé and Coll-Planas (2010)

13 While this guide is being prepared, the World Professional Association for Transgender Health (WPATH) is engaged in the task of updating the *Standards of Care* (SOC) for the first time since 2001. The new (seventh) version of the SOC will appear in 2011. This document is among those being reviewed by the WPATH governing body as part of the SOC revision process. The most significant question is whether the SOC revision will represent a mere updating of the medical treatments as opposed to a paradigm shift in favor of respect for diversity. Take note that the existing version of the SOC predates the latest progress—the organization of an international discussion that recognizes pathologization as a threat to trans persons' human rights.

Identity Disorder Clinics in Spanish hospitals serve as an example of the traditional model. We include a section that presents a comparison of the SOC health care model with one based on Best Practices principles.

Finally, we wish to state that the aim of this proposal is not to establish a new universal model, and so it must be understood in the context in which we created it. We hope that our work leads to additional progress by means of similar projects being undertaken that are responsive to specific local political, cultural and social environments.

3.2 AXES OF THE GUIDE

3.2.1 Where Intervention is Necessary

The objective of health care for trans people should be to **create conditions** that improve their quality of life. To achieve this, we first have to define the health care system's purpose in being involved with trans people.

The traditional model of medical care, based on the international diagnostic classifications and protocols referenced by the Standards of Care (SOC), designates transsexuality as a problem, such that a trans identity itself becomes the focus of intervention. The first requisite step in creating a best practices guide to trans health care is to re-conceptualize the prevailing medical paradigm, because it's not a trans identity that induces a person to seek medical care; instead, the impetus is the constellation of societal factors that makes the daily lives of trans people so difficult. Stated another way, the problem is not transsexuality—it's transphobia. The focus of public health intervention in such cases should therefore be the **health deficits** that result when the natural development of an individual is impeded by her or his failure to conform to the gender norms society imposes.

It's when the medical system fails to recognize society's transphobia that the pathologization of individuals' identities begins.

3.2.2 Depathologization

There are two means by which transsexuality is **pathologized**:

1. **PSYCHOPATHOLOGIZATION (“PSYCHIATRIZATION”)**: this has to do with viewing transsexuality as an illness or mental disorder, based either on a theoretical definition or on an accepted clinical practice. Up to this point in traditional medical practice, the psychopathologization of transsexuality has justified the customary involvement of mental health professionals. This involvement, based on the imposition of a **psychiatric diagnosis**, implies making a judgment regarding the identity of the individual.

The diagnostic procedure is characterized by at least two features:

- *The imposition of a diagnosis*: the diagnosis of mental disorder becomes a systematic practice that takes precedence over the issues expressed by those who present for counseling. This

feature arises from the formal requirements for practicing medicine and has nothing to do with the nature of the patient(s). Basically, a diagnosis of disorder is a given, preordained even before the trans person seeks assistance. Further, the burden of receiving the diagnosis is magnified when it's legally required in order for one to exercise his or her civil rights (such as in the Spanish example, where a gender dysphoria diagnosis by a physician, psychologist, clinician, etc. is a prerequisite for a change of name and sex on the national identification document).

- *The assessment of identity compared to the prevailing gender norms accepted by psychiatry:* here, it's the practitioner who does or does not classify a patient as transsexual, thereby allowing or blocking access to the rest of the transition process. This evaluation is based on the degree of conformity to gender norms, i.e., in terms of the physical and psychological characteristics the conventional model attributes to stereotypical men and women. The gender stereotypes utilized as a basic reference are those cited in the criteria of the DSM and ICD.

2. **ORGANIC PATHOLOGIZATION:** this has to do with considering transsexuality as an organic illness, and is based, just as much as in the case of psychopathologization, on the acceptance of a paradigm that postulates a biologically-based incongruity between sex and gender that involves faulty programming of both.

DE-PSYCHOPATHOLOGIZATION refers to treatment procedures that do not view transsexuality as a psychiatric disorder. Organic pathologization is not an automatic consequence of de-psychopathologization, but many times that has been the default tendency, resulting in trans identities being re-pathologized. The development of a best practices health care model has been based on the **DEPATHOLOGIZATION** of all trans identities. By depathologization we mean that no trans identity should any longer be considered as problematic, and that all identities should be considered as a reflection of human diversity.

The implications of de-pathologization are:

1. That transsexuality would no longer be viewed as a mental disorder (this is the mental dimension of depathologization);
2. That transsexuality would no longer be viewed as an organic illness, because the gender of a person, trans or not, is not biologically programmed (this is the organic or physical dimension of depathologization);
3. That psychopathologization and organic pathologization represent an aspects of the cultural environment that work to impair the health of trans people, while simultaneously generating transphobia;
4. That transphobia is a specific type of violence perpetrated against trans people as much by institutions as by individuals.

Therefore, the consequence of total depathologization of trans identities presupposes their removal from both the DSM and the ICD (at least in terms of psychological and organic pathologizing references). De-psychopathologization is the first step toward depathologization. When a psychiatric diagnosis is replaced by one of organic disorder, without a fundamental change in conceptualizing trans identities, what results is a type of re-pathologization.

The pathologization model continues to characterize transsexuality as a problem to be treated and eliminated, and functions in various ways to disallow the possibility that a trans person could have a viable and dignified life. The traditional medical model dictates a single approach to understanding trans identities—that they are stages in a process of overcoming one’s past and hypothetically assuming an eventual non-trans life.

As a result, and as will be further discussed below, the process of psychotherapy should become optional—the absence of coercion in itself being required for the legitimacy of the process¹⁴)— and should only be embarked upon at the initiative of the trans individual.

3.2.3 De-Medicalization

The **medicalization** of trans health care occurs when the gender identity of a person is seen as a legitimate problem calling for intervention and when medical procedures are seen as the solution. In the conventional SOC model, medicalization is the foundation of the three-phase (“triadic”) psychiatric-endocrinological-surgical process, with the understanding that these phases are to follow one after the other (with occasional allowance for exceptions). In the context of the three-phase process, various medical techniques—considered of universal effectiveness and to be applied to every patient—are recommended for the purpose of restoring the individual’s theoretical “true gender.”

Does this mean that a model proposing the de-medicalization of trans health care must abandon the use of such medical techniques when they are requested? No. De-medicalized health care for trans people simply involves redefining the gender transition process as one worthwhile and possible choice to which a person should have access. Medical treatments, whether endocrinological or surgical, are seen here as useful tools the trans person can request. In a de-medicalized model, neither an endocrinological nor a surgical phase will be considered a requirement of a patient’s medical treatment. As a corollary, undergoing or aspiring to any of these treatments will not be regarded as an indicator of the degree of any patient’s transsexuality.

The medicalization of trans identities is justified in part by the pathologization that results from their inclusion in the previously-mentioned medical manuals (DSM and ICD). This is connected to a type of biomedical model of intervention in which a health complaint is automatically correlated with an organic malfunction, which in turn can be

14 If we make psychotherapy obligatory while at the same time assuming no inherent illness, we set up a contradictory situation. What we propose is based on a person being able to choose treatments that he or she believes will be beneficial without being in any sense mandatory.

addressed through pharmacology or other techniques. Adherence to a biomedical model thus also serves to directly support the pharmaceutical industry¹⁵.

3.2.4 The Relationship With Intersexuality

Up to the present, a diagnosis of transsexuality has entailed separating out cases of intersexuality. In a pathologizing medical model, gender expression that fails to conform to prevailing social norms must have its origin in either a mental disorder or an organic illness. Also up until now, transsexuality has predominantly fallen within the province of mental disorder, while intersexuality has been assigned to the field of organic pathology.

Once again the starting point has been the presumption that gender identity is a function of biology, i.e., that it is biology that dictates the specific gender expression for the two separate sexes. The practice of excluding cases of intersexuality only becomes an issue when the following question is posed: “given that the gender identity of a certain person is not what by nature it ought to be, are we dealing with a problem of anatomy and physiology, or one of psychiatry?”

Ignoring the incidence of intersexuality in a trans health health care system is a medical strategy aimed at erasure. People diagnosed with various degrees of intersexuality and given a sexual assignment as infants fall outside the current guidelines that apply to those who elect a process of gender transition. In such situations those patients should be afforded an equal level of health care treatment, without the slightest trace of discrimination, and without any exclusion of patients who have been diagnosed as intersexual on the basis that they cannot be accommodated within the existing framework of the international disease classifications (DSM and ICD) or the Standards of Care (SOC).

We also note that the draft of the new DSM-V recognizes the possibility that both the traditional gender identities might conceivably reside in one person. However, the framework from which this notion arises is the same one that endorses a correlation between the socially-imposed duality of gender expression and its bio-medical counterpart. This correlation serves equally to justify the urgent modification of intersexual infants’ genitalia as it does to justify a mental illness diagnosis of “Gender Incongruence” for a person who has not adjusted her or his behavior to the gender role the medical professionals selected during the person’s infancy¹⁶. To repeat, we are proposing a flexible model that allows an individual to select from various available options, in which a diagnosis of intersexuality does not warrant exclusion or a different model of medical care by health professionals, and does not involve patients having to comply with different requirements in order for their treatment requests to be honored.

15 The reverse also occurs, for example, when physicians who have involvements with the pharmaceutical industry are give roles in revising the DSM.

16 At present, intersexuality is excluded from the framework of the DSM on which the Standards of Care (SOC) were based. In the most recent draft of the DSM-V under preparation, both intersexuality and transsexuality are pathologized.

3.2.5 Counseling and Decision-making

In order to develop a best practices model in the area of trans health care, the assessment function of the professionals involved in the process must be replaced by a counseling approach. Counseling seeks to promote and respect individuals' autonomy rather than usurp it. Decision-making should become the responsibility of the patient, and the counseling process should be collaborative. There is a multiplicity of approaches and outcomes that vary subjectively, and professionals need to keep in mind the variety of possible life trajectories, just as they must be aware of the influence of patients' cultural and class backgrounds.

What is implied is a conceptual framework for understanding the counseling process that can be sufficiently respectful to the meaning of the patient's life experience and that can differentiate between the patient's personal development and decisions to access any medical techniques or procedures that might at some point be chosen. Health care professionals, in order to provide quality counseling and to avoid encouraging inappropriate choices, should discard the man-woman and homosexual-heterosexual dichotomies and thereby challenge the categories used to pathologize sexual and gender diversity.

To summarize, whenever there is a request for treatment, be it endocrinological, surgical, etc., it should originate with the patient and not with the medical system.

3.2.6 Counseling and Connecting to Local Support Groups: Avoiding Double Victimization

Up until now for trans people, utilizing the traditional health care model has involved entering a new arena of discrimination and victimization. The health care provided by the hospitals has been compromised by diagnosing and approaching trans patients under the mental illness paradigm, which the former have seen as necessary in order to continue functioning. The consequences of this have been to reinforce the social myth that the identity of the trans person is a mistake of nature that the medical system, having all the answers, will hasten to correct.

We have already commented that it will be impossible to improve the medical system without definitively leaving behind the illness paradigm (either mental or organic). **If the health care system is to have any role to play in trans health, it's far less one of diagnosis, the administration of hormones or the provision of surgical services than it is one of supporting the subjective self-worth of patients.** The acceptance of a non-pathologizing viewpoint by health care professionals is a prerequisite, but is not in itself sufficient—there would still need to be movement toward a counseling approach in which linking to existing community support resources would play a vital role. Counseling must involve the patient being given access to viewpoints and life experiences that show trans identities as worthwhile life choices. Awareness of supportive spaces and groups outside the formal medical system decouples the concept of transsexuality from a medicalized vision and facilitates the autonomy of trans people. It's no longer possible to keep in place a model that takes as a given that trans people ought not exist. In complete contrast to that approach, the health care system must lay the groundwork for trans empowerment and self-worth. This should result in patients being able to attest to their capacity for informed consent and thus taking on responsibility for their own decision-making. There would be no need for anyone to make a judgment about the patient's

identity that would diverge from the person's own view of herself or himself in order for that patient to qualify for a certificate of informed consent.

The problem with the current informed consent model is that it's preceded by a phase of assessment and gatekeeping, leading to a patient being given a referral letter for access to another specialist (such as an endocrinologist) who in turn utilizes an informed consent document that the patient signs in order to demonstrate awareness of and assume responsibility for any potential consequences of requested treatments. Therefore, we propose that the prior gatekeeping process be abolished and replaced simply with the use of an informed consent document that would grant the patient sufficient flexibility to be able to follow a self-designed path that can be modified as time goes by to adjust to the individual's life at each moment, as opposed to the person being forced onto the same path as everyone else.

3.2.7 Professional Training

To guarantee a positive change in the health care environment for trans people, it will be necessary for the professionals active in the field to have a somewhat different background from what has been expected under the paradigm of illness.

In the first place, since a counseling process, rather than a diagnostic one, will be the focus of treatment, involvement by psychiatric personnel will no longer be mandatory. If the primary objective is furnishing social, psychological and sexual advice and counseling for those who request it, what will be required is a skill set centered on disciplines such as social work, sexology, and/or psychotherapy.

Second, **training in sexology and/or gender studies** from a non-pathologizing perspective should be an indispensable requirement of the curriculum of the professionals involved in trans health. This change in professional training is urgently needed. Gender studies are pertinent to the field of social development, but up until now it's been possible to set up gender identity clinics without requiring their staff to have knowledge and competence in understanding gender, just as it hasn't been considered necessary for there to be sexology competence in the clinics. This situation represents one of the risk factors in implementing a successful redesign of the trans health care system.

3.3 BASIC PRINCIPLES ON WHICH THIS GUIDE IS BASED

As a result of the foregoing analysis, we conclude that:

1. No health care protocol for trans people should attempt to suppress transsexuality, transgenderism, etc. as life choices. In present practice, this is what happens every time a person seeking assistance is told that one can only be either a man or a woman, and that the proper ways of being one or the other can be found in a manual or by means of a medical consultation or procedure.
2. No protocol, phase thereof or treatment should have as its objective the modification of an individual's gender identity, but rather should focus on the resolution of the discomfort arising from the social environment within which that gender identity is lived.

3. No health care professional should issue any opinion whatsoever concerning the gender identity of a person, much less make a judgment about whether he or she is or is not trans.
4. In order that the health care provided to trans people be equal to that provided to other users of the health system, no protocol should make the assumption that trans people manifest physical or mental pathologies. Such an approach is the result of stereotyping on the part of health care professionals working in the field.
5. No protocol should make judgments about an individual's conformity to prevailing gender roles and stereotypes, nor should it stipulate that such conformity be achieved as a way of controlling access to treatment.
6. No health care professional should favor a choice of heterosexual orientation by any person, whether from a belief that this leads to a correct gender choice by "correcting" an alleged homosexuality, or for any other reason.
7. No health care protocol should treat trans people differently if they've been diagnosed as intersexual, nor shall it require diagnostic verification of any such condition in instances where it is unconfirmed.
8. No health care protocol, health care professional or medical document should refer to a trans person in any way that is inconsistent with his or her self-defined identity. The self-identification of the individual should override the opinion of the professionals at all levels of medical practice.
9. No health care protocol should judge the identity of trans people seeking health care on the basis of their adherence to any conventional treatment regimen, nor on any other basis.
10. No health care protocol should accept a hypothetical distinction between "primary transsexuality" and "secondary transsexuality," nor assign different degrees of validity to people's life histories based on how consistent they might be with typical medical narratives.
11. No health care protocol should insist on the feminization or masculinization of a person, but should at all times respect the specific life situations that exist within the manifold diversity of gender expression.
12. No health care protocol or medical intervention should be based on the idea that gender is a biological expression, nor should it be based on the belief that a particular sex should give rise to a particular gender.
13. No person trained as a psychologist or sexologist is qualified to judge the gender of any patient. Decisions based on the assumption that a professional's own gender is more correct

and natural than that of a patient leads to authoritarianism and to unequal and discriminatory treatment of the patient.

14. No health care protocol or medical intervention should require a “real life experience” in order to verify the true gender identity of a person. Such a test, required of no other type of patients, suggests a misuse of authority on the part of the health care professional and also unjustly and unnecessarily places the patient in circumstances that can have very negative consequences for her or his life.
15. No health care professional should prioritize and/or prevent particular surgical interventions in favor of other similar ones. An example of this would be making access to mastectomy more difficult than access to mammoplasty, based on the professional’s subjective opinion that “cutting off” is not the same as “adding on.”
16. Every health care protocol and every medical treatment process should be aimed at the betterment of trans people’s lives, so they can develop their own form of expressing their gender and giving meaning to their bodies, free of the stigmatization that befalls trans identities, gender expressions and bodies that are found at the frontiers of traditional concepts of women and men.

3.4 THE EXISTING STANDARDS OF CARE MODEL AND THE BEST PRACTICES MODEL OF TRANS HEALTH CARE

3.4.1 Standards of Care Presently In Force

Roles Fulfilled by Health Care Professionals According to the Standards of Care Roles¹⁷.

1. Diagnose with precision the gender identity disorder of the patient.
2. Diagnose with precision any co-morbid psychiatric condition and carry out appropriate treatment.
3. Counsel the patient about the range of available treatments and their consequences.
4. Provide psychotherapy.
5. Assess the eligibility and readiness of the patient for hormonal and surgical treatment.
6. Make formal referrals to colleagues (physicians, surgeons, etc.).
7. Describe, in a letter of recommendation, the relevant life history of the patient.
8. Act as part of a professional team that studies gender identity disorders.
9. Educate families, employers and institutions about gender identity disorders.
10. Be available to patients for follow-up treatment.

(HBIGDA 2001: 6)

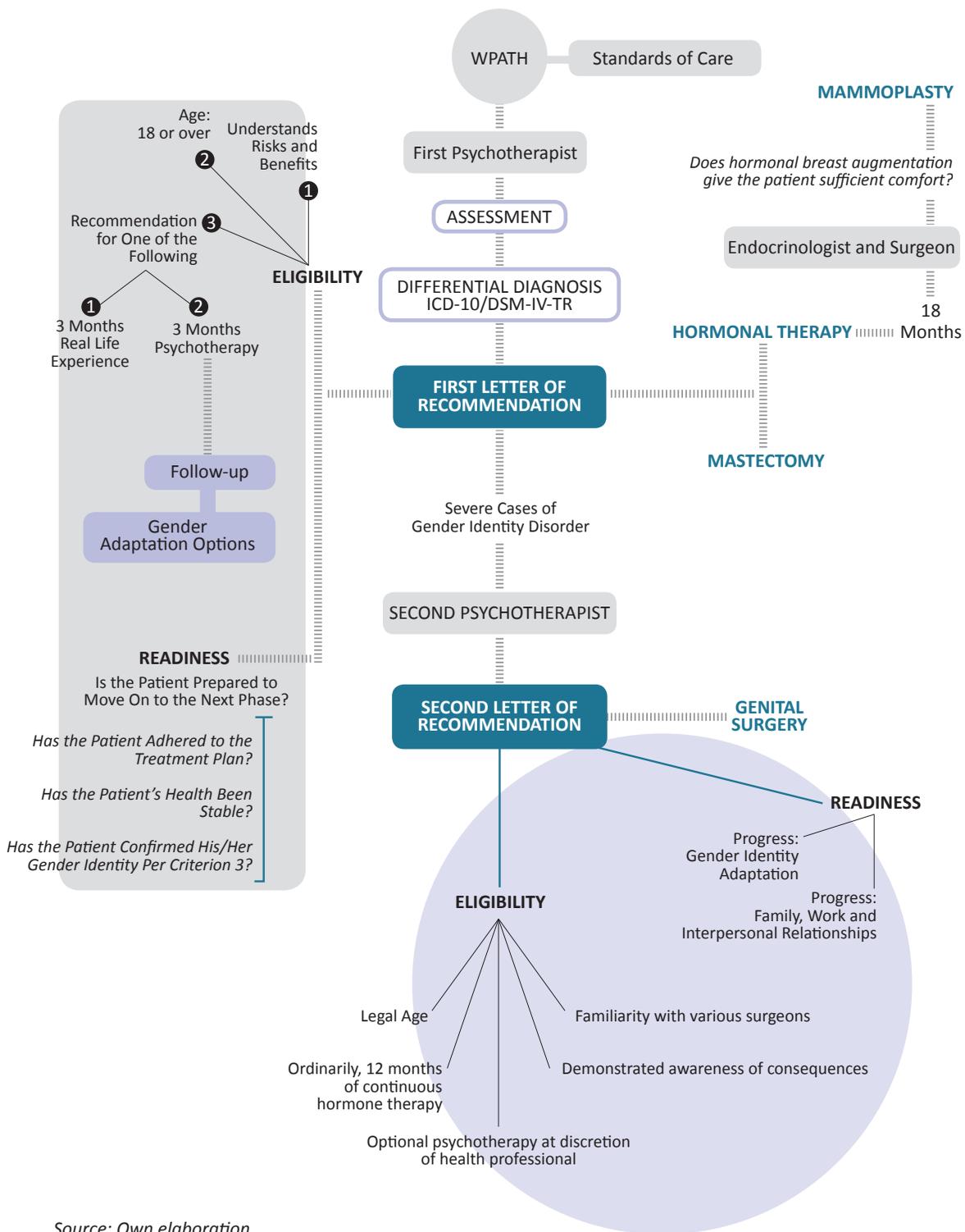
18 Excerpted from Standards of Care for Gender Identity Disorders (Sixth Version), HBIGDA, 2001. Full English text available at <http://www.wpath.org/documents2/socv6.pdf>

Health Care Professionals' Qualifications According to the Standards of Care

1. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have documented credentials from a proper training facility and a licensing board.
2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
3. Documented supervised training and competence in psychotherapy.
4. Continuing education in the treatment of gender identity disorders, which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.

(HBIGDA 2001: 7)

Figure 1: The Treatment Process under the Standards of Care



Source: Own elaboration

Description of the Standards of Care Protocol

As we can see in the diagram, the first phase is complete after assessment of the patient, and it's then necessary for the patient to obtain a first letter of recommendation. This phase, linked to the DSM-IV-TR and the ICD-10, is also called the "Diagnosis of Gender Identity Disorder," and as can be seen, is a prerequisite for being able to continue treatment, regardless of how far one wants to go with it.

Obtaining the first letter of recommendation signed by a psychiatrist or clinical psychologist signifies approval of the patient in terms of two sets of criteria, those of "eligibility" and those of "readiness."

Eligibility requirements entail the patient being of legal age, being aware of the risks and consequences of the treatments, and having completed at least three months of a "real life experience" (or, as a substitute, the completion of three months of psychotherapy).

The "real life experience" involves documenting that one has lived in the desired gender role, either masculine or feminine. Occasionally it is possible to skip the third criterion (real life experience or psychotherapy) in order to avoid having the patient resort to self-administration of hormones.

If the eligibility criteria are met, the patient is assessed to see if he or she is prepared to move forward with the next stage of treatment. In order to do so, the patient must meet the following criteria of readiness:

1. The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
2. The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality);
3. The patient is likely to take hormones in a responsible manner.

(HBIGDA 2001: 14)

In "serious cases" of gender identity disorder, complete gender transition treatment is recommended. Ideally, a triadic process is specified, encompassing psychiatric, endocrinological and surgical treatment. For access to surgery (excepting mastectomy), a second psychiatric evaluation is required, which once more assesses the patient's eligibility and readiness, utilizing the identical criteria as in the first evaluation. The waiting time before approval for surgeries can vary, but in general one can expect an initial three months of real life experience or psychotherapy, followed by 12 to 18 months of hormonal therapy (with concurrent "real life experience").

The additional assessment by a second health professional results in the issuance of an additional letter of recommendation that authorizes genital surgery.

3.4.2 Proposed Best Practices Health Care Protocol

Having made a critical analysis of existing trans health care procedures, and based on the logic of our arguments stated earlier, we propose the following:

Roles of the health care professionals in the new proposal¹⁸

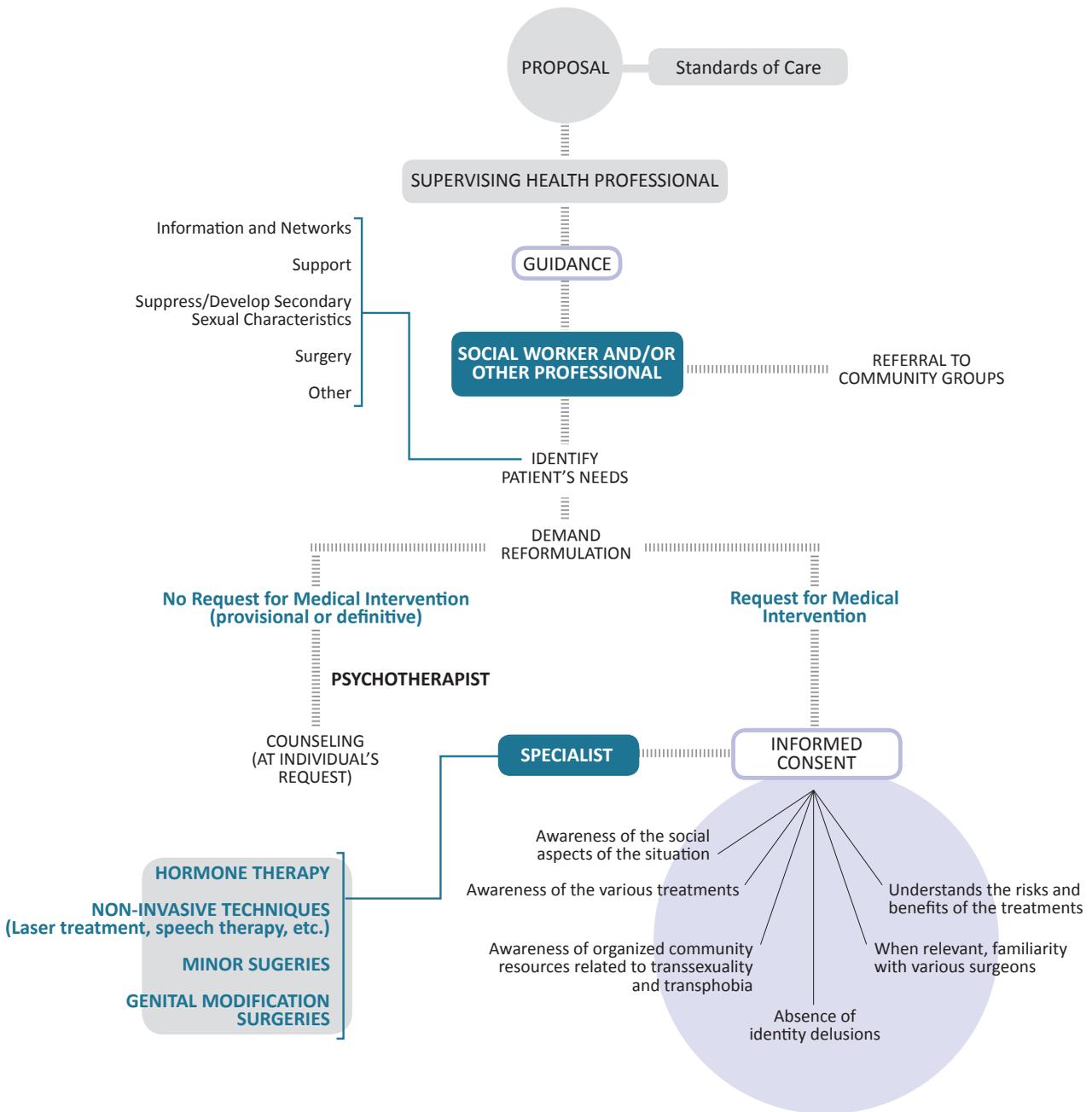
1. Help the patient understand that the problem is not his or her gender identity—regardless of the patient’s uniqueness or peculiarities—but is rather the social violence (transphobia) that is visited on those who do not conform to social norms.
2. Temper the expectations of the patient, bearing in mind that the treatment, with its perspective on the individual, is not stressing on the root of the problem, which is social.
3. Help the person interested in a transition process, which may include body modifications or not, to identify that their transition options are attainable and realistic
4. Inform the patient about various community resources and facilitate the patient’s engagement with social support networks.
5. Assure that the patient understands the various medical treatments.
6. Provide psychotherapy at the request of the patient.
7. Be a member of a team of expert professionals caring for transgender people.
8. Specialize in sexology or psychotherapy from a non-pathologizing perspective, or be a member of a gender studies group (feminist or gender equality studies).
9. Educate family members, health care professionals and institutions, both public and private, about gender diversity and the problem of transphobia.
10. Be accessible for follow-up health care.

Qualifications of Health Care Professionals in the New Proposal

1. A master’s degree or its equivalent in a clinical field of study such as sexology, psychology or psychotherapy with a non-pathologizing perspective. This degree, or another more advanced degree must have been granted by an institution approved by a recognized national or regional educational accreditation board.
2. Documented supervised training and competence in sexology or psychotherapy with a non-pathologizing perspective.
3. A specialized or more advanced degree in sexology with a non-pathologizing perspective, or in gender studies, conferred by a recognized institution (Sexology or Gender Studies/ Feminist Institute, etc.).
4. Continuing education in trans health care, which can include attendance at professional conferences, workshops and seminars, and participating in research studies related to gender identity issues.
5. Ongoing contact with community organizations that work to oppose transphobia.

18 Review by Garaizabal, Christina (2003), “Some Problems With Diagnosing Transsexuality” (“Algunos Problemas Diagnósticos de la Transsexualidad”) in Becerra, Antonio (ed.), *Transsexuality: The Search for an Identity (Transsexualidad: La Búsqueda de una Identidad)*. Ed. Díaz de Santos, Madrid.

Figure 2: Proposed New Protocol for Best Practices for Trans Health Care



The diagram above outlines a model in which the prospective patient contacts a supervising health professional who sets the health care process in motion by enlisting the participation of a social worker (or, alternatively, a psychologist or sexologist). Rather than being concerned with the patient's eligibility or readiness, the professional will help the patient engage with community support resources, consider various life choices including those that lie outside the conventional sexual binary, and decide whether or not to suppress his or her secondary sexual characteristics or undergo surgery. The existence of a prior psychiatric diagnosis should not constitute an impediment to accessing trans-related health care.

The model underlines the importance of community support group involvement, because social rejection and loneliness are some of the effects of stigmatization we've described earlier. Also, note that in this model, psychotherapeutic counseling would be optional.

After the patient's needs are clarified, he or she will proceed to consultation with specialists in surgical interventions and other treatments. In this phase, the patient should become informed not only about the techniques of various surgeons, but also about the social aspects, i.e., the risks and benefits, of making a physical transition. After surgery, the model specifies a means for follow-up health care if the patient desires it.

Conclusion

This Best Practices Guide is a proposal that we hope will stimulate debate over alternative ways to implement a non-pathologizing health care model for trans people that grants us decision-making power over the body-modification procedures we may desire, and that takes into account our variety of identities, life trajectories and gender expressions. We view this work as another turning point in a historic struggle. This work gives voice to the trans community, which invites all to join us in crafting new alternatives that replace the customary pathologization of our lives.

4

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