

## **Title**

Changing Minds: The Psycho-Pathologization of Trans People.

## **Abstract**

The concepts of psychiatric diagnosis and gender are both contested, and they are at their most controversial where they intersect around the diagnosis of trans and gender variant people as mentally disordered.

The World Health Organisation is in the process of revising the *International Statistical Classification of Diseases and Related Health Problems (ICD)*, with the eleventh edition expected in May 2018. This provides an opportunity to debate whether gender variance should continue to be classified as a mental disorder, be reclassified as a physical health or 'other' disorder, or be removed from ICD-11 altogether.

This article evaluates some of the assumptions on which the labelling of trans people as mentally disordered is grounded. It concludes that this process is based on the erroneous sex binary, outmoded views of gender, and the misattribution of the causes of distress trans people sometimes experience. It reflects Western society's medicalization of social issues, and is an example of the power that medical, particularly psychiatric, diagnoses have to define 'normality'. In the 21<sup>st</sup> century, the labelling of trans people as mentally disordered is as anachronistic as the psychiatric labelling of lesbian, gay and bisexual people. Medical professionals, policy makers, academics and practitioners have a duty to end the pathologization of this group.

## **Keywords**

Trans; Transgender; psycho-pathologization; ICD-11; Gender Identity Disorder

## **Introduction**

Notions of sex and gender permeate every aspect of our lives from birth. Most people are comfortable with the gender they are assigned and many never give it a second thought. However, some people are trans, or gender variant. These broad terms refer to people who challenge or attempt to alter their assigned birth gender, and sometimes its associated physical indicia. Some do this by surgically or medically altering their bodies to fit their gender identity, others by dressing in clothes or taking on certain roles usually associated with another gender to that which they were assigned at birth.

At the present time, across many parts of the world, these people can be labelled as mentally disordered. The most widely used diagnostic manual in Europe, the International Statistical Classification of Diseases (ICD) [1], supports such labelling through its inclusion of the diagnosis of Gender Identity Disorder in Chapter V, Mental and Behavioural Disorders. The World Health Organisation (WHO) is in the process of revising this manual, and changes to the inclusion and definition of gender variance are being considered. Publication of ICD-11 is expected by May 2018 [2]. Diagnostic manuals, such as the ICD, influence greatly not only how mental health professionals construct and understand mental disorder, but also how policy makers, health commissioners, lawyers, medical insurance companies and the general public conceptualise normality, difference and psychological distress [3]. The

inclusion or otherwise of gender variance within diagnostic manuals is therefore critical to the lives and experiences of gender variant people.

In addition to the proposed revision of ICD, four key factors signify that the consideration of this issue is particularly important at the present time:

***(i) Increased visibility:***

Despite facing ongoing transprejudice (negative stereotyping and discrimination), trans people are becoming increasingly visible in many spheres of public life including sport [4, 5], politics [6, 7], entertainment [8], and fashion [9]. In July 2014, Europe's first ever 'Trans Pride March' was held in Brighton, UK [10], and in the same year, the social media networking site, Facebook, announced it would permit worldwide users to identify on the site as any of 71 genders [11]. This increased visibility has led to a wider public debate about the nature of gender which crystallized, for example, in the furore over the South African athlete, Caster Semenya, who was ordered to undertake gender testing [12], and the public debate generated when a Canadian couple announced they were raising their baby as 'genderless' [13].

***(ii) Changes to research:***

In the past, most information about trans people was obtained from those who presented at Gender Clinics or who were active in clubs. Most of these 'subjects' were trans women – people who had been assigned a male gender at birth and expressed the desire to become female. Nowadays, previously hidden populations are coming to light, such as trans men - those assigned a female gender at birth who wish to become male - and people who refer to themselves as (amongst other things) 'trans-identified butches', 'genderqueers', 'non-binary' or 'genderless', and who do not necessarily wish to 'switch genders' from one to 'the other'. The growth

of the Internet has enabled wide coalitions of these people to form, and they now present a clear challenge to previously dominant normative views about gender. In addition, the emergence of researchers who are themselves trans [14, 15] has expanded this body of work, taken a more holistic view of the lives of gender variant people, and moved away from a focus on pathology.

***(iii) Legislative changes and challenges:***

Over the past decade, legislative and structural changes have taken place internationally in this field. For example, the United Kingdom (UK) parliament passed the Gender Recognition Act in 2004 and, in doing so, joined a number of other countries around the world in allowing trans people to alter their official identity documents to match their chosen gender, whether or not they have undergone hormonal or surgical treatment. More recently, the UK House of Commons Women and Equalities Committee published a report [16] calling for this Act to be updated and for greater protection and rights to be afforded to trans people. Additionally, a number of countries across the world, including Germany, India, and New Zealand, now recognise the legal right of their citizens to identify as a gender outside of the binary [17, 18].

***(iv) Revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM):***

Following a fourteen-year revision process, the American Psychiatric Association (APA) published the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in May 2013 [19]. In DSM-5, the previous diagnostic category of 'Gender Identity Disorder' has been replaced with one of 'Gender Dysphoria' which, it is claimed, shifts the diagnostic emphasis away from defining 'disordered identities', towards focusing on the distress experienced by some individuals. This

category was also moved from the Sexual Disorders chapter of the DSM to a new chapter of its own. Some other changes were made to the language, and the criteria now include an acknowledgement that some people identify with a gender that is other than exclusively male or female. However, the continued maintenance of a diagnosis of this kind in a psychiatric diagnostic manual, means that gender variance remains defined as a mental disorder.

Throughout its history psychiatry has labelled a number of powerless and minority groups as mentally disordered. Mainstream psychiatry has now rid itself of many of the overtly homophobic and racist diagnostic categories of the past, and yet gender variance remains anachronistically part of the diagnostic canon. It is time this designation of gender variant people as mentally disordered is challenged.

### **Is gender variance a mental disorder?**

The classification of gender variance as a mental disorder would seem to be underpinned by three main assumptions:

1. Sex is binary.
2. Gender is binary.
3. Trans people exhibit other psychiatric symptoms, indicating underlying mental disorder.

These assumptions need to be challenged.

#### ***Assumption 1: “Sex is binary”:***

Sex relates to a person’s anatomical and reproductive structures, and is determined by karyotype (chromosomes), gonads, external genitalia, hormonal patterns, and secondary sexual characteristics differentiated at puberty. Sex, and its physical indicia are usually presented as a ‘fact’: people are either ‘male’ or ‘female’.

However, despite being presented as such, sex is not a binary certainty and the reality is far more complex. For example, intersex people, who have ambiguous sex characteristics (chromosomal, hormonal and physical), make up an estimated 0.1% to 2% of the population [20, 21]. This alone indicates that people are not always so easily categorised as biologically male or female.

Current issues in international sport highlight further complexities. The International Olympic Committee and other sports federations insist that medical tests are carried out on female athletes who are suspected of having hyperandrogenism (a medical condition characterised by high levels of androgens in the body). Those found with naturally occurring higher than average testosterone levels are banned from competition unless they accept pharmaceutical or surgical interventions to lower them, as the authorities believe they have an unfair advantage against female athletes with 'normal' levels [22]. Crucially, the threshold for an 'acceptable' level of testosterone in a female athlete varies amongst sports' governing bodies [22]. So, in athletics at least, sex is not strictly binary – in fact, what it means to be physically 'female enough' to compete varies from sport to sport, and country to country.

***Assumption 2: “Gender is binary”:***

Gender can be understood as the “social interpretation” [23] of the biological markers of sex. Many of those who believe gender variance indicates mental disorder believe in a fixed, binary notion of gender in which there are two genders which correspond precisely with two sexes. Within this framework, males are expected to have masculine characteristics and identifications, whilst females are expected to have feminine characteristics and identifications. Often, anything outside of this is considered a deviation from the norm and, therefore, unnatural or pathological.

However, there is much evidence to suggest that, for many people, binary notions of gender do not reflect their lived reality [24].

Some of this evidence comes from anthropological studies which reveal that, in some other cultures, 'third gender' or 'mixed gender' people are tolerated or even embraced. Amongst South East Asian and Native American communities in particular, there are many accounts of people living successfully cross-gendered from their assigned gender, or outside of conventional social gender roles altogether [25-28]. In some countries, the gender rights of these people are actually enshrined in law [17, 18].

However, one has to be wary of interpreting data from one culture, through the prism of another: sometimes apparent acceptance masks at least some degree of discrimination. Another drawback of much of this research is that it focuses predominantly on people who were assigned a male gender at birth. It is impossible to know the exact number of trans people of any gender worldwide as studies often count only those who present for sex-reassignment surgery and they are "at an extreme end-point of a continuum of cross-gender identification" [29]. Historically, it has been thought that there are far fewer people assigned a female gender at birth who later identify as trans. However, although the figures vary internationally [30], many researchers now assume that the ratio of trans people assigned a female gender at birth to those assigned a male gender at birth is much more equal [31]. If this is the case, the experience of trans people who were assigned a female gender at birth would appear to be significantly under-researched. Despite these caveats, it is clear that not everyone in the world self-identifies according to the male/female or masculine/feminine binaries. And yet, it is only in some parts of the world that this is seen as indicative of mental disorder.

The boundaries of gender are porous and changeable in that what is considered 'appropriate' behavior for men and women varies enormously across time as well as place. For example, in the UK, until the 20<sup>th</sup> century it was relatively rare for (particularly middle-class) women to work outside the home, and those who did were sometimes viewed as 'unfeminine' [32]. In contrast, a recent report puts the UK employment rate of women at 67% [33]. Conversely, in Saudi Arabia, only a very limited number of jobs are considered suitable for women, and most do not work outside the home [34].

This almost universal framing of both sex and gender as binary can serve to reinforce the widespread understanding of trans people as disordered. Despite their acknowledgement of gender as a social construct, some trans-critical radical feminist writers such as Janice Raymond [35], Germaine Greer [36] and Sheila Jeffreys [37, 38] continue to reify essentialist notions of sex assigned at birth in a way that denies an understanding of gender as identity [38], and serves to pathologize and exclude trans people. For example, in responding to the campaign in favour of allowing trans people freedom to use the public toilet corresponding to their gender identity, Jeffreys states that as 'no change in biology takes place' [38], allowing trans women to use toilets also used by cisgender women (non-trans women who were assigned the female sex at birth and whose psychological gender is concordant with their anatomical sex) amounts to a 'de-gendering' [38] of women's space. In another example, Germaine Greer [36] compares the desire of trans people to change aspects of their physiology to "mutilations" [36] indicating behaviour that is "less rational" [36], and of the kind associated with body dysmorphic disorder [39].

Gender variance itself has only been the subject of the medical gaze for a little over a century, and a diagnostic category relating to it only entered the ICD in

1965 as part of its eight edition [40], effectively pathologizing large numbers of people overnight. Many people now, and across time, consider themselves to have a gender identity outside of the traditional male/female binary [41, 42]. It is certainly true that the majority of people conform to gender stereotypes, but a small yet significant minority displays consistently cross-gendered behaviour, and many others are at some point in between, displaying both gender-typical and gender variant behaviours [43]. In fact, the more that becomes known about sex and gender, the more it becomes clear that the binary separation of human beings into two sexes and two genders is a gross simplification of a much more complex reality [44].

***Assumption 3: “Trans people exhibit other psychiatric symptoms, indicating underlying mental disorder”***

Some studies, though by no means all [45], appear to show that trans people have higher lifetime rates of other mental disorders [46-50], particularly depression, anxiety, substance misuse and suicidal ideation. A problem common to many of these studies, however, is that they only measure the presence of psychopathology in people presenting at gender clinics. These clinical ‘subjects’ are potentially unrepresentative of the entire gender variant population, in much the same way that, until Hooker’s [51] influential study, many of the subjects of research into homosexuality were unrepresentative of most lesbian, gay and bisexual people. In addition, many people are keen to say the ‘right’ thing at clinics, perhaps over-emphasising their distress, in order to successfully negotiate the screening process, meet the criteria for diagnosis, and obtain their goal of treatment. Furthermore, the very few studies that address the issue of trans people with serious mental disorder,

also often group them together with cisgender lesbian, gay and bisexual people thus conflating the very different issues of sexuality and gender variance.

However, if the findings of these studies are to be accepted, and rates of mental disorder are indeed higher amongst trans people, there is evidence to suggest that the cause of this may lie not so much in their gender variance, but in the transprejudice (negative stereotyping and discrimination against trans people), social exclusion and discrimination trans people regularly experience as members of a society hostile to those who do not fit into binary gender roles [52, 53]. For example, it is estimated that more than 1,700 gender variant people were killed in the 7 years between 2008-2014 in hate crime incidents [54]. Even in the absence of violence, trans people are consistently marginalised in terms of marriage, employment and other legal rights [24]. Some governments even enforce their own discriminatory practices such as outlawing sex-reassignment surgery, or denying people the opportunity to legally alter their gender unless they undergo sterilization [55]. The mass media, and not exclusively the tabloid press, regularly depict trans people as freakish objects of ridicule or sexually deviant perverts [56, 57], and this exacerbates the social exclusion and stigma that many trans people feel [58].

Social and family support, an ability to be open about gender identity, and completed medical transition, have all been found to be protective factors in regard to mental health [48]. Studies of trans adolescents appear to show that those with supportive parents, peers and teachers do not report excessive impairment, distress or suffering [59], whereas those living in hostile, less accepting environments, are at high risk of self-harm and suicidal behaviour [60]. It is possible, therefore, that the distress experienced by some trans people, sometimes concretized in depression, anxiety and substance misuse, is a perfectly “*adequate* response” [24], and exactly

the same response a cisgendered person would have, to a hostile environment which, amongst other things, seeks to label them as intrinsically mentally disordered.

### **ICD-11: the proposed changes**

The WHO Working Group on the Classification of Sexual Disorders and Sexual Health is responsible for evaluating clinical and research data to inform the revision of the ICD categories relating to gender variance. Members of this group acknowledge that the historical classification of gender variance as mental disorder is “serendipitous” [61] in that it was based on the prevailing social attitudes of the time rather than any scientific evidence. However, rather than recommending the complete removal of the diagnosis from ICD-11, the WHO Working Group’s recommendation to the WHO, is that the diagnostic category relating to gender variance be moved out of the section relating to mental and behavioural disorders and placed elsewhere in the manual [61].

Initially, this proposal might seem perverse. After all, if gender variance does not meet the criteria for inclusion in the Mental and Behavioural Disorders chapter, why not simply remove it from ICD-11 altogether? However, there is another aspect to this debate which has historically made it more difficult to challenge the inclusion of gender variance in diagnostic manuals. In short, trans people differ from some other groups who have been wrongly labelled as mentally disordered (for example most cisgender lesbian, gay and bisexual people), in that sometimes they actively seek out a diagnostic label from the medical profession. This diagnosis can be crucially important for them. For example, it can be a requirement for altering one’s gender identity on legal documents and, in countries where cross-dressing is illegal, a diagnosis can legitimate this behaviour, thus avoiding censure [62]. Some trans

people also find a diagnosis provides them and their loved ones with an explanation for what is happening to them, as well as a reason for the very difficult feelings they may be experiencing [24].

However, most crucially, many trans people wish to maintain a diagnosis of some sort [63] because, in addition to exercising a 'social control' function, in modern societies, a medical diagnosis is often also essential in helping an individual to gain access to care and treatment [3]. Sex-reassignment surgery and hormone treatments are both very expensive, and the fear is that neither publicly-funded health providers nor private medical insurance schemes will pay for treatments that are not prescribed with the intention of relieving a diagnosed condition. Some trans people ultimately view the label of disorder as the price that must be paid for access to treatment [64]. For some, medical treatment truly is 'a matter of life or death' [44] and they fear the removal of it from diagnostic manuals could have devastating consequences. Members of the WHO Working Group acknowledge this quandary and insist that diagnostic manuals like the ICD must "find a balance between the competing issues of stigma versus access to care" [61].

A number of suggestions, therefore, have been made as to where a gender variance diagnosis should be relocated within the ICD-11. Some countries have, in fact, already taken the decision to unilaterally alter their classification systems, with France being the first country to do so by placing gender variance in the category of 'maladie rare', or long-term conditions that do not fit elsewhere within the manual [65]. Other solutions have been suggested including a decentralised 'Starfish Model' in which diagnostic codes related to aspects of treatment for trans people would be located in several different chapters throughout the ICD, thus enabling trans people to access healthcare in a variety of health settings without the need for a psychiatric

diagnosis [62]. Another option would be to recategorize gender variance as a physical disorder and locate it within Chapter IV 'Endocrine, nutritional and metabolic diseases' or Chapter XIV 'Diseases of the genitourinary system' of the ICD-11. However, the relevance of these placements is limited in that although genetic, hormonal and neuro-developmental factors have been suggested as pivotal to the development of gender identity, the aetiology of gender variance remains relatively unknown. Furthermore, not all trans people wish, or are able, to have hormone therapies or genital surgery.

The WHO Working Group's preferred proposal is that the diagnostic category relating to gender variance be located in a brand new chapter in ICD-11 [61]. Although this may seem the least contentious option in terms of placement, it is not entirely unproblematic. The very fact that a diagnosis will remain in the ICD, means that certain gender identities, and deviations from what are clearly porous binary gender categories, will continue to be pathologized. Given that it remains unclear how the interaction of genes, hormones, neurodevelopmental and social factors, brings about 'healthy' gender identity formation, it does not seem justifiable to continue to label certain gender identities as 'pathological' [44].

In addition to this, the diagnostic terms proposed by WHO Working Group bring with them their own challenges. The suggestion is that 'transsexualism' and 'Gender Identity Disorder of Childhood' should be renamed 'Gender Incongruence of Adults and Adolescents' and 'Gender Incongruence of Childhood' (for children below the age of puberty) [61]. These diagnostic categories are intended to more accurately describe the experience of trans people, and to serve as less stigmatizing than a diagnosis that implies a person's gender identity is disordered. However, the use of the word 'incongruence' suggests and, in fact, establishes in the diagnostic

canon, that there exists a normative state of 'congruence' with one's gender [66]. Given the clear flaws in the accepted gender binary, this seems misguided. The lived experience of a person's gender identity could be perfectly 'congruent', the only 'incongruence' being with societal expectations. Furthermore, given the influence of the diagnostic manuals on how the wider world perceives difference, the maintenance of such diagnoses, particularly in the light of the WHO Working Group's continued distinction between "normal and pathological gender identity" [61], serves only to perpetuate the pathologization of trans people, including very young children. Whilst gender variance remains in the ICD, the popular belief that there is something innately 'wrong' with trans people will continue to be granted credence by 'scientific authority'.

### **The only ethical way ahead: complete removal from the ICD-11**

Psychiatry has a long history of medicalizing social deviancy and 'policing' societal norms through the enforcement of prevailing social attitudes [3, 67, 68]. Gender variance appears to have fallen foul of this medicalization of social issues, and within this medico-psychiatric paradigm, other understandings of gender variance have been stifled by the dominance of diagnosis and the harsh economics of healthcare provision. Relatively little is known about how anyone, cisgender or trans, develops their gender identity, and yet some gender identities are diagnosed as disordered. These diagnoses, based on outdated, binary gender stereotypes, serve to pathologise, shame and punish any divergence from what are anachronistic notions of femininity and masculinity, based on sexist, heterosexist and homophobic standards for gendered behaviour [64, 69].

Psychiatric diagnosis and civil liberties are inextricably linked. Given the stigma surrounding a mental health diagnosis, it is hard to see how lesbian, gay and bisexual people could have made so many gains internationally in areas such as equal marriage, parenting and employment rights if homosexuality was still classified as a mental disorder [70]. In the same way, it is hard to see how trans people can gain equality whilst their very identities are labelled as disordered. The European Parliament [71] has urged the WHO to stop considering trans people as mentally disordered and to update the ICD-11 to reflect this, and the Council of Europe [72] has warned that the continued labelling of trans people as mentally disordered may become an obstacle to the full enjoyment of their human rights. But changing the name of the diagnostic categories and moving them to different sections of the manual, although laudable in intent, is not enough. It is essential that the next edition of the ICD not only de-psychopathologizes but de-pathologizes altogether trans adults and children [73].

As for healthcare funding, it is disingenuous to claim that the existence of a diagnosis currently automatically guarantees access to publicly funded treatment [24]. In the United Kingdom, for example, decisions on funding aspects of surgical treatment for trans people, including breast augmentation and facial feminisation surgery, are made by Clinical Commissioning Groups who each have different priorities for the allocation of their own budgets, therefore not guaranteeing parity of treatment for all [74].

It is unethical to provide treatment for trans people only if they are prepared to accept a diagnosis of mental or physical disorder. The consequences of not providing treatment to trans people who need it can be severe in terms of distress, alienation, and the potential risks involved in their attempts to access treatment from

unregulated sources [44]. There are also already many other examples of when medical treatment is provided for conditions that are not illnesses, such as pinnaplasty (ear pinning), fertility treatment, or breast reconstruction following the removal of tumours [75]. Treatment in these situations is not necessarily offered due to an illness or a 'disorder', it is offered in order to improve people's quality of life and psychological well-being [44].

In an environment of limited public healthcare resources, some form of rationing of treatment will always need to take place; but using the definition of 'illness' or 'disorder' to determine who should or should not receive publicly-funded treatment is wrong. In civilized societies access to health care should be based on need and future prognosis, not on outdated opinions, oppressive societal expectations, and flawed diagnostic classification systems.

Research in the United Kingdom, the United States and across Asia has shown that the belief that trans people are mentally ill is the most powerful underlying factor linked to transprejudice [76]. At this point in time, the World Health Organisation is in a position to make a real difference to the lives of trans people, not only in terms of care and treatment, but also in terms of their happiness and human rights. It is time that gender variance was removed altogether from the ICD so that individuals, and particularly children, gain the right to explore and create their gendered identities without being branded as mentally disordered.

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