

April 20, 2010

To the American Psychiatric Association:

The National Coalition for LGBT Health, a coalition of over 70 state and national organizational advocates and health services providers for the lesbian, gay, bisexual, and transgender (LGBT) community, welcomes this opportunity to comment on the American Psychiatric Association's draft revisions to the Diagnostic and Statistical Manual (DSM).

Fundamentally, the National Coalition does not support the continued inclusion of diagnoses regarding transsexuality, gender nonconformity, or gender identity in the DSM. As noted in the statement prepared by Callen-Lorde Community Health Center and the Lesbian, Gay, Bisexual, and Transgender Community Center of New York City, the proposed definition of a mental disorder in the DSM-5 explicitly prohibits the inclusion of diagnoses that are "primarily the result of social deviance or conflicts with society." The continued inclusion of transsexuality in the DSM-5 as "Gender Incongruence" (GI) contradicts this mandate by requiring transgender and gender-nonconforming people to validate and clinically manifest society's discomfort with gender nonconformity in order to access the medical care that they need.

The psychological or physical etiology of transsexuality is ultimately not the issue: regardless of the origin of each individual's deeply-rooted sense of gender identity, best practices in care for transgender and gender-nonconforming people, such as the Standards of Care maintained by the World Professional Association for Transgender Health (WPATH), continue to affirm that the safest and most effective treatment for the distress experienced by people who are otherwise unable to physically manifest their true sex is medical care that may include hormone therapy, surgical interventions, and other appropriate treatment as determined by the individual in consultation with their medical provider(s). A diagnosis guiding the provision of such care already exists in the Tenth International Classification of Diseases (ICD-10). Though this diagnosis is due for substantial revision, it is currently being used by providers in the United States and abroad to aid transgender and gender-nonconforming people in bringing their physical body into alignment with their gender identity.<sup>1</sup> While this course of care may include mental health services to deal with conditions such as depression and anxiety, these conditions are adequately represented in the DSM without reference to gender identity or incongruence. Requiring all transgender and gender-nonconforming people to present to a mental health provider with arbitrarily-defined "clinically significant" distress around their gender identity or expression does not ultimately assist in the pursuit of the highest quality of care. Rather, it imposes an unnecessary and demeaning obstacle to the provision of medical care that has been recognized as necessary by expert bodies such as the American Medical Association.<sup>2</sup> The National Coalition for LGBT Health strongly affirms that the medical requests of transgender and gender-nonconforming people deserve to be taken at face value rather than being subjected to unnecessary scrutiny and

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<sup>1</sup> ICD-10, Section F64, available from <http://apps.who.int/classifications/apps/icd/icd10online/>

<sup>2</sup> AMA Resolution 122, available from <http://www.ama-assn.org/ama1/pub/upload/mm/38/a08resolutions.pdf>

suspicion. Therefore, we join the Callen-Lorde Community Health Center, the LGBT Community Center of New York City, and numerous other providers of health and social services to transgender and gender-nonconforming people in the U.S. in recommending the removal of all diagnoses regarding transsexuality, gender nonconformity, or gender identity from the fifth revision of the DSM, including the diagnoses of “Gender Incongruence” and “Transvestic Fetishism.”

However, the National Coalition recognizes that proposals such as that replacing the diagnosis of “Gender Identity Disorder” (GID) with that of “Gender Incongruence” (GI) in the DSM-5 are laudable efforts by the APA to reflect increasing understanding that the gender identities and expressions of transgender and gender-nonconforming people are not pathological. Moreover, the current system of health insurance and legal precedent in the U.S. retains an important role for the DSM in assessing medical necessity and developing protocols by which transgender and gender-nonconforming individuals are able to access appropriate medical care and establish a legal identity that is reflective of their true gender identity. Therefore, given that transsexuality is likely to remain in the DSM-5 in some form, the National Coalition would like to take this opportunity to comment on the proposed changes.

The National Coalition for LGBT Health joins the National Center for Transgender Equality and many other advocacy organizations in supporting the proposed change of “Gender Identity Disorder” (GID) to “Gender Incongruence” (GI). This change more accurately reflects the fact that the focus of clinical attention should be on ameliorating the transgender or gender-nonconforming individual’s sense of an incongruity between their gender identity and their physical body, rather than on seeking to modify or repress their true gender identity.

The change to GI from GID is also an important step towards the DSM-5 draft’s stated goal of establishing an “exit clause” for individuals who have “transitioned and are psychosocially adjusted in the identified gender role.”<sup>3</sup> However, the National Coalition remains concerned about the way that this exit clause will be interpreted in practice by medical professionals, insurers, and policymakers: a transgender or gender-nonconforming individual who has received appropriate treatment and no longer experiences gender incongruence may still require a diagnosis to access continuing care (e.g., to maintain hormone therapy). The rationale behind encouraging “graduation” from the diagnostic criteria of the DSM while the individual continues to need the kind of care recommended by those criteria fails to eradicate the stigma attached to the original psychiatric diagnosis, and it emphasizes the role of the DSM as a gatekeeper that imposes extra burdens in time and financial resources on transgender and gender-nonconforming people seeking medical care. If transgender and gender-nonconforming people are expected to be able to access continuing care after taking advantage of the proposed exit clause, it is logical that such care should be provided from the very beginning under a medical rather than a psychiatric diagnosis. The assigning of a psychiatric diagnosis for a condition best treated with medical care promulgates the incorrect perception of transgender and gender-nonconforming people as mentally ill and diminishes the

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<sup>3</sup> APA 2010, available from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482#>

motivation for insurers to cover all treatments and care involved in the lifelong maintenance of a transgender or gender-nonconforming person's health.

As the endnotes in the Rationale for Section 302.85 appropriately suggest, subtyping by sexual orientation in the clinical assessment of GI cases should be ended in the DSM-5. Therefore, Severity Criterion A7 under draft Section 302.85, "Gender Identity Disorder in Adolescents or Adults," should be revised to eliminate the unnecessary focus on sexual orientation. The purported usefulness of sexual orientation subtyping for researchers in the field should not override the concern that research into the sexual orientation of transgender and gender-nonconforming people does not serve the best interests of this population – rather, it contributes to the construction of theoretical models divorced from the lived experiences of transgender and gender-nonconforming people and encourages the development of treatment protocols that discriminate on the basis of pre- or post-transition sexual orientation in the search for "true" transsexuality. Along these lines, Severity Criterion A8 should also be eliminated, as it helps perpetuate a hierarchy premised on a standard of "true" transgender or gender-nonconforming narratives rooted in childhood (i.e., the common therapeutic expectation that "true" transsexuality is present from earliest childhood and involves constant distress that impairs functioning in the assigned gender role).

The diagnosis described in draft Section 302.6, "Gender Identity Disorder in Children," should also be eliminated. Rather than a list of valid diagnostic criteria, the proposed criteria for Gender Incongruence in children are a collection of behaviors that are observable both in children who grow up to identify as transgender or gender-nonconforming and in those who do not. The DSM should not encourage clinicians or parents to subject children to stigma and psychiatric scrutiny for simply failing to conform to prevailing gender role stereotypes about their behavior or preferences.

Finally, the National Coalition advocates the elimination of the diagnosis described in draft Section 302.3, "Transvestic Fetishism." Given its focus on "cross-dressing" exclusively in males, it is clear that this diagnosis is premised entirely on society's discomfort with gender role transgressions. The diagnosis of Transvestic Fetishism merely helps police the gender role boundary by accusing men of mental illness should they voluntarily place themselves in the purportedly subordinate – i.e., female – role by surrendering traditional masculine attributes such as "typically male" clothing. The continued inclusion of Transvestic Fetishism reifies rigidly sex-stereotypical behavior and gender expression for men by imputing pathology and impairment to those who express their sexuality, sexual orientation, gender identity, or simply sense of self in a manner not condoned by the normative establishment, and it has no place in the next revision of the DSM.

In summary, the National Coalition for LGBT Health advocates the removal of all diagnoses regarding transsexuality, gender nonconformity, or gender identity from the DSM-5. Though we recognize that this is unlikely, we continue to hope that the proposed DSM revisions will constitute a step towards the eventual elimination of these

stigmatizing and unnecessary diagnoses. In the meantime, we would like to offer the following recommendations and critiques of relevant sections of the proposed DSM-5:

- Permanently change “Gender Identity Disorder” to “Gender Incongruence”;
- Clarify the “exit clause” and any anticipated interface between psychiatric diagnosis for initiating treatment for GI and medical diagnosis for continuing any necessary maintenance treatment after the alleviation of GI;
- Remove Severity Criterion A7 in draft Section 302.85, “Gender Identity Disorder in Adolescents or Adults”;
- Remove Severity Criterion A8 in draft Section 302.85, “Gender Identity Disorder in Adolescents or Adults”;
- Eliminate draft Section 302.6, “Gender Identity Disorder in Children,” as well as “Gender Incongruence in Children”; and
- Eliminate draft Section 302.3, “Transvestic Fetishism.”

Thank you again for the opportunity to comment on the proposed revisions to the DSM-5, and we look forward to working with the APA in the future to ensure that the DSM best serves the needs of transgender and gender-nonconforming individuals.

Sincerely,

National Coalition for LGBT Health