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3.1 Definition

3.1.1 Gender Dysphoria

The dictionary defines gender as the state of being male or female (typically used with reference to social and cultural differences rather than biological ones) [1] and dysphoria as the state of unease or generalized dissatisfaction with life, the opposite of euphoria [2]. The term dysphoria is from the Greek word *dysphoros* meaning “hard to bear” [3].

Below are two medical definitions of gender dysphoria, both from the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), the first from the earliest (1979) [4] version, Standards of Care, The hormonal and surgical sex reassignment of gender dysphoric persons, and the second from the current and seventh version (2011) [5] Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. Both documents and their intervening versions are written and distributed by WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA).

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3.1.2 1st SOC (1979)

Gender dysphoria herein refers to that psychological state whereby a person demonstrates dissatisfaction with their sex of birth and their sex role, as socially defined, which applies to that sex, and who requests hormonal and surgical sex reassignment. Gender dysphoria, herein, does not refer to cases of infant sex reassignment or re-announcement nor does it refer to those persons who, although dissatisfied with their genetically and socially defined sex status (i.e., transvestites and transgenderists), usually do not request sex reassignment. Gender dysphoria, therefore, is the primary working diagnosis applied to any and all persons requesting surgical and hormonal sex reassignment [6].

3.1.3 SOC 7 (2011)

Gender dysphoria – Distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) [7].

These two definitions, separated by 32 years between the first and the seventh guidelines, reflect the overarching change in the evolution of the professional approach to gender dysphoria.

Using the SOC as a mirror of the evolution, the original professional approach was a medicalized one, and these guidelines of care described

the medical management of gender dysphoria and presumed a full transition from one sex to another (the sex-change model).

The title, as noted above, of the 1st SOC was “Standards of Care, The hormonal and surgical sex reassignment of gender dysphoric persons.”

In the most recent SOC, the medical part of the definition (about requesting sex reassignment) has been intentionally omitted. The current professional approach has been to broaden the focus of transgender health [8], with an emphasis on health and not only on treatment. Individuals with gender dysphoria requesting medical care receive individualized health care, which may or may not include hormonal and/or sex reassignment. These SOC include other aspects of health care, for example, reproductive health, voice and communication therapy, lifelong preventive and primary care, and care in institutional environments [9]. Psychological care has been included from the beginning.

Thus, the title of the 7th SOC is “The Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People,” unlike the early ones that specifically mention sex reassignment.

Another major change from the original SOC, consistent with the above change from treatment to health, is a shift in gender paradigms.

Initially, a binary system of gender (man, woman, boy, girl) was the predominant paradigm. Now, the view is that gender falls on a spectrum and multiple gender identities and expressions are possible.

In addition, although not clear from these definitions, professional consensus has moved away from seeing gender dysphoria as a disorder and now sees it as part of an overall pattern of gender diversity [10].

The approach for providers in providing health care more broadly has, as its basis, an underlying emphasis and recognition of human rights. Health care is a human right. And trans rights are part of human rights.

The evolution of the name and approach is due to an interplay of several factors such as advancing knowledge and better clinical treatments, the aforementioned changing gender paradigms, input and participation from trans people themselves including human rights and the right to self-define,

the rise of the Internet, more global participation, and evolving shifts in how transgender people are seen by the culture. Expansion of knowledge beyond Western approaches is also part of the evolution. These changes have accelerated in recent years and are exponential rather than linear.

Other names used frequently in the literature include “*gender identity disorder* [11], the formal diagnosis set forth by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Rev. (DSM IV-TR) (American Psychiatric Association 1987) which is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one’s sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning”, “*transsexualism* (transsexual: an adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery) typically accompanied by a permanent change in gender role) [12]”, and “*transgender* (an adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender). The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth [12]”.

Although gender dysphoria, an essentially neutral label, is the term most commonly used in the current medical literature, that neutrality was not always so. Until recently, the value-laden gender identity disorder, which by definition implied a “disordered condition,” was the most commonly used term. Although the name gender dysphoria has come full circle, approaches to care have evolved.

These names cannot be separated from the evolution of professional understanding.

3.2 Evolution and SOC

This chapter describes the evolution of the name and professional approaches to the condition start-

ing with the 1st international symposium on gender identity, in London, in 1969, and the beginnings of HBIGDA, in 1979, followed by the seven versions of the SOC that document the evolution of the nomenclature and the prevailing approaches to care, and then ends with the 23rd 2014 WPATH Symposium, Transgender Health from Global Perspectives, held in Bangkok, Thailand.

3.2.1 WPATH and SOC

WPATH (formerly HBIGDA) writes and disseminates the SOC.

It is the oldest and only international multidisciplinary professional organization devoted solely to the health of trans people with the mission to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.

Hence, the organization is in a good position to publish guidelines that reflect the state of the art and science and evolution of care.

The SOC document the evolution of the nomenclature and prevailing medical standards and are based on the best available science and expert professional consensus.

Revisions to the 1979 Standards of Care (1980, 1981, 1990, 1998, 2001, 2011) have occurred concurrent with the advancement of knowledge.

Other classification systems naming this phenomenon are the Diagnostic and Statistical Manual of Mental Disorders (DSM) put out by the American Psychiatric Association (APA) and the International Classifications of Diseases (ICD) put out by the World Health organization (WHO). These manuals have also evolved, often along parallel lines to the SOC. Although the last publication of ICD, ICD-10, was in 1990 [13], ICD-11 has a planned publication in 2017. As both the DSM and ICD have contributed to and reflect evolving notions of health care, their nomenclature will also be described.

WPATH has worked with APA and the WHO during the period of writing of SOC7 (the SOC7 process) and beyond. WPATH has had formal consensus processes advising the workgroups for APA and the WHO regarding the nomenclature for both DSM 5 and ICD-11.

This chapter will not describe the terminology and health care of children.

By necessity, broad-brush strokes will be used to provide an overview of the evolution.

Information on the background and beginnings of approaches is followed by briefer descriptions of middle periods where the interplay of factors brings us to the dramatic shifts in recent years.

Some things have not changed such as the complexity of the condition, ethical concerns, the interdisciplinary nature of the field, and the need for social understanding and education.

Major changes include the growing number of people involved in the field including more transgender people themselves. The addition of transsexual, transgender, and gender-nonconforming people joining with providers in the evolution of approaches has had a major impact. Mainstream growing acceptance is also a factor.

3.3 Pre-SOC to 1979

3.3.1 1950s and 1960s

The possibility of medical treatment for gender dysphoria entered the popular imagination in the early 1950s when Christine Jorgensen, an American GI, had a sex-change operation in 1951 in Denmark and then returned to the United States. Although not the first to have a “sex change,” Dr. Harry Benjamin, an early pioneer in the field [14], remarked that Jorgensen’s “sex conversion” and the worldwide publicity it created was perhaps the most important milestone in the history of transsexualism. Her surgeon Christian Hamburger in his 1953 report [14] urged the medical and legal professions to help the plight “of these unfortunate people for whom psychotherapy proved useless.”

The aforementioned Benjamin, a NY endocrinologist, saw many patients and wrote the first article about the condition in 1953 [15] in the no longer existing International Journal of Sexology.

In 1966 [16], he published his magnum opus, *The Transsexual Phenomenon*. In it, he interpreted transsexualism as a form of psychic intersexuality, the intensity of which varies. He suggested that the condition was due to complex factors,

most likely had more than one causation, and was primarily a neuroendocrine disorder. He argued that since there was no cure, it was in the best interest of both transsexuals and greater society to alleviate this intense suffering of transsexuals by sex reassignment, in selected cases [17].

Also in 1966, the Gender Clinic, championed by renowned medical psychologist Dr. John Money, opened at Johns Hopkins. The clinic lasted until 1979 when it was forced to close by pressure from psychiatry, asserting that it was treating a mental disorder by doing surgery [18].

Hopkins served as a model for gender clinics scattered throughout the United States.

The oldest and largest gender identity clinic in the world began operations in the mid 1960s and is still in operation located in Hammersmith in London and is sometimes known as Charing Cross Gender Identity Clinic [19].

Don Laub, M.D., Chief of Plastic Surgery at Stanford and also founder of Interplast, which was the forerunner of medical humanitarian ventures worldwide, founded another gender clinic, known as “the Stanford Program.” Laub led medical teams on humanitarian surgical trips to the developing world and at the same time developed new surgical techniques for sex-reassignment surgery. Eventually, he moved to private practice but was never forced to close. Laub was instrumental in the foundation of the organization that was later to become WPATH, serving as President from 1981 to 1983 [20].

Psychiatrist and lawyer Richard Green and medical psychologist John Money (eds) published a multidisciplinary volume *Transsexualism and Sex Reassignment* in 1969, which, along with instructions on hormonal and genital sex reassignment, included sections on social and clinical aspects of transsexualism. Topics included such as psychological aspects, somatic aspects, treatment aspects, and medicolegal aspects, are themes that continue to be major topics today.

The editors dedicated the volume to Harry Benjamin, M.D., the pioneer of transsexual research, stating: His compassion and courage in treatment of the transsexual patient opened a new frontier in the knowledge of human nature [21].

Hence, foundational themes and key points from the earliest years included the following: Gender dysphoria cannot be cured via psychotherapy.

A medical necessity for surgical sex reassignment exists in some cases.

The field is interdisciplinary.

Compassion and courage are foundational.

3.3.2 1970s

Early pioneers and early conferences

Prior to the 1st SOC, a small group of interdisciplinary professionals supported by wealthy transsexual Reed Erickson via his foundation, the Erickson Educational Foundation, assembled at six conferences in Europe and the United States to discuss the new medical condition known then as either gender disorientation, transsexualism, or gender dysphoria, starting in July 1969 with the 1st International Symposium on Gender identity: Aims, Functions, Clinical Problems of a Gender Identity Unit, London. These international symposia continue to this day, with the 23rd just held in February 2014 in Bangkok, Thailand. The next will be held in Amsterdam, the Netherlands, in 2016.

The people involved were pioneers and highly respected in their fields.

Some of the concerns of the early conferences are equally compelling today.

In the opening address of the first conference in 1969, Professor C. J. Dewhurst from Queen Charlotte’s Hospital, London, states, “I actually regard this to be one of the most difficult conditions I have ever come across in clinical medicine. If we consider the condition as an anomaly that would be cured by getting the patient to accept their true anatomic sex, can we say that is ever possible?” To paraphrase Dr. Dewhurst, “What do we know of its origin? Under what circumstances does it arise? If we medically intervene, what are criteria and at what age? What is their legal sex? Can they marry?” [22].

The cover of the brochure states the following: *In addition to the medical and research aspects of the problem, there is urgent need for greater*

academic and professional understanding and for education, the latter of which could be said to be the most pressing need today.

At the 1971 2nd International Gender Identity Symposium in Denmark, there was a recognition that *this is an interdisciplinary, complex condition and area of human rights*. The brochure stated that the field calls attention on the problem of gender identity and “gender disorientation, not only as a psychiatric entity but also as an area of specialized medical study and treatment and social understanding” [23].

The 1973 3rd Symposium on Gender Identity in Dubrovnik included families along with surgery and etiology as topics of discussion [24].

The 4th conference on Gender Identity in Palo Alto in 1975 was the first to use the Harry Benjamin name in the title. It also focused on the interdisciplinary exchange of scientific information and how to achieve greater acceptance. In a first-person recollection, Roy Mackenzie stated that the “first step was to make it professionally respectable to even study such material” [25].

At the 1977 5th International Gender Dysphoria Symposium in Norfolk, VA, a founding committee for an interdisciplinary international organization named after Harry Benjamin, the Harry Benjamin International Gender Dysphoria Association (HBIGDA), was founded and charged with developing Standards of Care guidelines based on knowledge and ethics at that time. Paul Walker, Ph.D., a protégé of John Money, was named as chair [26].

3.3.2.1 Literature

Aside from the literature coming from the above pioneers, most of the literature was psychodynamic and pathologizing, positing dysfunctional family, mostly mother–child dynamics, as the cause of the condition and recommended reparative psychotherapy and psychoanalysis. Examples of literature in that vein include Stoller’s [27]) *Perversion* among other books [28–30] and a series of articles by psychoanalysts Ovesey and Person [31, 32] and Person and Ovesey [33, 34, 35].

Other psychological treatments were behavioral, for example, Rekers and Lovaas [36], designed to extinguish cross-sex gender expressions and reinforce gender normative behaviors.

3.3.3 Nomenclature Pre-1st SOC

SOC – The SOC did not exist.

DSM I (1952) – There was no nomenclature for the condition.

DSM II (1968) – (Parent) sexual deviations; (diagnosis) transvestism.

ICD-6 (1948) and ICD-7 (1955) – There was no nomenclature for the condition.

ICD-8 (1965) – (Parent) sexual deviations; (diagnosis) transvestism.

ICD-9 (1975) – (Parent) sexual deviation; (diagnosis) transvestism and transsexualism.

3.3.4 Summary

This period marked the beginning of gender clinics, the first surgeries, and the beginning of psychopathologization as a sexual deviation in the nomenclature. The paradigm was clearly binary.

The two strands of literature and approaches still continue today, but one (reparative) is now considered unethical and is not part of mainstream care. The early specialized conferences draw surprising parallels to today.

3.4 1979–1981

SOC v1. 1979 Standards of Care

The hormonal and surgical sex reassignment of gender dysphoric persons

SOC v2. 1980 Standards of Care

The hormonal and surgical sex reassignment of gender dysphoric persons

SOC v3. 1981 Standards of Care

The hormonal and surgical sex reassignment of gender dysphoric persons

The 1st 3 SOC had the same name. The health-care approach for all was comprised of the triadic sequence, the three required steps to medically transition from one sex to another. These three included living in the preferred gender for 1 year termed the life test, hormonal, and finally genital sex reassignment. The first SOC used the name gender dysphoria.

The paradigm about gender was binary.

HBIGDA was incorporated, and the first Standards of Care were approved by the membership of the fledgling society in 1979 at the seventh conference in San Diego. From the beginning, it was made up of interdisciplinary international providers, most from Western Europe and North America, primarily from the United States. Much of the hard science came out of Europe.

One purpose of having guidelines was to gain respectability. The purpose of the new organization and the SOC was to gain academic acceptance among professional peers, to provide a place for professionals to share knowledge, to move the field forward, and to protect trans people from disreputable surgeons.

The term gender dysphoria was adopted as a descriptive and accurate label [37]. Dysphoria was about the subjective distress of the mind/body mismatch. Later, the word was extolled as being value-free compared to other labels that included the designation disorder.

The first Standards were only eight pages long, and although contributed to via professional consensus, they were actually written by Psychologist Paul Walker from the University of Texas at Galveston. Dr. Walker was the first President of HBIGDA, who later started a private practice in San Francisco, before his untimely death in 1991.

These first SOC covered such items as definitions, principles, description of the triadic sequence, and recognition of the interdisciplinary nature of the field. Strict eligibility requirements for medical treatments, including two evaluations by mental health professionals for surgery and one for hormones, were also described. Psychotherapy was compulsory.

Meanwhile, providers were excoriated on multiple fronts.

McHugh [18], pointing to studies showing that operated patients were no better off than they had been before treatment, shut down the Hopkins gender clinic in 2006. He neglected, however, to take into account that most were subjectively happy about their surgeries and few had regrets [38].

Also in 1979 radical feminist Janice Raymond, in her book *The Transsexual Empire*, proposed that male-to-female transsexuals transitioned as a way to invade female space. She also accused

providers of creating a medical treatment “empire” as a means to make money [39].

The term gender identity disorder (GID) as a subset of psychosexual disorders was first introduced in DSM III (1980) [40] (for children), which initiated the language of disorder. GID would become the language for adults in DSM II-R (1987) [41]. The term suggested that one was at core disordered, this supposition becoming the basis of future protests from trans people and professionals alike. The mental disorder designation became the default position. Although no concrete evidence existed for a psychological or a physical basis for the condition, DSM III suggested that a predisposing factor was a disturbed parent–child relationship [40] consistent with Stoller [42]. One also wonders if the stigma of cross-gender behavior may have played a role in the decision regarding this placement in the nomenclature [43].

3.4.1 Nomenclature

SOC 1979, 1980, 1981 – Gender dysphoria.

DSM III (1980) – (Parent) psychosexual disorders, (diagnosis) transsexualism. Gender identity of childhood was introduced.

ICD-9 (1975) – (Parent) sexual deviations, (diagnosis) transvestism and transsexualism.

3.4.2 Summary

Today’s preferred term gender dysphoria was used in the first SOC whereas the term gender identity disorder was first used elsewhere, in DSM III.

3.5 1981–1990

SOC v4 (1990) Standards of Care – The hormonal and surgical sex reassignment of gender dysphoric persons

SOC v4 had the same name as the first three versions; the health-care approach concerned medical transition from one sex to another, the triadic sequence, and used the name gender dysphoria.

The paradigm about gender was binary and the condition was still considered primarily a mental disorder.

During this period, competing theories abounded, suggesting how little was actually known.

Blanchard developed a new typology based on sexual orientation. In his view, there were two types of male to female transsexuals, one early onset and attracted only to men and the other a later onset type recognizable by a sexual orientation directed toward an inner image of oneself as a woman, which Blanchard labeled autogynephilia [44]. This eroticism of identity has created much dissension particularly among the trans community and remains a point of contention even today.

Also in 1987 Green published the influential *Sissy Boy Syndrome and the Development of Homosexuality*, which continues to have influence although the title remains controversial. In a study still cited, Green found that most children with GID grow up to be gay, not trans, and that one cannot predict adult outcomes based on childhood behavior [45]. Although this chapter is not about children, a big question regarding children has to do with who will benefit from early medical transitions and who will not? How do we predict outcomes?

Another example, presented at the HBGDA 1989 conference in Cleveland and in his writings, Leslie Lothstein, a psychoanalytic clinician, described the etiology and treatment of FTM transsexualism. He posited that FTMs suffered from severe impaired object relations and borderline psychopathology requiring long term psychodynamic psychotherapy rather than medical intervention [46, 47].

3.5.1 Nomenclature

The SOC were still using the term gender dysphoria while others started or continued using the term GID.

DSM III-R (1987) – (Parent) disorders usually first evident in infancy, childhood, or adolescence; (diagnosis) transsexualism, gender identity disorder of adolescence and adulthood – nontranssexual type.

ICD-10 (1990) – (Parent) gender identity disorders; (diagnosis) transsexualism, dual-role transvestism, other gender identity disorders, gender identity disorder, unspecified. This ICD is still in use. ICD-11 will not be out until 2017 [48].

3.6 1991–1998

SOC Version 5 (1998) – The Standards of Care for Gender Identity Disorders

The 1998 SOC, to be consistent with DSM III, for the first time called the condition GID, rather than gender dysphoria.

Nevertheless, despite the shift in terminology, a beginning of change in approach was evident.

Although the triadic sequence was prioritized, the standards suggested that other approaches (described in the psychotherapy section) might be helpful for some people in adapting to the condition. For the first time, psychotherapy, although highly recommended, was not a prerequisite for treatment.

As a precursor to the current emphasis on human rights, the SOC stated that although GID was still considered a mental disorder, a disorder designation was not a license for stigma.

SOC v5 stated that the overarching treatment goal was “lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment” [49]. This goal remains in place today.

Although difficult to break down how things changed exactly, a pattern emerged via an interplay of forces. The issue of labeling the condition a disorder was becoming more controversial. The literature marked a shift away from the binary into a spectrum paradigm. Biological differences were also noted. Moreover, the community started to have a larger voice.

For example, in 1994, Gil Herdt’s 614-page series of articles entitled “Third Sex Third Gender, Beyond Sexual Dimorphism in Culture and History, Recognizing Global Diversity Outside the Binary” was published, describing many variations on the trans spectrum. On the biological side [50, 51], reported differences in

the size of brain structures among homosexual and heterosexual men and transsexual women, in the part of the brain that regulates circadian rhythm, with the nuclei of the transsexual women being the largest [51].

3.6.1 Community

The community was beginning to have more authority among themselves and providers began to listen. The role and importance of the trans community started to grow. People started defining themselves.

The term transgender came from the community and this increasingly vocal community started to reject medical models.

For example, transgender activist and writer Dallas Denny, at a recent conference on transgender history (2014), described the impact of Holly Boswell's article (1991) "The Transgender Alternative" where she described the term transgender as a middle ground between transsexual and transvestite [52]. According to Denny, "The impact of "The Transgender Alternative" was immediate and dramatic. By 1994, the term transgender had become the consensual umbrella term for all of us. That does not mean everyone liked it. Essentialist transsexuals in particular felt they had little in common with crossdressers and transgenderists." As an aside, these differences continue to this day, hence the inclusive and respectful use of language in current terminology such as the title of SOC7. Regarding the community's relationship to the provider community, Denny noted, "It's a community in which we look to professionals for help, but not for direction. It's a community that rejects medical models of transsexualism and cross-dressing and the harmful labels that accompany them. And it's a community that has demolished all-or-nothing binary notions of gender and embraced our diversity and wholeness" [53].

Press for Change, an influential activist group (and one of the many to come), was founded in the United Kingdom in 1992. According to its welcome page on the website, Press for Change has been a key lobbying and legal support organi-

zation for trans people in the United Kingdom since its formation (<http://www.pfc.org.uk>) [54].

Bornstein [55] in her iconic book *Gender Outlaw* continued the theme of describing the trans perspective from outside the gender binary.

Google Search was initiated in 1997. The impact of the Internet on the rise of the trans community cannot be overestimated. Originally isolated, members were able to communicate and discuss common concerns and issues, including discussions about nomenclature. Members of the community questioned the terms used and, more tellingly, posed the question, who decides on the name of this condition? Who gives providers this right?

3.6.2 Nomenclature

SOC 5 (1998) – Gender identity disorder

DSM IV (1994) – (Parent) sexual and gender identity disorders, (diagnosis) gender identity disorder in adolescents or adults

ICD-10 (1990) – No change

3.6.3 Summary

This period was the beginning of change toward a more varied approach, marking the use of the term transgender as an umbrella term and the rise of a more vocal trans community.

3.7 1999–2001

Version 6 (2001) – The Standards of Care for Gender Identity Disorders

The SOC continued to use the name gender identity disorder.

3.7.1 Evolution and Literature

The SOC v6 offered more flexibility and more individualized treatment. Given that there was no name change and for other factors that remain unclear, an increasingly unhappy client population did not recognize these changes.

The popularized term transgender was mentioned in this SOC, not as a formal diagnosis but as a term that does not connote psychopathology [56] indicating recognition for providers to shift away from stigmatizing language and the binary paradigm.

3.7.2 Community

An example of the growing voice of the trans community was the 1999 *Reclaiming Genders* by legal scholar and Professor Stephen Whittle BCE who was later to become the first transgender President of WPATH [57].

The increasing vocal community became more critical to providers, using the common complaint that they were required to “jump through hoops” to receive medically necessary services. A growing tension developed between providers and service end users.

Trans academics groups began to form. Movies such as *Boys Don't Cry* (1999) and *Southern Comfort* (2001) portrayed trans people as recipients of horrific treatment: murder by his peers in the former when his identity as a trans man was discovered and murder by neglect from medical professionals in the second, who refused to provide treatment to a trans man with ovarian cancer [58, 59]. These sympathetic portrayals began to bear witness to trans people's plight in the popular imagination.

3.7.3 Nomenclature

SOC – No change

DSM – No change

ICD – No change

3.7.4 Summary

This period was marked by continued flexibility in the SOC, more support in the popular imagination, and continued growth of the community without change in the nomenclature.

3.8 2001–2011

3.8.1 SOC7 (2011)

Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People

This 10-year period marks a major shift in the approach to health care in the SOC and among providers in general, summarized by a change from a focus on treatment to one of overall health and individualized care. In SOC7, the name has been quite consciously changed back to gender dysphoria and the condition is no longer considered a disorder.

The paradigm shifted from a binary to a spectrum.

The rate of evolution moved from linear to exponential concurrent with the continued massive growth of the Internet.

The exponential rate of change can be seen in the following chronology, which is marked by more of an emphasis on human rights. Other concrete examples include the newly named WPATH and the vastly different seventh version of the Standards of Care.

The literature began normalizing the condition with books such as the award winning and compassionate 2004 *Transgender Emergence* by Arlene Lev and the 2004 autobiographical *Becoming a Visible Man* by trans man Jamison Green, who later became WPATH President in 2014 [60, 61]. Although some literature remained focused on disorder such as Bailey's 2003 *Man who would be Queen*, supportive of Blanchard's typology emphasizing the sexual nature of the condition [62], the book was met by a tremendous outcry from the community and other professionals. Although discussion of the latter theory is outside the scope of this chapter, the degree of dissent highlights the power of the voices demanding normalcy as well as the growing power of the transgender movement.

In 2006, the Harry Benjamin International Gender Dysphoria Association's (HBIIGDA) name was changed to the World Professional Association for Transgender Health (WPATH). This change was a major milestone reflecting broader changes

in the field. For example, the inclusive and umbrella term transgender in the title marks an emphasis on multiple trans identities and gender diversity, accentuating the change from a binary to a spectrum paradigm. The term health, as in SOC7, underscores that the field now emphasizes health rather than treatment.

Moreover, while the Standards were being developed, the field was growing internationally.

For example, a group of experts in human rights met in Indonesia and wrote the Yogyakarta Principles (2007) on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity [63]. Although not legally binding, these set of principles were and are intended to apply international human rights law to Sexual Orientation and Gender Identity.

In 2007, Dr. Gail Knudson, current WPATH President-Elect, founded the Canadian Professional Association for Transgender Health (CPATH), modeled after WPATH, but at the national level.

At the 2009 WPATH Oslo Conference, then President Dr. Walter Bockting announced that WPATH's primary goal would be to broaden the focus of transgender health [64].

In 2009, the Council of Europe Commissioner for Human Rights recommended that anything related to gender identity should not be classified as a mental disorder in ICD-11 [65].

In 2010, the WPATH Board of Directors issued a press release and policy statement depathologizing gender variance worldwide. This statement, now known colloquially as the "depath statement" says the following: "The WPATH Board of Directors strongly urges the depsychopathologisation of gender variance worldwide. The expression of gender characteristics, including identities that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon, which should not be judged as inherently pathological or negative" [66].

This statement was shortly followed by the Identity Recognition Statement (2010), emphasizing the human right to self-define. The statement reads as follows: "No person should have to undergo surgery or accept sterilization as a condition of

identity recognition. If a sex marker is required on an identity document, that marker could recognize the person's lived gender, regardless of reproductive capacity. The WPATH Board of Directors urges governments and other authoritative bodies to move to eliminate requirements for identity recognition that require surgical procedures" [67].

Consistent with self-definition, medical clinics with an informed consent model such as Fenway Health in Boston and Callen-Lorde Community Health Center in NYC flourished.

Major changes in SOC7 paralleled and underscored these changes in the field.

For example, the names used in the title are inclusive and respectful of names used by trans people themselves and include transsexual, transgender, and gender-nonconforming people rather than using the term gender identity disorder.

The title is about health, not treatment. The document is evidence based, has multiple authors, and is 115 pages long with 265 references compared to the 1st SOC, for example, that was only 8 pages long, had no references, with input from a small group of professionals, and was written by basically one author. Psychotherapy is no longer a requirement and the new SOC are compatible with informed consent models.

Finally, the 2011 SOC recognize its Western-centric nature and supports global adaptations. It calls for more partnerships outside of Western Europe and North America.

3.8.2 Community

Prior to writing SOC7, the WPATH leadership called upon an international advisory committee comprised of carefully selected leaders from the trans community. One of these, Christine Burns, commented on the improved SOC and implicit improved provider and service end user relationship with the following:

If I had to sum it up then it would be that whereas previous versions of the SOC were always perceived to be about the things that a trans person must do to satisfy clinicians, this version is much more clearly about every aspect

of what clinicians ought to do in order to properly serve their clients. That is a truly radical reversal... one that serves both parties very well [68].

3.8.3 Nomenclature

SOC – Name returns to gender dysphoria.

DSM 5 workgroup is in the process of changing to gender dysphoria.

ICD-11 workgroup is in the process of selecting a name.

3.9 Post SOC7

Since 2011, a tipping point has occurred in trans health and the rate of change is clearly exponential and not linear.

SOC7 has been met with almost universal acclaim. It has been translated into eight languages, with more to come. As a living document, updates will be introduced as knowledge advances. Support for the development of companion documents for resource-poor nations exists. PAHO has developed such a document, the Blueprint for the Provision of Care for Trans Persons and Their Communities in Latin America and the Caribbean PAHO under the leadership of Rafael Mazin, M.D. [69].

Exchange of knowledge has moved from Western to global. The goal of WPATH President Lin Fraser, during this period, has been global expansion and educational exchange. WPATH 2014, the 23rd International Symposium, was held for the first time outside of Western Europe and North America. The conference, entitled Transgender Health from Global Perspectives, convened in Bangkok, Thailand, and was attended by people from 34 countries and 6 continents. Plenaries were held on the following topics, indicating new directions in the field: new research regarding transsexual brain differences; surgical centers outside the West; ICD-11 where diagnostic placement will no longer be in mental health, furthering depathologization models; uterine transplants; and reproductive and hormonal possibilities. Trans thought leaders were invited

and convened a special session series on “Trans People in Asia and the Pacific.”

More partnerships are developing between professionals and providers.

WPATH convened an international gathering of global thought leaders in San Francisco February 2013 to continue its ICD Consensus Process to advise the WHO on ICD-11 and invited trans activists to be part of the process. The PAHO Blueprint was a joint professional/activist process. More trans people are also professionals, who bring added richness and depth to the conversation.

The field is growing at a rapid rate and the demand for education and training is following suit. WPATH has founded a Global Educational Initiative (GEI) to address this huge need to educate providers, policy makers, and other interested parties worldwide. GEI is designed to educate from both a human rights and standard medical education models. The hope is that education will be multimodal, both face2face and via the Internet, and in collaboration with global partners.

3.9.1 Nomenclature

SOC – No change.

DSM 5 2013 – Gender dysphoria.

ICD-11 – The name is undecided but it will not include the term disorder and will not be placed in the mental disorders section.

3.9.2 Summary

This period can be summarized by the exponential growth of the field, perhaps best described by the designation “transgender beyond disorder.”

Conclusion

Finally, although the field has enjoyed remarkable growth, rapid change, and new knowledge, as providers, we might still listen to the wise words of the early pioneers. We can listen to Hamburger in his 1953 report, urging the medical and legal profession to help, to the

brochure at the 1969 first conference calling for the *Need for better understanding, and urgent need for education*, to heeding the topics on the program of 1971 2nd International Gender Identity Symposium in Denmark, *recognizing that this is an interdisciplinary, complex condition and area of human rights*.

The foundational themes, such as compassion and courage are as relevant today as they were 60 years ago.

The subject matter in Green and Money's 1969 epistle and the early conferences echo the plenary topics at the recent Bangkok symposium.

The call for education is as much a crying need today as it was then and needs to be responded via medical education and human rights work.

As from the beginning, much needs to be done, and as interdisciplinary health-care providers partnered with others, we have much to do. The clarion call today is for training and education as we move from transgender beyond disorder to all facets of transgender health.

We could do worse than follow in the footsteps of our forebears.

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