

Health Care System Discriminating and Pathologizing Trans Identified Individuals
Seeking Medical and Mental Health Care Services Related to Gender Identity

Reporting Organization

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Seeking equity, equality, balance and peace in law enforcement.

I. Issue Summary

In the United Nations 1984 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, it explicitly states that ensuring the rights of all societal members is the 'foundation of freedom, justice, and peace in the world' and that these rights are built upon the 'inherent dignity' of all persons.¹ Since the 2011 United Nation's decision that human rights are universal, specifically affirming rights to transgender people, many nations have had to address the systematic abuse, discrimination and violence against trans variant people² in their countries. In a U.N. News Centre report dated December 15, 2011, "Homophobic and transphobic violence has been recorded in every region of the world...and ranges from murder, kidnappings, assaults and rapes to psychological threats and arbitrary deprivations of liberty" often at the hands of "religious extremists, paramilitary groups, neo-Nazis, extreme nationalists and others, as well as family and community violence."³

In the United States, the concerns warranting the most attention related to transgender persons pertain to the harassment and unlawful arrest of transgender people where often they are humiliated at the hands of local police. For example, transgender women are four times more likely to experience police violence compared to all victims of police violence.⁴ Thirty percent of transgender folks who have interacted with the police indicate that they are often disrespected while 22% indicated that they were harassed, physically assaulted, or sexually assaulted by officers.⁵ While confined in prisons and jails, 37% of trans identified people indicated that they were harassed by correctional staff while a sizable

¹ United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984.

² Trans variant individuals represent a multitude of gendered identity expressions, behaviors, presentations and self-identifications. The terms used in this document are used interchangeably can be defined as those individuals who identify and attempt to live in the gender category different from their assigned natal sex. Winter. Sam. 2009. "Cultural Considerations for the World Professional Association for Transgender Health's Standards of Care: background and recommendations." *International Journal of Transgenderism*. 11:19-41.

³ U.N. News Centre. 2011. "UN Issues First Report on Human Rights of Gay and Lesbian People." <http://www.un.org/apps/news/story.asp?NewsID=40743>

⁴ Hate Violence Against Gay, Lesbian, Bisexual, Transgender Queer (LGBTQ) and HIV-Affected in the United States in 2018, National Coalition of Anti-Violence Programs.

⁵ Grant, Jaime, M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: national Center for Transgender Equality and National Gay and Lesbian Task Force.

portion had reported being physically (16%) and sexually (15%) assaulted.⁶ These rates increased slightly for those from impoverished and minority racial backgrounds.⁷ However, while these abuses continue, what gets overlooked is the discrimination and violence experienced by trans variant people seeking health care within U.S. prisons and in free society. Trans people are continually refused treatment and when administered, are often provided with substandard care and limited health insurance coverage.⁸ For example, transgender individuals indicated that they are often harassed in medical settings (28%) or refused care (19%) altogether. Over 50% of trans people stated that their practitioners were uneducated on how to treat them.^{9,10} Such experiences resulted in alcohol and drug abuse to cope with mistreatment (25%) and/or the deferment of seeking medical services (28%).¹¹

Often seen as legitimizing trans identity and providing much-needed medical and mental health care services, the process of administering care by medical and mental health professionals is minimally challenged or critiqued. The two main documents used in the treatment of trans variant individuals in the U.S., the Diagnostic Statistical Manual of Mental Health Disorders (DSM-5) and the World Professional Association of Transgender Health Care's Standards of Care (SOC-7), while viewed by some as an improvement, violates the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment because they continue to needlessly pathologize and discriminate against the transgender community. The most pressing issues include: (1) the lack of formal education and training for providers; (2) lack of institutional support for treating professionals¹²; and (3) the inherent discriminatory and pathologizing effects of the Diagnostic Statistical Manual of Mental Health Disorders (DSM-5), namely the diagnosis of Gender Dysphoria (GD), and the World Professional Association of Transgender Health's Standards of Care (SOC-7). The purpose of this report is to elucidate discriminatory practices experienced by trans variant clients in the course of navigating the U.S. medical and mental health system.

There is a lack of sufficient training and education related to meeting the needs of transgender patients and for this the U.S is in violation of Article 10 of the Convention. With the exception of a few LGBTQ related courses and perhaps short trainings, no formal program exists that teach future medical and therapeutic professionals about the needs of trans identified patients. With little to no available formal training, many providers treat trans identified patients without the necessary skills to respectfully

⁶ *ibid.*

⁷ *ibid.*

⁸ Gay and Lesbian Medical Association, *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*. San Francisco, 2001.

⁹ Grant, Jaime, M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: national Center for Transgender Equality and National Gay and Lesbian Task Force.

¹⁰ Dewey, J. 2008. "Knowledge Legitimacy: How Trans-Patient Behavior Supports and Challenges Current Medical Knowledge." *Qualitative Health Research*. 18(10): 1345-1355.

¹¹ Grant, Jaime, M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: national Center for Transgender Equality and National Gay and Lesbian Task Force.

¹² Dewey, J. 2008. "Knowledge Legitimacy: How Trans-Patient Behavior Supports and Challenges Current Medical Knowledge." *Qualitative Health Research*. 18(10): 1345-1355.

interact with them, much less provide quality care. In many cases, providers refuse to treat altogether. Due to the lack of training, finding educated and experienced practitioners, surgeons, and therapists is challenging. Patient choices regarding their health care is severely limited, forcing patients to endure extreme forms of gatekeeping by professionals willing to treat or seek out services, such as hormones from the internet. Those providers who wish to assist trans variant patients must self-educate or seek out fellow providers for advice. They must rely on a small group of treating providers, often reproducing rather than creating new knowledge and ideas about how to best care for trans people.¹³

In addition to the lack of training, many providers find that their treatment decisions are not generally supported by the public or the institutions that employ them. Fear of liability and losing one's medical license is magnified when the medical facilities that employ these professionals fails to formally support trans related treatments, such as hormones and gender confirming surgeries. The lack of training and institutional support force professionals to provide inadequate care or refuse care, both which lay the foundation for further pathologization and discrimination experienced by trans variant individuals.¹⁴

The DSM-5 and the SOC-7 perpetuate discrimination in the treatment process of trans people because it focuses on patient mental stability, competency, and strict binary gender conformity as required for treatments. All patients who desire treatments must navigate both the therapeutic and medical systems and carefully present themselves as aligned with the above mentioned documents or risk losing the opportunity to access vital medical interventions, which can result in severe mental torture for some patients. With the recent release of the DSM-5 in May 2013, Gender Identity Disorder (GID) was changed to Gender Dysphoria (GD) and was removed from the section on Sexual Dysfunctions and Paraphilic Disorders. This change was to depathologize and destigmatize trans variant individuals by recognizing those who experience dysphoria around their gender while not diagnosing as mentally ill all people who experience gender variance.¹⁵ However, DSM criteria still require that all patients whose current gender identity is contrary to gender assigned at birth will be diagnosed with GD. Moreover, while a diagnosis of GD is no longer formally required by the newest version of the Standards of Care (SOC-7) to access treatments, many doctors still require it to provide treatments such as hormones and gender transitioning surgeries. Although the term 'disorder' has been removed in the new diagnostic term 'gender dysphoria' it still remains in the DSM-5, a manual of mental health disorders, and therefore, is still considered a mental disorder by the American Psychiatric Association. The removal of GD from the section on Sexual Dysfunctions and Paraphilic Disorders, while arguably legitimizing some identities, works to further disparage those labeled with Transvestic Disorder (TD). Delineating these two groups perpetuates that gender and sexuality must be mutually exclusive, valuing 'real' gender identity as disconnected from a sexual self. Moreover, when only two categories are presented, the reality of human variation surrounding gender and sexuality are essentially erased. Finally, while the GD diagnosis carries importance between medical professionals as it is needed to secure medical interventions, it is not useful in accessing insurance coverage. Most insurance companies do not cover any services related to gender dysphoria; therefore, many providers will diagnose patients with anxiety

¹³ *ibid.*

¹⁴ *ibid.*

¹⁵ Drescher, Jack. 2014. "Controversies in Gender Diagnoses." *LGBT Health*. 1(1):10-14.

or depression. Alternative diagnosing may provide the needed coverage, yet it inadvertently conflates gender incongruence with mental illness and further pathologizes individuals. For those few insurance programs that do cover gender-related services, providers find that they must use Gender Identity Disorder, the former and more pathologizing DSM-IV-TR diagnosis that still exists in the International Classification of Diseases (ICD-10).

The SOC-7, a clinical document revised in September 2008, may prove just as regulatory as the former SOC-6. While still indicating that these clinical guidelines can be used fluidly, the SOC-7 retains that they are minimum requirements. The most significant changes to the SOC-7 is that it appears to be less pathologizing in its choice of language and in its removal of therapy as a requirement to access hormones, notably the removal of the strict triadic therapy where patients must live in their chosen gender for three months prior to hormones (Real Life Experience or RLE) and one year before accessing gender confirmation surgery. While long-therapy is no longer required for hormones, it is for other surgical interventions. Moreover, even before the administering of hormones patients must still have persistent gender dysphoria that is well-documented and undergo a psychosocial assessment by a qualified health professional who is 'competent in using the DSM' and has a degree in the clinical behavioral sciences.¹⁶ Therefore, despite SOC-7 revisions, patients must still navigate both the medical and psychiatric health systems and submit to a process of pathologization by being required to engage in a gender assessment by a therapist or physician who feels competent in conducting the assessment.

While providers no longer have to formally diagnose a patient with GD to administer transitioning treatments, they still must decide if patients have the 'capacity to make informed decisions'.¹⁷ While one could argue that informed consent is expected of most, if not all, patient groups, for trans variant patients the ability to be viewed as good decision makers is exponentially burdensome. Being perceived as competent decision makers rely on their ability to appear mentally stable and gender normative. The paradox is that trans variant patients must present as mentally stable while succumbing to a mental health diagnosis. Additionally, they must present as culturally readable 'men' and 'women' prior to accessing the services they want to align their outer appearance with their felt gender. The paradox is that patients must present as mentally healthy and as good decision makers when the assumption presented by the DSM and SOC is that, inherently, they are not. Additionally, through the construction of the letter of recommendation, still required for some surgical interventions and gender confirmation surgery, providers must create a narrative of normality and rationality where a patients' social, physical, psychological, and emotional life is unnecessarily investigated. For example, if a procedure is considered medically necessary then it should not matter if a patient has a supportive family or if they have the ability to recover comfortably, barriers to treatment often discussed with trans patients seeking services. As it stands, the DSM and the SOC are not useful tools for many treating professionals. Moreover, they work to further pathologize trans identities while providing a modicum of legitimacy. Worse, by presenting only two diagnoses, the DSM, in conjunction with the guidelines outlined in the

¹⁶ Loren S. Schechter, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie and Ken Zucker. 2011. "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7." *International Journal of Transgenderism* 13(4):165-232.

¹⁷ *Ibid*

SOC, may work to erase the various gender and sexual identities that actually exist because patients will feel compelled to present in readable ways. Medical and psychiatric guidelines and documents should emerge from the realities that exist, both in how providers treat and the needs of their patients. In this sense, the documents and how they are applied to trans variant individuals forced to navigate the medical and therapeutic system, infringes on trans peoples human rights because it sees them as inherently ill, violating their human dignity and freedom to make informed decisions about their health care. Moreover, the lack of formal training and patient pressure to present contrived presentations to access the care they need reproduces the existing medical knowledge about trans health care, ensuring that they will continually be perceived as inherently mentally ill in need of gatekeeping by medical authorities rather than as equal participants in their own health care.

II. Concluding Observations

In 2006, the Committee Against Torture requested an independent and swift investigation into all ‘reports of brutality and ill-treatment of members of vulnerable groups’.¹⁸ While this report was specifically focused on the experiences of those detained and requested an inquiry into the treatment of marginalized groups at the hands of law-enforcement personnel, it can also be extended to include transgender clients who lack adequate services because they are incarcerated or while they are ‘imprisoned’ when being forced to navigate a health care system that establishes their difference and perpetuates their inequality.

III. U.S. Government Report

In its 2013 Periodic Report to the Committee Against Torture, the United States addresses Article 1 by stating that it does not support psychological torture or ill-treatment and further clarified its position by including the statement that ‘mental pain or suffering refers to prolonged mental harm.’¹⁹ In pursuant with article 10, the Committee asked whether the U.S. educated and trained all law enforcement, military personnel and medical personnel regarding treatment of detainees as well as recognizing when those held within U.S.-run prisons are being tortured or improperly treated. In addition, the Committee inquires whether appropriate methodological tools are applied to evaluate the effectiveness of implementing such education and training. The U.S. responds that at all levels (e.g. FBI, state-level prisons, etc.) proper guidelines for handling detainees are in place, as well as how to report violations of those guidelines. However, specific techniques adopted by each group are not listed. Pertaining to medical personnel, the U.S. indicates that all such persons are trained to recognize and report abuse and ill-treatment at the hands of detaining officers but does not recognize that such torture and ill-treatment can result do to administering or withholding health care *by* medical staff. Not recognizing this possibility obscures the ways the health care system, within or outside prisons, can harm trans identified patients and is in violation of the Detainee Treatment Act of 2005 that states that no individual in the custody or under the physical control of the U.S. government regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment’ and that it is the duty of the healthcare personnel, to ‘protect detainees’ physical and mental health and provide

¹⁸ CAT report: Consideration of Reports Submitted by States Parties Under Article 19 of the Convention.(ochrc.org)

¹⁹ Ibid.

treatment for disease²⁰ The U.S. did not respond to the Committee's request for methodological investigation into the effectiveness of training and educational programs for their personnel.

The proper treatment of women based on marginalized status is stressed further in Article 16, although it does not address transgender men and women specifically. The U.S. indicates that it has taken steps to recognize abuse against women and those reports are 'independently, promptly and thoroughly investigated.' While the U.S. has made some attempts to support women who are abused and hold perpetrators accountable, there is no mention of how trans men or women's experiences with ill-treatment is being addressed. In terms of survey methodology, the U.S. does address updates to its National Crime Victimization survey but this instrument fails to identify abuse, violence and ill-treatment as withholding or providing poor health care and because it is a national random sample, cannot elicit a high enough response rate from trans identified individuals to address their specific problems.

IV. The CAT Committee General Comments

In 2007, the Committee Against Torture's (CAT) General Comment 2, Implementation of Article 2 by States Parties, they present responses to two articles. According to Article 16, State parties are obligated to 'prevent torture and other cruel, inhuman, or degrading treatment or punishment...the obligation to prevent ill-treatment in practice overlaps with and is largely congruent with the obligation to prevent torture'.²¹ According to this document, the Convention also indicates that State Parties are responsible for all acts and omissions of those working within any capacity under the State, one example being the care received within hospitals. The principle of non-discrimination within the CAT report is also pertinent to the experience of trans variant individuals within the health care system in that laws practiced by any State must be applied equally to 'all persons regardless of race, colour, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual orientation, transgender identity, mental or other disability, health status, economic or indigenous status'.²² The Convention stresses the need to recognize and address 'gendered violations of the convention', even as it relates to transgender individuals. Therefore, States are required to identify, evaluate and eradicate discriminatory practices that create gender-specific ill-treatment that can or may evolve into forms of torture.

In addressing Article 14 of the Committee Against Torture's General Comment 3, CAT states that it is the responsibility of State Parties to provide compensation, rehabilitation, restitution, enact legislation and ensure non-repetition to victims of torture or ill-treatment. The most significant one to address in this case is the need for medical and psychological rehabilitation to those who have been harmed. What is not considered is that the harm stems from the application or withholding of medical and psychological services. Therefore, legislation has to consider the ill-treatment and forms of torture that are inherent in the process of providing health care to trans variant individuals. Moreover, the goal of rehabilitation,

²⁰ DoD Instruction 2310.08E (Medical Program Support for Detainee Operations) Section 1.3, issued June 6, 2006- found in the U.S. government report from 2013

²¹ Committee Against Torture, General Comment 2, Implementation of Article 2 by States Parties, Un.n. Doc. CATC/GC/2CRP.1/Rev.4 (2007). http://www1.umn.edu/humanrts/cat/general_comments/cat-gencom2.html

²² *ibid*

and to perhaps health care overall, 'should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society.'²³ State Parties are further required to eliminate future situations of torture and ill-treatment as well as craft 'effective legislative, administrative, judicial, and other measures to prevent acts of torture.'²⁴

V. Other UN Body Recommendations

In 2011, President Obama released a memorandum where he made clear his support of equality for individuals based on sexual orientation and gender. The focus of this report was to address the heads of executive departments and agencies calling for all groups abroad to 'promote and protect the human rights of LGBT persons'²⁵ In his 2013 speech at the National Defense University, President Obama restated that the United States has 'unequivocally banned torture'.²⁶ Two of the seven actions President Obama requires of agencies abroad is that they engage in swift and meaningful responses to the violation of rights of GLBT individuals abroad (Section 4) and that a report be submitted from each agency within 180 days of the memorandum and every year thereafter that report on progress of accomplishing these directives (Section 6). However, there was no mention about the problems pertaining to securing rights for GLBT individuals within our own borders, specifically to how we might eradicate discriminatory practices here in the U.S.

In 2013, the U.N. presented its Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General specifically addressing discriminatory laws, practices and acts of violence against the LGBT community. This report emerged in response to its resolution 17/19, where the Council requested a detailed study documenting various forms of discrimination experienced by people based on their gender identity and sexual orientation. Under the section on health care, the report highlights lack of formal training of providers, lack of insurance coverage and providers' sexist and transphobic attitudes and practices as reasons why trans variant individuals either refuse to seek assistance or are mistreated within medical and mental health system. It is our conclusion based on this information that the concerns presented in the issue summary are of utmost importance to the U.N. and that these problems still exist in the United States.²⁷

According to Article 12(1) of the International Covenant on Economic, Social and Cultural Rights, all 'State parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'²⁸ In addition, in 2011 the U.N. stressed the universality of human rights, specifically recognizing the occurrence of discrimination and acts of

²³ Convention Against Torture and Other Cruel, Inhuman, and Degrading Treatment, General Comment No. 3 of the Committee Against Torture, 2012.

²⁴ Ibid.

²⁵ Presidential Memorandum—International Initiatives to Advance the Human Rights of Lesbian, Gay, Bisexual, and Transgender Persons. <http://www.whitehouse.gov/the-press-office/2011/12/06/presidential-memorandum-international-initiatives-advance-human-rights-l>

²⁶ 2013 U.S. Government Report to the United Nations Committee Against Torture.

²⁷ Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General

²⁸ http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf

violence experienced by gender variant individuals, when it passed its resolution on Sexual Orientation and Gender Identity. The U.N. calls for all nations to respond to the various forms of systemic discriminatory practices against its transgender societal members. Gleaned from these two documents, it is apparent that the U.N. supports that all people, regardless of gender identity, should be able to access and receive the highest standard of health care.

VI. Recommended Questions

What kinds of formal training pertaining to the treatment of trans variant individuals are offered in educational institutions that offer medical and therapeutic degrees and credentialing for medical and mental health providers? Can we provide training for all students in medical schools to ensure they can provide basic care and respect to patients? What kind of training is offered to medical personnel within the prison setting? Who is responsible to evaluate and respond to abuses committed by medical personnel within or outside prison settings?

How do professionals who treat trans identified individuals learn about the Diagnostic Statistical Manual and the Standards of Care as they pertain to trans variant individuals, as well as the continual revisions being made to these documents?

Why is it that Gender Dysphoria appears in the DSM when its use is not useful in securing insurance coverage for mental health or medical treatments and when alternative coding, such as anxiety and depression, must be used to secure mental health care coverage?

How can we provide services to trans variant individuals without pathologizing?

How do we evaluate current practices of medically and therapeutically treating trans variant patients as well as monitor instances of ill-treatment and torture at the hands of the health care system inside and outside prison walls?

VII. Suggested Recommendations

Medical and Educational institutions should support the U.N. and the U.S. formal stance that no one should be discriminated against based on sexual orientation and gender identity. This should appear in their mission statement to protect those providers who currently provide treatment and set precedence that all will be served and respected.

All medical and educational institutions should have some form of training in place that specifically speaks to the needs of trans variant patients/clients and/or encourage/support gender non-conforming individuals to enter medical and psychiatric educational programs.

Remove Gender Dysphoria from the DSM. If people are depressed about their gender, then they can seek therapeutic services and can receive a diagnosis of depression. People are not mentally ill because they experience gender incongruence.

Considerable research needs to be conducted concerning the understanding and applicability of the Standards of Care. To respect human rights, we need to respect trans variant patients that they can make their own decisions. The SOC and how providers apply them conflate mental illness with gender incongruence and values strict gender presentation as fully 'male' or 'female' as the only choices. Forcing patients to present in ways that fit with the existing SOC and DSM documents and forcing them to engage in a pathologizing process violates their human right to quality health care and places an undue burden on them based on their gender identity.