



Reflections on the SOC-7

STP 2012, International Stop Trans Pathologization Campaign

From the coordination team of the International STP 2012 Campaign, we have followed with interest the publication of the new version of the Standards of Care SOC-7¹, presented in the Biennial Symposium of WPATH, World Professional Association for Transgender Health, that was celebrated in September 2011 in Atlanta. During the past few years, trans depathologization activism has focused its attention on the DSM and the ICD, as well as on the SOC revision process, being aware of the important role of these three documents in the health care, legal and social situation of trans persons in different regions of the world.

In reading the new version of the Standards of Care, we can identify both advancements and critical points. In the following text, we will expose some reflections on aspects we have identified in the SOC-7 document, apart from presenting the STP 2012 proposal of a trans health care model based on depathologization, gender diversity and the right to informed decision. We share the following ideas with the goal of opening a space for reflection and discussion about the possibilities for a trans health care centered around trans people's perspective.

1. Advancement Aspects

We observe various advancements in the SOC-7 in comparison with former editions of the Standards of Care², in the sense of a change of direction towards including a depathologization perspective, although in some areas we consider this change to be partial and still in need of completion.

Language Use

We value positively the intention of maintaining a less pathologizing and stigmatizing language throughout the document, as well as the inclusion of an explicit reference of the culturally

¹ WPATH, World Professional Association for Transgender Health (2011). [Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People](#).

² WPATH, World Professional Association for Transgender Health (2005). [Historical Compilation of Standards of Care Version 1-6](#).



specific character of terminology and the importance that the translation is sensible to cultural differences. Nevertheless, this use of a non pathologizing language is not maintained in all chapters, as we will specify below.

Principles of Diversity and Flexibility

Another aspect of advancement is the recognition of a broad range of gender expressions, trajectories and identities, already acknowledged with the inclusion in the title of the terms *“Transgender”* and *“Gender Nonconforming”*. In coherence with this recognition of the plural character of gender transitions, the SOC-7 proposes the substitution of the triadic therapy model, present in the SOC-5 and SOC-6³, for a conceptualization of the Standards of Care as *“Flexible Clinical Guidelines”* (WPATH 2011: 2) and the consideration of a *“variety of therapeutic options”* (WPATH 2011: 9). This change constitutes an adaption of clinical practice to the existence of a broad diversity of trajectories and health care needs for trans persons, and responds to the critique expressed by the trans depathologization movement regarding the presumption of a ‘unique path’ for physical transition. Indeed, the persistence of an assessment model limits this flexibilization of health care routes.

De-Psychopathologization

We evaluate positively the reaffirmation of a previous declaration of the WPATH Board of Directors⁴ that noted that *“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 [that] should not be judged as inherently pathological or negative.”* (WPATH 2011: 4). We highlight that, in the SOC-7, the experience of distress is not conceptualized as inherent to trans identities, but as an effect of social stigmatization processes, in the sense of *“minority stress”* (WPATH 2011: 4). Furthermore, we also believe it is an advancement to consider psychotherapy as an option and not a compulsory requirement for access to trans-specific treatments.

Meanwhile, this push towards a depathologization of trans identities becomes limited by the parallel justification of a continued classification of gender transition as a mental disorder.

³ WPATH, World Professional Association for Transgender Health (s.a.). [Historical Compilation of Standards of Care Version 1-6](#).

⁴ WPATH, World Professional Association for Transgender Health, Board of Directors (2010). [WPATH De-Psychopathologisation Statement](#).



Ethical Aspects

As another important aspect, we would like to point out the explicit references to the unethical character of both a *“treatment aimed at trying to change a person’s gender identity and lived gender expression to become more congruent with sex assigned at birth”* (WPATH 2012: 32) and of the exclusion of access to trans-specific surgeries based on seropositivity.

Recommendation of Public Coverage of Trans Health Care

Being aware of the inequality regarding access to state-funded trans health care in different parts of the world, the SOC-7 includes an explicit recommendation of public coverage of trans health care, the principle of continuity of care and absence of discrimination in access, especially in institutional contexts, such as prisons or residential facilities.

This recommendation coincides with STP 2012’s demand of guaranteeing public coverage for trans health care of the highest attainable quality.

Transcultural Adaptation

Furthermore, we value positively the acknowledgment of the Western character of the SOC. We consider important the explicit reference to the need of adapting the Standards of Care to each specific cultural context and the recognition of a broad cultural diversity regarding gender transitions, social acceptability and health care needs of the people who are transitioning. We hope that these recommendations lead to a flexibility in the application of the SOC or to the development of culturally specific guidelines.

Processes included in Trans Health Care

We consider the reference of trans-specific aspects in other health care processes to be a positive one, including processes such as reproductive health, long-term follow up and preventive care, as options open to those persons who wish to access them.

However, we would like to express our ambivalence towards over-medicalization tendencies of gender transitions. In observing these processes, we would like to stress the importance of continuing to work towards social recognition of diverse bodies, sexualities and gender identities, in order to reduce the weight of social pressure in the decision-making processes regarding any desired body modifications.



Citizenship Rights

Finally, we value positively the recognition of the importance of guaranteeing citizenship rights for the health of trans persons, as well as the WPATH's commitment to the defense of these rights in the context of public policies and legal reforms. We hope that this declaration of interests will be translated into concrete actions for the health care and legal rights of trans people.

2. Critical Aspects

In parallel to these aspects of advancement, we identified various critical points in the SOC-7.

Justification of a Classification of Trans Identities as a Mental Disorder

We observe with concern the justification of a continued classification of gender transition processes as mental disorder. We note a contradiction between the statement, on one hand, of *"Gender Nonconformity"* (WPATH 2011: 5) as not inherently pathological and of distress as a social process, in the sense of a *"minority stress"* (WPATH 2011: 4) and, on the other hand, the adherence to a diagnostic model based on the classification of *"Gender Dysphoria"* as a mental disorder, understood as a *"discomfort or distress"* related to the *"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)"* (WPATH 2011: 5).

From our perspective, access to a high-quality and state-funded trans health care, including optional services of counseling and psychotherapy services for those who require them, should not depend on a mental disorder diagnosis, but be understood as a fundamental health right for trans people. Furthermore, we do not agree with the justification of psychiatric categorization for research reasons.

We consider that mental health diagnosis per se can increase the discrimination that trans people frequently experience in their daily lives, thus fostering the risk of an iatrogenic effect that could raise future health care needs.

Continuation of an External Assessment Model

Another critical point is the continuity of the external assessment model in accessing trans-specific treatments, which becomes present in the compulsory need for referral letters, the requirement of fulfilling the diagnostic criterion of a *"[p]ersistent, well-documented gender*



dysphoria" (WPATH 2011: 34, 59, 60), both for hormonal treatment and for surgical interventions, as well as the requirement of "12 continuous months of living in a gender role that is congruent with their gender identity" (WPATH 2011: 60) in accessing metoidioplasties, phalloplasties and vaginoplasties.

We consider that the external assessment reinforces the gatekeeper role of mental health professionals, restricts trans people's access to trans health care and fails to fulfill principles and recommendations established in international declarations and strategic documents, such as the principle of informed decision on treatments⁵, the recommendation to guarantee trans health care without the requirement of a mental disorder diagnosis⁶ and the recommendation to change the current classification⁷.

- **Referral letters:** We critique the continued requirement of referral letters to access trans-specific treatments. We consider that its compulsory character comes into contradiction with the recognition that "*decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare*" (WPATH 2011: 27).
- **Requirement of "12 continuous months of living in a gender role that is congruent with their gender identity"** (WPATH 2011: 60): Although the term "*real life experience*", present in the SOC-5 and SOC-6 (WPATH 2005: 46, 80)⁸, has been erased, the decision to maintain the requirement of '12 continuous months of living in a gender role congruent with their gender identity' encloses a continued assessment and interference in the privacy of trans individuals, giving mental health professionals the power to decide on the adherence to established diagnostic criteria of the physical appearances and gender presentations of trans people. Additionally, the requirement does not take into consideration the social, family and labor circumstances of trans people that, on some occasions, can hinder a public life in the chosen gender role. We are concerned that the justification of maintaining this requirement is only based on professional consensus, without taking into account the perspective and experience of trans persons.

⁵ [Yogyakarta Principles](#) (2007); United Nations, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2009). [Report to the General Assembly \(Main focus: right to health and informed consent\)](#).

⁶ Council of Europe Commissioner for Human Rights Thomas Hammarberg (2009). Issue Paper "[Human Rights and Gender Identity](#)"; Council of Europe (2011). "[Discrimination on grounds of Sexual Orientation and Gender Identity](#)".

⁷ Council of Europe Commissioner for Human Rights Thomas Hammarberg (2011)-Human Rights Comment "[Clear laws needed to protect trans people from discrimination and hatred](#)"; European Parliament (2011). "[European Parliament resolution of 28 September 2011 on human rights, sexual orientation and gender identity at the United Nations](#)".

⁸ WPATH, World Professional Association for Transgender Health (2005). [Historical Compilation of Standards of Care Version 1-6](#).



- **Requirement of gender dysphoria:** We consider that the requirement of a “[P]ersistent, well document gender dysphoria”, (WPATH 2011: 34, 59, 60) in order to access trans-specific hormone treatment and surgical interventions limits accessibility for trans people who desire to modify their bodies without feeling “discomfort or distress” (WPATH 2011: 5) and forces the adaptation of the personal experience to a preestablished medical narrative.
- **Requirement of hormone therapy to access genital surgery:** We consider that the requirement of 12 months of hormonal therapy in order to access genital surgery limits individualized care and the recognition of a broad range of trajectories and health care needs.

Limitation of the Informed Consent and Harm Reduction Models

The SOC-7 makes references to informed consent and harm reduction models present in clinical practice, while specifying that, unlike an informed consent model, the SOC-7 “puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment” (WPATH 2011: 36).

At the same time, “[c]apacity to make a fully informed decision and to consent for treatment” (WPATH 2011: 34, 59, 60) constitutes one of the requirements in the access to trans-specific hormone therapy and surgeries. We observe that this application of informed consent is reduced to making the trans person responsible for knowing the risks of treatment and signing the form, as opposed to an understanding of the concepts of ‘informed consent’ and ‘informed decision’ as a continued process of information, optional counseling and professional accompaniment in the decision process. Similarly, the recommendation of a harm reduction approach is limited to situations of a lack of resources or personal / social circumstances of the person seeking care.

Role of Mental Health Professionals

We observe, with concern, the maintenance and reinforcement of the role of mental health professionals in the SOC-7, as well as the prioritization of assessment over counseling. As may be observed in the list of tasks assigned to mental health professionals, assessment is located in first place, in contrast to the less prevalent reference of the professional role as one of providing information, counseling and accompaniment.



In addition, there is no mention of potential conflicts inherent in the double role of assessment and counseling, in the case that these are both carried out by the same professional, even though this situation could make it difficult or impossible for the trans person to express doubts or questions about the process due to fear of risking access to the desired treatments. It is only in those cases in which no mental health care professionals are available due to a lack of health resources, that their substitution by other health care professionals is accepted.

Binary Aspects in the Description of Gender Transition Processes in Childhood

In the section dedicated to treatment of children and adolescents, we observe a phenomenological description based on a binary model (preference for *“clothes, toys and games that are commonly associated with the other sex”* (WPATH 2011: 12), as well as a focus on experiences of discomfort and anxiety. This description differs from the subsequent recommendations of a trans health care based on the principle of non-discrimination and recognition of the gender nonconformity expressed by children and adolescents, and also differs from the recognition of a diversity of gender expressions and identities in other parts of the document.

Pathologizing Approach in the Chapter about Intersexuality

In the Chapter about trans health care addressing people with a parallel diagnosis related to intersexuality who wish to engage in a gender transition process and trans-related body modifications, we are concerned about the clearly pathologizing approach and language that is used and, therefore, abandons the intention of a non-discriminatory language present in the other parts of the document. Furthermore, we denounce the absence of a statement condemning the current clinical practice of genital mutilation and other normalizing and non consensual treatments of intersex newborns, children and adolescents.

The Western Character of the Document

We would like to call attention to another critical point, which is the continued ethnocentric bias in the document, based on the perspective of professionals mostly from the North American and European context. An example for this is the limitation of the description of informed consent models to health centers in the US context. The awareness of this bias expressed in the document, as mentioned above, opens up the hope that this tendency will be changed in the next revision process.



Lack of Participation Opportunities in the SOC Revision Process

Although the participation of trans activists is highlighted in the SOC revision process, we observed, in practice, a lack of participation opportunities for the trans movement.

3. STP 2012 Proposals

As a conclusion of these reflections on the SOC-7, we would like to add some basic principles of the trans health care model that we propose, the implementation of which we will continue working on.

We propose a trans health care model based on:

- An **informed decision** approach, in which informed consent is not understood as limited to signing a consent form, but is conceptualized as a continued process of optional information, accompaniment and counseling, adequate to the needs of the trans person seeking care.
- The **abolition of the external assessment process** in the access to trans-specific treatments, of the requirement of '12 continuous months of living in a gender role congruent with their gender identity', as well as the requirement of hormonal therapy to access genital surgery.
- The recognition of a **broad range of gender expressions, trajectories and identities, as well as health care needs**, reaffirming the importance of individualized health care based on the respect for diverse bodies, sexualities and gender identities.
- The awareness of a **cultural diversity** of gender expressions and identities, as well as community and health care models worldwide. We consider important to include perspectives proceeding from different parts of the world, including indigenous knowledge and non-western cultural perspectives, in the process of elaborating standards of care or guidelines.
- **Active participation** of trans people in the process of elaboration of standards of care or guidelines, with the goal of developing documents based on the perspectives, experiences and needs of trans people.
- The **recognition of the health rights of intersex persons**. We demand the abolition of the current clinical practice of genital mutilation and other normalizing and non consensual interventions carried out on intersex newborns, children and adolescents, and we claim the right to accessing trans health care for persons with a



parallel diagnosis related to intersexuality who wish to engage in gender transition processes and trans-specific body modifications.

- The **right to access state-funded trans health care of the highest attainable quality** without the need for a mental disorder diagnosis, for those trans persons who wish to access trans-specific treatments.
- A continued work for a broader **social recognition of diverse bodies, sexualities and gender identities.**

Being aware that the current Standards of Care SOC-7 are still partially distant from a model of trans health care based on a depathologization and informed decision perspective, we would like to highlight the proposal of cultural adaptation named in the SOC-7. We encourage trans activists and health professionals to carry out participative processes to elaborate principles for trans health care adapted to their specific cultural contexts that are based on the trans people's framework, on the principle of informed decision and on a depathologization perspective.

Finally, we would like to announce that the upcoming **International Day of Action for Trans Depathologization** will take place on Saturday, **October 20th, 2012**. As in previous years, we invite activist groups and organizations worldwide to organize demonstrations and other actions in support of trans depathologization within the framework of this day of international mobilization.

Coordination Team of STP 2012, International Stop Trans Pathologization Campaign, July 2012.

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