

## **Democratising diagnoses?: The role of the depathologisation perspective in constructing corporeal trans citizenship**

### **Abstract**

In the scope of the current revision process of the diagnostic manuals *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and *International Statistical Classification of Diseases and Other Health Problems (ICD)*, an international trans depathologisation movement has emerged that demands, among other claims, the removal of a diagnostic classification of gender transition processes as a mental disorder. The call for submissions launched by the American Psychiatric Association (APA) and World Health Organisation (WHO) seems to provide the opportunity for a participation of civil society in the DSM and ICD revision processes. These developments open up a number of questions for us that will be discussed in this article. We conducted a meta-narrative review to explore the trans depathologisation movement's contribution to the DSM and ICD revision process, uncover evidence of a 'democratised turn' in the process and review depathologisation proposals implemented in trans healthcare practices, human rights frameworks and legal gender recognition processes. We argue that the trans depathologisation movement has had little impact on medical practices in trans healthcare. However, there is some movement in local health services towards an informed consent model for limited healthcare interventions. Within some European and South / Central American legal frameworks, the depathologisation movement's demands to free legal gender recognition from medical interventions and examinations have, in different degrees, been incorporated into legal recommendations and enacted in some recent gender recognition laws.

## **Introduction**

The revision processes of the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) and the *International Statistical Classification of Diseases and Related Health Problems Volume 10* (ICD-10) generated a broad public debate regarding trans-related diagnostic categories between academics, clinicians, and activists. The DSM is a diagnostic manual of mental disorders published and updated periodically by the American Psychiatric Association (APA). In spite of being developed for the US context, the DSM is known to be applied in a range of countries worldwide. Developed by the World Health Organization (WHO) and approved by the World Health Assembly, the ICD is an international diagnostic classification system applied worldwide for diagnostic and statistical purposes, as well as for regulating reimbursements. It includes both ‘mental disorders’ and physiological diseases alongside providing numerous codes related to other healthcare procedures for registering them on clinical records. Gender transition processes have been included as mental disorders in the ICD since 1975 and in the DSM since 1980. In many countries, the connection between medicine and civil status has historically been mandated in the process of legal gender recognition for trans people, by means of requiring a trans-specific diagnosis and other medical requirements (Monro and van der Ros, Monro et al., in this issue).

Over the last few years, a trans depathologisation movement has emerged with active participation of international and regional trans activism networks and groups (Suess Schwend, 2016). Trans depathologisation activism demands the de(psycho)pathologisation and removal of gender transitions as a mental disorder from both the DSM and ICD. However, the demand for depathologisation has raised concerns regarding state-funded access to healthcare, both from within the trans community and from health professionals. Therefore, the trans depathologisation

movement is petitioning to attain state-funded transitioning healthcare within a human rights framework. Another request is a change in the trans healthcare model, from the current psychiatric assessment model to an informed consent approach. A further demand is the freeing of legal gender recognition from both medical interventions and diagnostic requirements. The depathologisation of gender diversity in childhood is also an important demand from the movement.

The depathologisation perspective draws on a human rights framework established in the Yogyakarta Principles, which are based on the application of international human rights law in relation to sexual orientation and gender identity and were developed in 2006 by an international group of experts and presented in 2007 in the UN Human Rights Council (O’Flaherty, 2015). The rights to human dignity, self-determination, bodily integrity and protection from medical abuse has achieved significant importance in the demands for the depathologisation movement and in the process of challenging the power that medical professionals hold in the distribution of citizenship rights (Suess Schwend, 2016).

The APA and WHO, in the case of the DSM and ICD respectively, said that they would include contributions not traditionally considered during the revision processes. These gestures of including research and opinions from medical stakeholders, members of trans communities and political advocacy groups seems to be a novel method of creating diagnoses for trans people (Davy, 2015b; Platero, 2011; Suess Schwend, 2016). Internal workgroups from the APA and WHO were tasked with developing diagnoses that reflect trans people’s medical, economic and social lives. The APA working groups were established in 2008 and operated for six years (APA, 2013), while the WHO working groups were active from 2007 for nine years (WHO, 2017a).

The workgroups collected and exploited the evidence that they gathered in different ways. These developments opened up a number of questions for us:

1. What were the contributions and responses to the DSM and ICD revision process from the trans depathologisation movement?
2. If and to what degree has the process of creating trans-related diagnoses in the DSM and ICD taken a democratised turn?
3. To what extent have the depathologisation movement's proposals been incorporated into standards of care and trans healthcare policies?
4. In what ways have human rights frameworks and legal gender recognition been impacted by depathologisation discourses?

### **Methodological approach**

We conducted a meta-narrative review (Gough et al., 2012), which explored the depathologisation debate and potential impact on medico-legal and policy contexts for trans people. We synthesised the findings and conclusions from existing policy documents, commentaries and declarations from academic, medical, legal and activist bodies to address the research questions (above). Because the conclusions and commentaries vary within different research paradigms, have political leanings and function within structural parameters ontologically, epistemologically, theoretically and ideologically (Gough et al., 2012), a meta-narrative review was chosen to analyse the ways in which the debate about creating new trans diagnoses and medicolegal policies was understood and positionally argued from. The first analytical stage developed a disciplinary framework, upon which the authors agreed. The literature was assigned a 'disciplinary label' from the following: trans depathologisation movement and allies, medical responses, international and regional human rights discourses and

domestic legal responses. From this, we developed an analysis that mapped, then reviewed the claims and declarations made by the trans depathologisation movement and its academic and medical allies and sought to analyse the inclusion of the depathologisation perspective in medical and health policy documents, and legal statutes. We did this, by drawing out if and where trans depathologisation contributions and responses were included in the published DSM-5 and in the ICD-11 Beta Draft, and in declarations about health service provision, international and regional human rights documents and legal statutes in a number of countries. The importance of garnering an understanding of the impact was to highlight the trans depathologisation movement's social and paradigmatic influence within the DSM and ICD revision processes, the international and regional human rights framework and medico-legal legislation in a number of countries worldwide.

We reviewed 157 documents published between 2009 and 2016 by local, regional and international activist groups and networks, among them 74 issued by regional and international activist groups and networks. Furthermore, we reviewed the following documents issued between 2009 and 2016: a selection of 150 concluding observations from UN treaty bodies, 12 resolutions from the Council of Europe Parliamentary Assembly, one issue paper from the Commissioner for Human Rights and one recommendation from the Committee of Ministers. Further, we reviewed trans people's access to legal gender recognition in 17 countries by identifying national laws that either were passed or amended between 2009 and 2016 that have clear conditions for legal gender recognition, and that do not precondition one or more of the following requirements: a trans-related diagnosis, hormone therapy and/or surgical interventions. Of these, we chose a sample of 10 national laws.

We start our analysis with a short contextualisation of the appearance of diagnoses in the DSM and ICD and the power that psychiatrists hold in relation to medical and healthcare for trans people. This provides the context in which the trans depathologisation movement has arisen. We will then look at some of the transformations in policy towards patient-centred medicine, which the movement is drawing on to challenge the pathologisation of trans people. We analyse the degree to which the demands of the trans depathologisation movement were considered in the DSM-5, in the ICD-11 Beta Draft, in international and regional human rights documents and in the legal statutes considered in this article. As a caveat, we are not testing the ways that the demands and declarations are utilised by health practitioners or how they impact those people the DSM and ICD diagnostic classifications and legal statutes (will) affect, although these would be worthwhile future projects. We are providing descriptions of claims in the debate to demonstrate the use of trans depathologisation demands and declarations in institutional documents. Particularly we provide an analysis of the published discourses emerging during the revision of trans-related categories in the DSM and ICD from academic and activist perspectives. We will also explore the participation in the revision process. Furthermore, we will illustrate the level of trans depathologisation frameworks introduced in the standards of care and trans healthcare practices. To end the article we will describe the human rights discourse underpinning legal gender recognition and examine the role that trans-related diagnoses play in law in a number of countries.

### **Politics of psychiatric diagnoses**

Prior to the 1960s, some early clinicians from private, non-academic gender clinics provided trans people transitioning surgery on demand and justified it on grounds of correcting what they

considered (intersex) ‘anomalies’ (Stone, 1991). In the 1960s, clinicians began to refuse surgery on demand, because of the professional risks of performing experimental medicine. Clinicians started to develop criteria for approval onto gender identity programs (e.g. Benjamin, 1966). The diagnosis of transsexualism as a psychiatric ‘disorder’ appeared in the ICD-9 in 1975 (WHO, 1975) and in the DSM-III in 1980 (APA, 1980). There have been a number of diagnostic changes relating to trans people’s gender identity issues since. Any changes in trans diagnoses have been developed by workgroups consisting of psychiatrists and sexologists appointed by the APA and WHO. Clinicians and researchers have previously said that the diagnostic changes have occurred because of advances in both science and culture (Levine and Solomon, 2008). While we do not have the space to consider the nuances of what psychiatric diagnoses endorse for trans people, we observe that, with the exception of a few recent changes in some countries, a psychiatric diagnosis is a prerequisite for major citizenship and healthcare rights for many trans people.

Jutel (2011) argues that diagnosis changes the practice of medicine from a purely biomedical process to a medico-social practice with intersecting social, political, technological, cultural and economic forces. According to Frank (2016), however, the diagnosis must not support any secondary gains, which is not always the case with psychiatric approaches to trans people. Secondary gains for trans people are varied, including providing referrals to surgeons for surgery, or providing evidence for amendments to the civil status of a patient’s gender. In this sense, psychiatric diagnostics are personal-political-economic matters that masquerade as medical measures (Szasz, 2009).

Some recent research about psychiatric practices addresses the justice and equality issues inherent in some psychiatric practices (Kallert, 2008; Lidz et al., 2000). Psychiatry relies on ‘talking’ and pharmacological strategies that coerce people into acting in line with the attendant

psychiatrist's standards of behaviour, while advocating what is 'normal' and 'abnormal' conduct. Trans depathologisation discourses, together with anti-psychiatric perspectives, have started to discuss how psychiatric diagnosis can be coercive, even in the face of widespread health policies shifting towards patient-centred medicine.

### **Patient-centred health policy**

Major transformations in policy towards patient-centred medicine<sup>1</sup> from the late 1960s (Balint, 1969) and changes in approaches from physicians and psychiatrists has resulted in a debate about the importance of people being at the forefront of their own healthcare. Health policy in Europe over the last ten years has acknowledged research demonstrating the benefits of shared decision-making, and promotion of individual and collective patient rights as dominant values and goals (Newdick and Derrett, 2006). Some research shows great gains in health outcomes and the benefits of patient-centred healthcare provision (Mead and Bower, 2000; Saha et al., 2008). However, there has been some research that shows attempts to negotiate shared decision making is sometimes fraught with difficulties from both patients' (Frosch et al., 2012) and practitioners' perspectives (Caldon et al., 2010).

The introduction of an informed consent model for hormone therapy in the USA has been welcomed by many trans people and health service providers (Deutsch, 2012). Informed consent healthcare for trans people has not been widespread, and rarely extends to surgical interventions, if so desired. As such, the ways that trans people are treated, within healthcare policies and clinics, continue to be sites of activist and lay negotiations and much political, cultural, legal and scientific wrangling (Davy, 2015b; Drescher, 2013; Drescher et al., 2012; Platero, 2011, Van der Ros, 2013).

## **Trans depathologisation movement**

Critical challenges by trans people about their healthcare have often evolved through health social movements (HSM). HSMs engage in generating research of their own, democratising the production of scientific knowledge. This research variably helps to shape health policies and influence treatments and protocols (Brown and Zavestoski, 2004). For instance, the entwined trans diagnoses, governance and citizenship rights mechanisms in social policy and legal statutes have received some international scrutiny (Cabral and Viturro, 2006; Spade, 2003; Stone, 1991; Suess Schwend, 2016; Whittle, 2002; Wilchins, 1997). Trans depathologisation discourses have emerged from Africa (Gunguluza, 2012), Asia (Winter, 2009; Winter et al., 2009), Latin America (Adrián, 2013; Cabral, 2010, 2014), North America (Winters, 2006, 2008, 2013) and Europe (Davy, 2011; Meyer-Bahlburg, 2010; Richardson and Monro, 2012; Suess Schwend, 2016).

Contemporary trans HSMs are divided in the ways that they should tackle policy and access to healthcare. The analysis of activist campaigns over the last few years, however, shows an increasing consensus about the removal of psychiatric diagnoses while preserving access to healthcare (Suess Schwend, 2016). Nonetheless, according to Meyer-Bahlburg (2010), Franklin Romeo of the Sylvia Rivera Law Project in New York has suggested that a DSM diagnosis is crucial in court proceedings concerning access to insurance-facilitated healthcare in the USA where public health care is scarce. In Romeo's view (Meyer-Bahlburg, 2010), the removal of trans diagnoses would be disastrous for US trans people. Nevertheless, the Argentinian Gender Identity Law, enacted in 2012 (see below) provides the right to legal gender recognition without medical requirements while establishing the right to state-funded trans healthcare within an

informed consent model. The Argentinian law now sets a reference point for the development of other national legal frameworks and health policies that many trans activists cite as encompassing their rights for human dignity, bodily integrity and self-determination.

International trans depathologisation activism has continued to emerge, achieving a broad dissemination of their praxes in different world regions. Since 2009, STP, International Campaign Stop Trans Pathologization launches each year a Call to Action for the International Day of Action for Trans Depathologization. On this day and throughout the month of October, activist groups, organisations and networks from different world regions organise activities advocating for trans depathologisation. In October 2016, more than 120 activities took place in 47 cities worldwide. Furthermore, by June 2017 STP received endorsements from 412 activist groups and networks, public institutions and political organisations in Africa, Asia, Europe (including Western and Eastern Europe), Latin America, North America and Oceania. The main demands of STP are the removal of the mental disorder classification of gender transitioning processes from the DSM and ICD, the right to the provision of state-funded trans healthcare, changes to existing trans healthcare models, legal gender recognition without medical requirements, depathologisation of gender diversity in childhood, and protection against discrimination and transphobia. In order to facilitate state-funded trans healthcare provision, STP proposes: 1. The elaboration of a human rights-based framework for trans healthcare, 2. The introduction of a non-pathologising code in the ICD, as a health process not based on disorder or disease, and 3. The elaboration of context-specific strategies (Suess Schwend, 2016).<sup>2</sup>

International activist networks have published declarations supporting the demand for trans depsychopathologisation<sup>3</sup> and many local activist groups have launched similar declarations (Suess Schwend, 2016). Trans academics, many of whom are activists, have

recently contributed to the debate about trans depathologisation (Cabral, 2010, 2014; Davy, 2015b; Gunguluza, 2012; Missé and Coll-Planas, 2010a, 2010b; Platero, 2014; Suess, 2010; Suess Schwend, 2016; Suess et al., 2014; Thomas et al., 2013; Winter, 2014, 2015; Winter et al., 2009; Winters, 2008, 2013, 2014). This debate has built on trans activism that emerged a few decades ago (e.g. Burns, 2005; Spade, 2003; Stone, 1991; Stryker, 1994; Wilchins, 1997; Wilson, 1997, 2010; Winters, 2006; for activist actions see Suess Schwend, 2016). Apart from publishing declarations, activist groups and networks participated in the Call for Proposals launched by the APA by sending reviews of the trans-related diagnostic categories published on the *DSM-5 Draft* website, including proposals for their reform or removal. After the publication of the DSM-5 (APA, 2013), STP criticised the continued classifications *Gender Dysphoria in Adolescents and Adults*, *Gender Dysphoria in Children* and *Transvestic Disorder* (APA, 2013), demanding the complete removal of trans-related categories from DSM-5.

In 2011, the WHO called for proposals on the revision process of trans-related categories in the ICD (Drescher et al., 2012). Among the received proposals, listed in Drescher et al. (2012) was a report developed by Global Action for Trans Equality (GATE), which summarises the results of an International Expert Meeting that congregated in The Hague in November 2011. In the meeting, a proposal for non-pathologising trans-related codes in ICD-11 were elaborated on, in order to facilitate access to state-funded trans healthcare. In 2013, GATE organised a second meeting in Buenos Aires, and focused on developing arguments for the removal of the diagnostic classification of gender diversity in childhood from the ICD. Furthermore, the meeting produced an alternative proposal for the ICD-11 based on codes listed in ICD-10 Chapter XXI, *Factors influencing health status and contact with health services*, with the aim of facilitating access to psychosocial support for those gender diverse children and their families who require it.

Over the last two years, several international and regional trans activist networks have published statements demanding the removal of a diagnostic classification of gender diversity in childhood. By June 2017, 231 health professionals and researchers from different world regions signed a statement supporting this demand (Winter et al., 2016). Trans authors and allies have questioned the maintenance of diagnostic categories for pre-adolescent children (Adams, 2014; Cabral, et al. 2016; Suess Schwend, 2016, 2017; Winter, 2014, 2015; Winter, Diamond, et al. 2016; Winter, Ehrensaft, et al. 2016; Winter, Riley, et al. 2016; Winters, 2013, 2014). This questioning is based on earlier critiques of the diagnostic classification of gender diversity in childhood (Bartlett et al., 2000; Langer and Martin, 2004). Furthermore, several activist groups and networks have demanded the publication of the WHO workgroup proposal so that trans activists can make a formal critique of it.

After the proposal of the Working Group on the Classification of Sexual Disorders and Sexual Health being published in the ICD-11 Beta Draft in August 2014 (WHO, 2017b), several activist networks launched press releases, praising the removal of trans related categories from the chapter ‘Mental and Behavioural Disorders’. The networks also agreed with the inclusion of a trans-specific category for adolescents and adults in the proposed chapter ‘Conditions related to sexual health’ (WHO, 2017b), while criticising the continued classification of gender diversity in childhood and the concept ‘gender incongruence’.

Trans depathologisation activism has also demanded a change in healthcare provision by suggesting replacing any system using psychiatric assessments as a precursor to the provision of hormone treatments and trans-related surgeries with an informed consent approach. The informed consent model focuses on information and counselling and recognises trans people’s right to bodily autonomy and informed decision making (Suess Schwend, 2016). During the

revision process of the sixth version of the *Standards of Care* (SOC-6 – HBGIDA, 2001) by the Harry Benjamin International Gender Dysphoria Association (now WPATH, World Professional Association for Transgender Health), activist groups and networks worldwide provided alternative proposals, based on a depathologisation framework, taking into account some culturally specific aspects of trans people's lives. After the publication of SOC-7 in 2012 (WPATH, 2012), several activist networks published their reviews of the new edition. The networks acknowledged that there had been some improvements: the conceptualisation of gender transitions as non-pathological, the use of non-discriminatory language, the inclusion of a broad diversity of gender expressions, transitioning trajectories and gender identities, the need for flexibility in trans healthcare pathways, the explicit condemnation of reparative therapies and the recognition of the cultural diversity of trans people. Simultaneously, the activist networks criticised the use of a pathologising diagnostic framework, the continuation of an assessment model, including the requirement of '12 continuous months of living in a gender role that is congruent with [trans people's] gender identity' (WPATH, 2012: 60, 106), and the pathologising terminology used in the chapter on intersex.

In relation to legal gender recognition, the trans depathologisation movement demands that future gender identity laws be without medical requirements and restrictions related to the civil status, such as having to be divorced if married, age or nationality. Furthermore, they insist that governments remove such requirements from existing gender identity laws (Suess Schwend, 2016). Trans depathologisation activists consider that the compulsory legal requirements of diagnosis, hormone treatment, sterilisation, genital surgery or divorce constitute human rights violations and are an obstruction to the right to bodily integrity and right to a family life. Moreover, they highlight that medical requirements are contrary to the rights established in the

Universal Declaration of Human Rights, and Yogyakarta Principles. Trans depathologisation activist groups and networks have celebrated the Argentinian Gender Identity Law and legal gender recognition advancements, such as the approval of gender identity laws without medical requirements in Denmark, Malta, Colombia, México D.F., Ireland and Norway, the removal of the sterilisation requirement in Sweden, as well as other law proposals, such as in Chile. Simultaneously, activists continue to denounce any legal criminalisation and persecution, social and labour exclusion and transphobic violence. This leads us to a discussion about the level of impact that depathologisation discourses have had within the human rights framework and legal gender recognition processes.

### **Depathologisation as a human rights issue**

The rights of trans people regarding legal gender recognition and access to trans healthcare have gathered momentum under the case law of the European Court of Human Rights (ECtHR) based on the court's interpretation of article 8 of the European Convention on Human Rights (ECHR), which ensures the right to respect for a private life (*Christine Goodwin v. the United Kingdom; van Kück v. Germany*). Pathologisation of transsexuality has had limited discussion against the backdrop of international human rights law. Yet, depathologisation can be addressed under article 8 detailing the right to a private life in the ECHR and in article 17 of the International Covenant on Civil and Political Rights. Gender identity is one of the most intimate aspects of a person's life, which falls within the ambit of article 8 (Goodwin). Article 8 protects the right to personal development, to establish details of one's identity, and the physical and psychological integrity of a person (Goodwin; van Kück). To be labelled as mentally ill encroaches on the integrity of people and cannot be justified under article 8 (2). Depathologisation falls also under

the right to health (article 12) and non-discrimination (article 2(2)) under the International Covenant on Economic, Social and Cultural Rights (ICESCR), particularly because of the stigma attached to pathologisation and how being labelled as mentally ill affects the health of trans people (Theilen, 2014). The pathologising of trans people and not cis people cannot be justified, according to Theilen (2014), and amounts to discrimination. An increased body of soft law supports these views, such as the Yogyakarta Principles.

The Yogyakarta Principles are not legally binding, but the Principles have attained wide international recognition as ‘an important tool in identifying the obligations of states to respect, protect and fulfil the human rights of all persons, regardless of their sexual orientation or gender identity’ (Hammarberg cited in O’Flaherty, 2015: 291). Of interest to this article, is Principle 18, which declares:

Notwithstanding any classifications to the contrary, a person’s sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed.

When addressing medical requirements for legal gender recognition, human rights mechanisms are increasingly pursuing this view, as well as urging states to abolish trans-related diagnosis as a precondition for legal gender recognition and to ensure access to trans-specific healthcare without requiring a mental illness in line with the demands of the depathologisation movement. For example, in its 2011 Concluding Observation to Germany, the UN Committee on Economic, Social and Cultural Rights stated:

The Committee notes with concern that transsexual and inter-sexed persons are often assimilated to persons with mental illness and that the state party’s policies, legislative or

otherwise, have led to discrimination against these persons as well as to violations of their sexual and reproductive health rights (arts. 12, 2.2).

Yet, in the 150 concluding observations reviewed, UN treaty bodies only address medical requirements for legal gender recognition and/or access to trans-specific healthcare in four of the concluding observations. Sexual orientation and/or gender identity are mentioned in 63 concluding observations, and particularly in relation to protection against discrimination.

In 2009, in the Issue Paper *Human Rights and Gender Identity*, the former Council of Europe Commissioner for Human Rights Thomas Hammarberg (2009: 25) emphasised that ‘[f]rom a human rights and healthcare perspective no mental disorder needs to be diagnosed in order to give access to treatment for a condition in need of medical care.’ Further, in five out of 12 Council of Europe Parliamentary Assembly (PACE) resolutions that include trans people or gender identity, explicit reference to medical requirements for legal gender recognition and access to trans-specific healthcare was made. In 2015, for example, PACE expressed its concern about the human rights violations trans people face when seeking legal gender recognition that requires inter alia sterilisation and a diagnosis of mental illness. PACE (2015) and the Council of Europe Committee of Ministers (2010) call on European member states to abolish sterilisation, compulsory medical treatments and a mental health diagnosis to gain legal gender recognition, while ensuring access to and reimbursement by public health insurance schemes for gender reassignment procedures. While human rights mechanisms have primarily been focusing on sterilisation, depathologisation and access to state-funded healthcare are increasingly gaining attention as a human rights issue.

## **National law reforms on legal gender recognition**

The demands of the depathologisation movement to 1) free legal gender recognition from medical interventions, such as genital surgery or sterilisation, 2) to detach legal gender recognition from any medical requirements, including surgical interventions, medical examinations and diagnoses, and 3) to ensure state-funded transitioning healthcare will facilitate a complete distinction between medicine and legal gender recognition. Recent national legal gender recognition laws have responded to these demands in varying ways.

Before the establishment of an international depathologisation movement, local groups worked actively in freeing legal gender recognition from medical requirements. As a result, in the UK (2004) and Spain (2007) laws were enacted that did not require surgical interventions. However, the British Gender Recognition Act requires a diagnosis of either gender dysphoria or evidence of surgical interventions, whereas the Spanish gender identity law requires gender dysphoria and two years of medical treatment, usually hormone treatment. From 2009 to 2016, national legislative bodies in different countries enacted laws that freed legal gender recognition from more medical requirements.

The depathologisation movement demands that legal gender recognition shall be detached from medical interventions. The 2011 Portuguese gender identity law requires the applicant to be diagnosed with gender identity disorder and be over 18 years (article 2). A diagnosis must appear in a report prepared by a multidisciplinary clinical sexology team (article 3 (1) b). The registrar shall decide on the request for change of legal gender within eight days (article 4). Contrary to the Swedish act (see below), the act explicitly requires the diagnosis of gender dysphoria.

In 2013, the 1972 Swedish Act legally recognising trans people was amended and the infertility/sterilisation requirement repealed. Contrary to the acts mentioned above, the

requirement of a diagnosis or medical examination follows from an interpretation of the wording of the law, which shows similarities with the definition of the diagnosis of gender dysphoria (SOU 2014: 91, para 7.9.1) and from medical recommendations. Common for these laws is that they comply with the demand of freeing legal gender recognition from requirements of sterilisation or infertility. However, legal gender recognition requires medical examinations or a diagnosis.

Contrary to the laws mentioned above, the Argentine Gender Identity Act (2012), the Danish Act on the Civil Registration System (as amended 2014), the Maltese Gender Identity, Gender Expression, and Sex Characteristics Act (2015), the Columbian Gender Recognition Act (2015), the Civil Code of Mexico City (as amended 2015), the Irish Gender Recognition Act (2015), the French Gender Identity Act (2016), and the Norwegian Act on Change of Legal Gender (2016) all detach legal gender recognition from medical interventions for people above 18 years. In 2012, the Argentine Senate enacted the Law 26.743, including a regulation for the right to gender identity and comprehensive state-funded healthcare for trans people. The act introduced an unprecedented law for trans people based on human rights principles. No medical diagnosis or treatment is required for a change of legal gender and it allows children to consent to change their legal gender when supported by their legal representatives.

Similarly, the Maltese Gender Identity, Gender Expression, and Sex Characteristics Act adopted 2015, complies with most of the demands of the depathologisation movement. The Act explicitly ensures the right of all Maltese citizens to recognition of their gender identity (Section 3), and a correction of the recorded gender without any requirements of diagnosis or medical treatment (Section 4). Any change of a recorded gender is self-declarative. Additionally, the act enshrines the bodily integrity and physical autonomy of minors when outlawing sex assignment

treatment and/or surgical intervention on the sex characteristics of a minor (Section 14 (1)). By way of an amendment to the act in 2016, pathologisation of any form of gender identity or gender expression as classified under the ICD or any other similar internationally recognised classification is invalid in Malta (Section 15 (2)). Further, the Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act, enacted in 2016, prohibits pathologisation of any gender identity or gender expression. However, trans-specific state-funded healthcare is not ensured under the law.

The French act frees legal gender recognition from medical interventions and examinations, but requires a court procedure rather than self-declaration of gender. The Norwegian act provides change of legal gender based on self-declaration from the age of 16. For children between the age of six and 16, change of legal gender requires, as a main rule, consent from those with the parental responsibility, but no diagnosis or medical examination is required. However, for children below six years, the act introduces a diagnostic requirement where healthcare professionals must document that they have ‘a congenital somatic sex development uncertainty’ for the correction of legal gender to be granted. Further, the act does not ensure a right to state-funded trans-specific healthcare (Sections 2, 4 and 5; Monro and van der Ros, in this issue; Sørli, 2016). Thus, the Act only partially meets the demands of the depathologisation movement. Under the Irish Act, people over the age of 18 years can self-declare their gender (Section 9). For children who have attained the age of 16 years but not 18 years, however, a certification from two medical practitioners, parental consent and court order are required (Section 12). The act does not allow children below the age of 16 years to obtain legal gender recognition. Neither the Irish act nor the Norwegian act cuts off the ties to the medical profession completely.

A lack of available trans-specific healthcare may negatively affect the health of trans people and their right to respect for their private life sanctioned under article 8 of the ECHR and the right to health under article 12 of the ICESCR, as demonstrated above. Yet, of the gender recognition acts enacted or amended between 2009 and 2016, it is only the Argentine gender recognition law that ensures access to trans-specific healthcare. Article 11 of the Act approves a self-determined right to ‘total and partial surgical interventions and/or comprehensive hormonal treatment to adjust their bodies (cited in Giosa et al., 2015: 580).

The developments in some national legislation law reforms follow the Argentine example by casting aside medical interventions, medical examinations and trans-related diagnoses. Yet, in most countries, there is still a need for much improvement of national gender recognition laws to meet the demands of the depathologisation movement. Particularly, this concerns those countries in which gender recognition laws require sterilisation and genital surgery, but also those countries in which diagnosis is maintained, for example, England, Spain and Portugal, alongside more recent legislation, such as the Irish, French and Norwegian gender recognition acts. According to TGEU and Balzer (2016a, 2016b), in 29 of 62 mapped countries / territories worldwide in which legal change of gender is possible, sterilisation and/or genital surgery are still required for a change of the gender marker, and in 54 of the 62 countries / territories, a diagnosis requirement is maintained.

### **Summary and conclusion**

The first question we raised at the start of this article was about the contribution of the depathologisation movement to the revision process of trans-related diagnoses in DSM and ICD. Some trans people have concerns about removing the diagnostic classification of gender

transition processes, based on the fear of losing access to state-funded trans healthcare (García Becerra and Missé, 2010; Missé and Coll-Planas, 2010b). Trans depathologisation activism has responded to this concern by developing arguments based on a human rights framework (Suess Schwend, 2016).

During the DSM and ICD revision processes, trans depathologisation groups and networks demanded a higher level of participation; however, we observed in relation to our second question about the democratisation of diagnosis that the opportunities for trans activists and networks to participate were curtailed within the consultation process. Trans authors and allies have been able to contribute critiques on the participation process and the proposed and final content, but have no guarantees that their critiques were heard or taken into consideration. Stakeholders were also unable to take part in the final decision making processes. Activists have also illustrated that there are tensions between challenging the diagnostic framework while participating in its reform, and managing the fear of reduced activist impact in the negotiation process (Fernández, 2010; Missé, 2012). As such, a ‘democratisation of diagnosing’ (Davy, 2015a) seems to be still incipient.

Trans depathologisation activism criticises the maintenance of an assessment model in the most recent edition of the Standards of Care SOC-7 (WPATH, 2012), as well as in trans healthcare practice. Activists are proposing the use of an informed consent approach and convincingly highlight its relation to patient-centred healthcare and shared decision-making models, which are increasingly being applied in wider healthcare settings (Balint, 1969; Mead and Bower, 2000; Newdick and Derrett, 2006; Saha et al., 2008). However, these proposals have had little impact on medical practices in trans healthcare. Nonetheless, there is some movement in health services. For instance, there are a few trans healthcare centres in the USA that use an

informed consent model for access to hormone therapy (Callen Lorde Community Health Center, 2014; Radix, 2011; Tom Waddell Health Center, 2011). Also, there is a guarantee in the Argentinian Gender Identity Law of an informed consent approach for state-funded trans healthcare (Congreso Argentino, 2012), and there are trans healthcare services based on informed decision-making in the public healthcare system of Andalusia, Spain (Junta de Andalucía, 2017a, 2017b).

In relation to the ways that human rights frameworks and legal gender recognition has been impacted by depathologisation discourses, we have demonstrated that the human rights principles of human dignity, bodily integrity, self-determination and protection from medical abuse are significant in trans depathologisation activism as reference points, and as part of an argumentation strategy. At the same time, recent strategic documents published by European political and legal institutions have recommended the removal of the diagnostic classification of gender transition processes as a mental disorder in the ICD, integrating the demand of depathologisation in their agenda (Suess Schwend, 2016).

We note that in many countries worldwide trans people still lack opportunities for legal gender recognition. In achieving legal recognition of their gender identity, some trans people's human rights are violated through processes of coercive diagnosing and sterilisation. In countries like Spain, the UK and Portugal the requirement of a trans-related diagnosis continues to be coupled with legal gender recognition. According to Sharpe (2010), British legislation presupposes body modification even though no surgical or hormonal requirements were written into law. This is so, Sharpe argues, because trans people must exhibit gender dysphoria, which is usually understood as distress about 'sex' characteristics. Consequently, legal requirements based upon trans-related diagnoses pose a risk of reintroducing surgical and hormonal practices

through the back door. Moreover, these diagnoses act as gatekeeper to other healthcare services and citizenship rights. This then constitutes a coercive relationship by offering something positive – healthcare and legal recognition – in exchange for compliance with psychiatry. The Argentinian Gender Identity Law, however, is exemplary at guaranteeing trans rights – both legal recognition and healthcare access – within a human rights framework, setting a reference point for recent law reforms, as well as for the ICD revision process. Trans movement participation should be encouraged in the processes of guaranteeing human rights for trans people.

## Notes

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<sup>1</sup> Recently, the term ‘person-centred healthcare’ or ‘people-centred healthcare’ is given preference over ‘patient-centred’ and is considered more inclusive, empowering and focused on the person’s and community’s needs (WHO-WPRO, 2016).

<sup>2</sup> A list of activist documents published between 2009 – 2015 can be found in Suess Schwend (2016). Declarations published between January 2016 and June 2017 are available on the websites of APTN, Asia Pacific Network; GATE, Global Action for Trans Equality; ILGA-World; Iranti.org; STP, International Campaign Stop Trans Pathologization and TGEU, Transgender Europe.

<sup>3</sup> Depsychopathologisation is a demand shared by all activist groups in relation to changes in trans-related diagnostic categories. Simultaneously, there are different proposals providing an alternative diagnostic category for the ICD ensuring public coverage of trans healthcare, resulting in different levels of ‘depathologisation’ claims.

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