

Destigmatization Versus Coverage and Access: The Medical Model of Transsexuality

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Article

In recent years, the GLB community has been more receptive to (and even energized in) assisting the transgender community, but regularly asks what its needs are. One that is often touted is the “complete depathologization of Trans identities” (quoting from a press release for an October 7, 2007 demonstration in Barcelona, Spain) by removing “Gender Identity Disorder” (GID) from medical classification. The reasoning generally flows in a logic chain stating that with homosexuality removed from the Diagnostic and Statistical Manual (DSM, the “bible” of the medical community) in 1974, gay and lesbian rights were able to follow as a consequence - and with similar removal, we should be able to do the same. Living in an area where GRS (genital reassignment surgery) is covered under provincial Health Care, however, provides a unique perspective on this issue. And with Presidential candidates proposing models for national health care in the U.S., it would obviously be easier to establish GRS coverage for transsexuals at the ground floor, rather than fight for it later. So it is important to note, from this “other side of the coin,” how delisting GID could do far more harm than good.

Granted, there are concerns about the current classification as a “mental disorder,” and certainly as a transgender person myself, it’s quite unnerving that my diagnosis of GID puts me in the same range of classification as things such as schizophrenia or even pedophilia. And when the emotional argument of “mental unfitness” can lead to ostracism, discrimination in the workplace or the loss of custody and / or visitation rights of children, there are some very serious things at stake. But when the lobbies are calling for a reclassification -- or more dramatically a total declassification -- of GID, one would expect that they had a better medical and social model to propose. They don’t.

Basic Access to Services

The argument for complete declassification is a great concern, because unlike homosexuals, transgender people - especially transsexuals -- do have medical needs and issues related to their journey. Genital reassignment surgery (GRS), mastectomies and hysterectomies for transmen, tracheal shave, facial hair removal and breast augmentation for transwomen... there are clear medical applications that some require, even to the point of being at risk of suicide from the distress of not having these things available (which is an important point to keep in mind for those in our own communities who assume that GRS is cosmetic surgery and not worthy of health care funding). And we need to use caution about taking psychiatry out of the equation: GID really does affect us psychologically, and we do benefit from having a central source of guidance through the process that keeps this in mind, however flawed and gated the process otherwise might be.

Declassification of GID would essentially relegate transsexuality to a strictly cosmetic issue. Without being able to demonstrate that GID is a real medical condition via a listing in the Diagnostic and Statistical Manual (DSM), convincing a doctor that it is necessary to treat us, provide referrals or even provide a carry letter that will enable us to use a washroom appropriate to our gender presentation could prove to be very difficult, if not impossible. Access to care is difficult enough even with the DSM-IV recommending the transition process -- imagine the barriers that would be there without it weighing in on that! And with cases regarding the refusal of medical services already before review or recently faced in California, Ontario and elsewhere, the availability of services could grow overwhelmingly scarce.

A Model of Medical Coverage

And then there is health care coverage, which often causes a lot of issues of itself, usually of the “not with my tax money” variety. But no one just wakes up out of the blue and decides that alienating themselves from the rest of the world by having a “sex change” is a good idea. Science is developing a greater understanding that physical sex and psychological gender can, in fact, be made misaligned, causing a person to be like a stranger in their own body. In extreme cases (transsexuals), this often makes it impossible to function emotionally, socially, sexually, or to develop any kind of career -- and often makes one constantly borderline suicidal. The medical community currently recognizes this with the existing medical classification, which is why GRS surgery is the recognized treatment, and why it (GRS, that is, and usually not things like breast augmentation) is funded by some existing health plans.

Canada provides an interesting model on this, as the nation has universal health care, and several provinces fund GRS with some limitations (British Columbia, Newfoundland, Saskatchewan and Quebec fund vaginaplasty, hysterectomy and breast reduction for FTMs, Alberta funds those plus phalloplasty, and Manitoba funds 60% of GRS-related costs). Funding may be restored in Ontario and gained in Nova Scotia, pending some ongoing activism.

This exists specifically because it is classified as a medical issue, and is treated according to the recommendations of WPATH. There are some idiosyncracies, of course -- a diagnosis of Intersex, for example, overrides a diagnosis of GID, and if someone is diagnosed as IS, the treatment is different (namely, GRS is not covered). Phalloplasty and metoidioplasty (FTM surgeries) are not covered in several areas because they are considered “experimental.” Some provinces insist on treatment only in publically-funded hospitals, resulting in the rather unusual situation of Quebec sending patients to the U.S. or overseas, even though one of the top-rated (but privately-owned) GRS clinics in the world is located in Montreal. And many provinces direct transsexuals to the notoriously restrictive and obstacle-laden Clarke Institute (CAMH in Toronto) for treatment. Waiting lists can be long, and only a select few GID-certified psychiatrists are able to be a primary signature on letters authorizing surgery and funding. Still, the funding provides opportunity that many non-Canadian transsexuals would leap at within a moment, if they could.

Future Considerations

This possibility, remote as it may seem, is also out there for future American transsexuals. Both Democratic Presidential nominees have discussed developing a national health care program. The time is now for the trans, gay / lesbian / bisexual and allied communities to lobby insurance companies to

develop policies that cover GRS. The time is now to lobby companies to seek out group policies for their employees with such coverage, and with more emphasis than the HRC's impossibly easy Corporate Equality Index (CEI), in which providing mastectomies for breast cancer patients qualifies as "transgender-related surgeries." The more prevalent health care coverage is for transgender persons when a national program is developed, the more effective the argument is that a national program should include it. Certainly, it will be much harder to lobby to have it specifically added later.

This possibility, remote as it may seem, exists because of the current classification. Even some existing coverage of and access to hormone treatment is called into question in a declassification scenario. And certainly, where coverage is not available, it is the impoverished, disenfranchised and marginalized of our community - who quite often have more to worry about than the stigma of mental illness - who lose the most.

So a total declassification is actually not what's best for the transgender community. Too, if anyone had been thinking that proclaiming that "transsexuality is not a mental disorder" would magically change the way that society thinks about transfolk, then they are spectacularly and embarrassingly wrong.

The Question of Reclassification

At some point in the future, I expect that we will find more biological bases for GID, and that transgender people will perhaps become a smaller part of the larger intersex community (rather than the other way around). Recent studies in genetics have demonstrated some difference in chromosomal structure in male brains versus female brains, and the UCLA scientists who conducted the study have also proposed that their findings demonstrate gender dysphoria as a biological characteristic. Other studies into endocrine disrupting chemicals (EDCs) could open new discoveries related to variance in gender correlation. A reassessment of GID is almost certainly something that will be on the medical community's table at some point in the future, but it definitely needs to be in the DSM somewhere. But for now, GID is not something that can be determined by a blood test or an ultrasound, and is not easy to verifiably place with biological conditions. The science is not there; the evidence and solutions are not yet at hand.

This is why reclassification is not yet feasible. It's difficult to convince scientific and medical professionals to move a diagnosis when the current model is workable in their eyes (even if not perfect), while the alternatives are not yet proven, cannot be demonstrated as more valid than the current listing, and no modified treatment system has been devised or proposed. Any move of the diagnosis is not likely to be very far from the current listing, and from the literature I've seen, I doubt that those in the community who advocate to changing or dropping the current classification would be happy with that. For some, even listing it as a "physical disability" could constitute an "unwanted stigma." I have heard one WPATH doctor suggest the term "Body Morphology Disorder" - for many, I suspect, this would still be too "negative."

"Unnecessary Mutilation"

That's not to say that complacency is an answer. In the face of conservative reluctance and new activism on the left by the likes of Julie Bindel, claiming that GRS is "unnecessary mutilation," we need to demonstrate the necessity of treatments, in order to ensure that any change would be an improvement on the existing model, rather than a scrapping of it. This is, of course, something that

affects a small portion of the transgender community in the full umbrella stretch of the term, but the need for those at the extreme on the spectrum is profound -- not simply a question of quality of life, but often one of living at all - or at least a question of being able to function. If and when a reclassification occurs, it will need to be this sense of necessity that will determine the shape of what will be written into any revision.

The solution isn't to destroy the existing medical model by changing or eliminating the current classification of "Gender Dysphoria." Collecting data, demonstrating needs, fighting for inclusion in existing health plans, examining verifiable and repeatable statistics on transgender suicide and success rates and other information relevant to the medical front is where medical-related activism should be focused, for the moment.

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