

Scaremongering

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Article

Dr. Marshall Forstein, Chair of the Work Group on Practices Guidelines on HIV Psychiatry for the American Psychiatric Association (not to be confused with the American Psychological Association), has written a reply to the drive to have Drs. Kenneth Zucker and Ray Blanchard removed from the Work Group developing the revisions for “Sexual and Gender Identity Disorders” for the planned DSM-V. In it, he writes:

“I hope that what I have written makes us pause a bit before we do something to alienate even our supporters and friends in the American Psychiatric and the American Psychological Association who have been very pro-gay and pro-trans in their deliberations so far. There will always be a vocal minority that claim otherwise, but the process is vetted by many people committed to scientific integrity and evidence.”

I and others have been accused of scaremongering in the ongoing debate(s) surrounding this issue. Dr. Forstein has some excellent points for us to examine. Some of the other aspects and debates, though, I still stand behind.

In the later part of the discussion on “Uh-oh,” along with the article here on “Destigmatization Versus Coverage and Access: The Medical Model of Transsexuality,” Henry Hall accuses me of scaremongering with regard to my concerns about removing any diagnosis of GID from the DSM, without some better model to replace it. He writes:

Those who claim that an end to the GID pathology will mean an end to treatment of transsexualism are merely scaremongering, trying to frighten people into a continued acceptance of being abused and controlled.

Medicine is evidence-based and patient-satisfaction driven. Perhaps there was a time when psychiatry was needed to justify endocrinology and surgery for transfolk. That time has passed. It is now well-accepted medicine that hormones, surgery and change of legal sex work as treatment. They are not going to go away merely because some shrink’s theory is debunked at last. Instead some other justification will be found to continue treatment that have proven their value and are known to be highly successful. We have nothing to fear from the removal of transgender diagnoses from the DSM except fear itself.

I don’t mean to single out Mr. Hall specifically -- there are a number of similar thoughts circulating in discussions elsewhere, including those that have taken place at Gender_ID_Coalition. His comments, however, are the most direct ones to respond to.

As a “baby activist” (that is to say, relatively new on the scene, roughly about 2 years as a trans advocate), it has quickly become apparent to me that the current DSM diagnosis is a powerful and underused tool in our arsenal. While addressing the medical community, for example, in a bid to widen both understanding of transgender people and to widen the pool of “transgender-friendly” resources, the diagnosis becomes a firm foundation to build upon. Scientific breakthroughs in the study of Endocrine Disrupting Chemicals and other biological validations of transsexuality would provide a better basis, one that stands firm outside the realm of “mental health” issues, but they’re not conclusively proven, yet. So for now, I have the DSM.

I’m also fortunate to live in an area where there is coverage of genital reassignment surgery by public health care. It exists because of the DSM, and with talk of funding possibly being delisted here in the next few months, the DSM provides the most stable basis upon which we can fight such an action. Similarly, the DSM has provided bases for cases which have fought for funding in the military, in prisons, in other situations in which medical care must be provided, and it provides the potential (however remote it might seem) for battles for coverage in any public health care system, including ones that are being postulated for a potential national health care program in the U.S. The recent restoration of funding of gender reassignment surgery (GRS) in Ontario simply underscores this point.

I am not fearmongering: I am saying, don’t cut the trapeze rope until we know that the next bar is within reach.

Hall later says that:

“To suggest otherwise is mere scaremongering and an attempt to perpetuate bogus mental illnesses for financial and power gain.”

As a transgender advocate, I have no reason to want to “frighten people into a continued acceptance of being abused and controlled” -- in fact that is the very thing I would logically fight. I also have no means to gain financially and in terms of power from the continuance of the current diagnosis. AlbertaTrans’ budget continues to be my pocket, and with not enough people interested in forming a board of directors, I don’t expect to be able to fundraise any time in the near future, either. My motive continues to be the betterment of the community that I care about, and nothing more.

What I will grant Mr. Hall is that treatment options would likely remain available for those who are able to pay for them. Trans-friendly doctors and therapists will still be out there to be found (although it sometimes takes some searching). GRS surgeons would continue to provide GRS -- hell, it’s a good living for many of them, and they will face the same criticisms for providing this service from others in the medical community, regardless of if GID is in the DSM. The status quo would mostly remain, perhaps somewhat reduced (especially in terms of financial coverage, where it exists), without the GID diagnosis.

Maybe it’s just me, but I’m not content to stick with the status quo. Which is why I appreciate having the DSM to stand on.

As mentioned earlier, though, Dr. Forstein has a stronger statement to make about the larger issue of Drs. Zucker and Blanchard being involved with the revision of the DSM classification.

Now I admit to being more than a little panicked, myself, right from the first moment I'd read in Lynn Conway's updates that these two doctors were potentially charting the future of GID treatment. The only thing that I could think of was, "uh-oh" (hence the title of the crossposted blog article). That, of course, was "uh-oh" to the same understated degree of Egon Spengler's "bad," from "Ghostbusters:"

Dr. Egon Spengler: There's something very important I forgot to tell you.

Dr. Peter Venkman: What?

Dr. Egon Spengler: Don't cross the streams.

Dr. Peter Venkman: Why?

Dr. Egon Spengler: It would be bad.

Dr. Peter Venkman: I'm fuzzy on the whole good/bad thing. What do you mean, "bad"?

Dr. Egon Spengler: Try to imagine all life as you know it stopping instantaneously and every molecule in your body exploding at the speed of light.

Dr Ray Stantz: Total protonic reversal.

Dr. Peter Venkman: Right. That's bad. Okay. All right. Important safety tip. Thanks, Egon.

Drs. Zucker and Blanchard are persons with controversial and chequered reputations in the transgender community. The fact that treatment of transsexuality in the province of Ontario is filtered exclusively through their clinic has resulted in the Province's restoration of funding for Gender Reassignment Surgery being considered by many to be a bittersweet and "hollow" victory, rather than what should be a massive win. While we acknowledge that they may feel that they have our best interests at heart, historically, their practice and writings have been a source of great anxiety to transgender people. The American Psychiatric Association needs to realize that giving these personalities any degree of authority and validation will invariably stir up a significant amount of consternation and apprehension within the transgender community.

That said, Dr. Marshall Forstein has made an important statement:

"Sexual orientation is NOT even an issue for the DSM committee to consider. Transgender Identity is a bit more complicated, especially in childhood. The DSM work group will struggle with these issues in coming up with criteria for what to diagnose as a true gender identity disorder. I WANT TO EMPHASIZE THAT TREATMENT RECOMMENDATIONS ARE NOT A PART OF THIS ENDEAVOR. Any treatment recommendations that the American Psychiatric Association makes are the result of significant process of creating EVIDENCED based research.

I am currently the Chair of the Work group on Practices Guidelines on HIV Psychiatry for the American Psychiatric Association, and so am intimately aware of the process. Guidelines go through rigorous research review for controlled studies in order to make recommendations. Hundreds of people review these guidelines before publication, and the same will be true of the criteria set forth by the work group on the DSM gender identity subcommittee.

EVEN if there is literature out there that disturbs those of us who are comfortable with the concepts of transgender identity, unless it meets peer review by legitimate journals (i.e. non religious based periodicals) it will not be considered in the development of criteria for diagnosis or treatment."

I can admit that my own personal panic led me to overlook the fact that the DSM itself does not

recommend treatment. I was wrong and my inexperience got the better of me. This is not a small point, and we need to take some comfort in that. Scaremongering? Perhaps, though not intentionally.

I do, however, remain concerned about what I repeatedly admit is a projected model of what Drs. Zucker and Blanchard are likely to propose based on their history, on four counts:

1. The possible transformation of the definition of the paraphilia “Transvestitic Fetish” into Dr. Blanchard’s theory of “autogynephilia,” even if not in name.
2. A likely diagnostic division made between “homosexual transsexuals” (male-bodied androphiles and female-bodied gynophiles) and “autogynephiles” (which include all other orientations). The current treatment at the CAMH (Clarke) in Toronto, where Dr. Blanchard is Head of Clinical Sexology Services and where Dr. Zucker practices, distinguishes between transsexuals based on their sexual orientation, and considering point #1, there is a potential for this separation to affect a great number in our community, redefining them as paraphiliacs (“autogynephiles” / “transvestitic fetishists”) by diagnosis, rather than as persons with GID.
3. A possible division of diagnosis between transsexual youth and transsexual adults. I do still wonder if Dr. Zucker’s appointment in the first place is a fearful response to the public controversies surrounding revolutionary new treatments of transgender youth in recent years.
4. Even if they do not write treatment into the DSM-V, being the authorities behind the diagnosis can be seen to legitimize them as being authorities on the treatment. Perception speaks volumes.

Taking the panic out of the equation is crucial to moving forward and conversing with the medical community. But I still do feel that this dialogue is necessary. It is reassuring that the process is designed to be screened carefully. Some of that reassurance seems iffy to us simply because we really have no idea if we have allies within the APA to advocate for us, or how many. It would also be reassuring if the American Psychiatric Association’s position on “reparative therapy” could be expanded to specifically include transgender persons.

Dr. Forstein closes with: “Please let me know how I can help to keep the issues clear.” I would be interested in further discussion, and appreciate whatever involvement he is willing to have in the conversation, as I would any other moderates and allies within the APA. I also do believe that he would find me -- and many other trans community advocates -- to be reasonable, and as willing to listen as to talk.

(crossposted to The Bilerico Project, Transadvocate, TransGroupBlog, DentedBlueMercedes and by email to Dr. Forstein)

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