Contradictions and Compromises of Principle in the SOC8

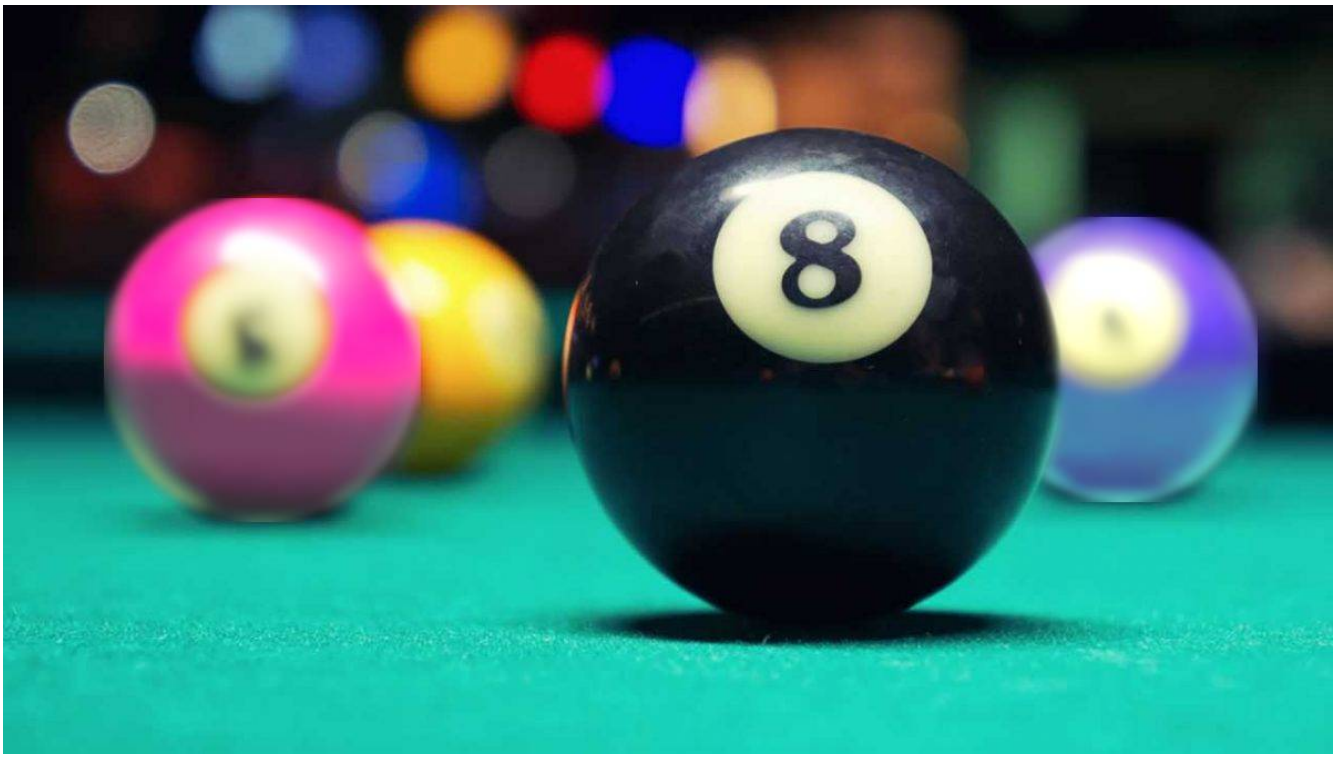

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Table of Contents

Index of Tables

Acknowledgments

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Introduction

The first Standards of Care for health services to Transgender and Gender Diverse (TGD) people were published in (1979) by the Harry Benjamin International Gender Dysphoria Association (now the World Association for Transgender Health, WPATH). In the decades since, clinical attitudes and health policies have very slowly trended toward acceptance of human gender diversity and more affirming, accessible, and evidence-based approaches to care. Key milestones in WPATH's evolution included public policy statements that asserted international professional consensus on principles of medical necessity of gender-affirming endocrine, surgical, and other care (WPATH, 2008; 2016) and depsychopathologization of human gender diversity (2010). These foundational principles of ethical and respectful treatment of TGD people were prominently stated in the seventh SOC version (WPATH, 2011), even while their implementation in the SOC7 was far from consistent. However, the appearance of these ethical principles gave hope for a future when Trans and Gender Diverse and cisgender human beings, alike, might participate authentically in society and access medical and surgical services with equal agency and dignity. These hopes were dimmed, with publication of the Eighth SOC Version (WPATH, 2022).

At 258 pages, the SOC8 is well over twice the page count of the 7th Version and 29 times that of the first Standards of Care. The 8th Version contains a great deal of thoughtful, evidence-based, affirming content. For example, the chapters on primary care, lead by Dr. Madeline Deutsch, and on mental health, lead by Dr. Dan Karasic, are exemplary and urgently needed. However, the positive attributes of the SOC8 are undermined by contradiction and compromise of previously established principles of ethical and effective TGD health care. Developed amid growing theo-political extremism that targets TGD people as a scapegoated class (Williams, 2021), the SOC8 reflects a struggle between factions within WPATH—between those who advocate affirming, medically necessary care and those who see TGD people primarily as mental patients subject to doubt and discouragement. Antiquated stereotypes of psychopathology that begrudge or indefinitely delay affirming medical care still abound in the SOC8, especially for TGD adolescents. Contradiction and confusion in the SOC8 on WPATH's foundational ethical principles will certainly be cherry-picked by disaffirming health systems and exploited by transmisist theo-political factions to deny Trans and Gender Diverse individuals access to confirming and affirming care.

I offer this white paper to provide an accessible, tabular reference to help TGD community members, health professionals, and scholars sort out the tangle of affirming vs. regressive content in the SOC8. I urge WPATH leadership and SOC8 editors to recommit to WPATH's established, ethical principles of care, especially depsychopathologization and medical necessity of affirming and confirming treatments. These shortcomings in the Standards of Care need to be corrected without delay.

Medical Necessity of Gender-Affirming Care

Medical Necessity is a legal doctrine and principle of medical policy that prioritizes and facilitates access to care in public and private medical and mental health systems. In the United States, for example, federal and state legislation and health policies define medical necessity to inform eligibility and authorization for services. The federal Medicare program defines "medically necessary" in terms of accepted medical standards:

> *Medically necessary*
> *Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine* (CMS, 2022)

The State of California definition refers to objectives and outcomes:

> *For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.* (CA WIC, 2021)

Generally, treatments that are experimental, investigational, or solely cosmetic (directed at appearance and not related to diagnosis, treatment, or prevention of a condition or improvement of life function) fall outside of the meaning of medical necessity. Political and ideological opposition to gender-affirming medical care has often argued against its medical necessity, with claims that treatments are cosmetic, purely elective, or experimental. However, such arguments trivialize the

factual reality of the distress of gender incongruence and fall flat against internationally accepted standards of care and a deep body of clinical evidence. For example, the U.S. Tax Court ruled in 2010:

> *Petitioner's hormone therapy and sex reassignment surgery were essential elements of a widely accepted treatment protocol for severe GID. The expert testimony also establishes that...petitioner would not have undergone hormone therapy and sex reassignment surgery except in an effort to alleviate the distress and suffering attendant to GID. Respondent's contention that petitioner undertook the surgery and hormone treatments to improve appearance is at best a superficial characterization of the circumstances that is thoroughly rebutted by the medical evidence.* (O'Donnabhain v. Commissioner)

WPATH Policy Statements on Medical Necessity

In 2008, WPATH released a policy statement on medical necessity to address barriers to care in the United States and false presumptions that gender-affirming or confirming treatments were experimental, unproven, inefficacious, unnecessary, cosmetic, or elective:

> *WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.*
>
> *...The current Board of Directors of the WPATH herewith expresses its conviction that sex reassignment, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria*
>
> *...The medical procedures attendant to sex reassignment are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition*
>
> *...These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient.* (WPATH, 2008)

Additionally, WPATH reaffirmed the medical necessity principle in numerous other public policy statements and papers (2009, 2017, 2019, 2020A, 2020B, 2021). Typical among these:

> *The Board of Directors of the World Professional Association for Transgender Health (WPATH) affirms the medical necessity of gender affirming treatments and procedures for those individuals whose lives are impacted by gender incongruity and for whom such care is deemed appropriate by their health care providers in concert with the patients and their families whenever possible, according to the latest edition of the Standards of Care (Version 7).* (WPATH 2020B)

WPATH later expanded the scope of the medical necessity policy statement from the U.S. to "Transgender and Transsexual People Worldwide" and tabbed its content directly to the WPATH home web page (2011B). In (2016), WPATH updated terminology in the medical necessity position statement to its current form, clarifying "gender affirming/confirming treatments and surgical procedures."

Medical Necessity Policies by Other Health Authorities

The medical necessity of affirming endocrine and surgical care for TGD individuals who need them (including suppression of incongruent puberty) has been long been recognized by a consensus of medical authorities. Beyond WPATH/HBIGDA, these include the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the American Academy of Family Physicians.

Accompanying the first WPATH "Clarification on Medical Necessity" in 2008, the American Medical Association passed their own similar resolution:

> *An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID...Health experts in GID, including WPATH, have rejected the myth that such treatments are "cosmetic" or "experimental" and have recognized that these treatments can provide safe and effective treatment for a serious health condition.* (AMA, 2008)

The American Psychological Association passed their own resolution that same year:

> *APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments.* (American Psychological Association, 2008)

The APA's current update is listed as Resolution H-185.950 (2022). In 2009, the American Psychological Association published a comprehensive *Report of the APA Task Force on Gender Identity and Gender Variance*, which stated:

> *For individuals who experience such distress, hormonal and/or surgical sex reassignment may be medically necessary to alleviate significant impairment in interpersonal and/or vocational functioning. Indeed, when recommended in clinical practice, sex reassignment surgery is almost always medically necessary, not elective or cosmetic.* (2009, p. 32)

This was followed by similar statements of medical necessity in *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015).

A year after publication of the SOC7, the American Psychiatric Association (2012) and the American Academy of Family Physicians (2012) issued similar policy statements that endorsed the

medical necessity of affirming medical and surgical care. The APA "Position Statement on Access to Care for Transgender and Gender Variant Individuals" was most recently updated in July (2018). This was followed by an American Psychiatric Association position statement, specific to care for Trans and Gender Diverse youth:

> *Due to the dynamic nature of puberty development, lack of gender-affirming interventions (i.e. social, psychological, and medical) is not a neutral decision; youth often experience worsening dysphoria and negative impact on mental health as the incongruent and unwanted puberty progresses. Trans-affirming treatment, such as the use of puberty suppression, is associated with the relief of emotional distress, and notable gains in psychosocial and emotional development, in trans and gender diverse youth.* (APA 2020)

The medical necessity of affirming care for TGD adolescents and adults was publicly acknowledged by WPATH, AMA, AAFP, and both APAs, spanning fourteen years, before publication of the SOC8 in 2022. Expert consensus on this fundamental principle of ethical care, and the harmful consequences of withholding affirming care from those who needed it, were well established when the SOC8 working groups were convened.

Medical Necessity Policy in Early SOC Versions

In many ways, early Versions of HBIGDA/WPATH Standards of Care served, not so much as actual standards of medical care, than as gauntlets of obstacles to care. This intent to minimize access to care was explicit in the SOC1 (HBIGDA, 1979, pp. 1-2):

> *[Definition] 3.1 Standards of care. The Standards of care, as listed below, are minimal requirements and are not to be construed as optimal standards of care. It is recommended that professionals involved in the management of sex-reassignment cases use the following as minimal criteria for the evaluation of their work. It should be noted that some experts on gender identity recommend that the time parameters listed below should be doubled, or tripled.* (WPATH, 1979, pp. 1-2)

Nevertheless, the SOC1 made reference to medical necessity, even while limiting care to few of those who needed it: "4.1.2. Principle 2. Hormonal and surgical sex-reassignment are procedures requiring medical justification and are not of such minor consequences as to be performed on an elective basis." (p. 2)

The first direct statement that gender-affirming or confirming medical and surgical care was medically indicated and necessary appeared in the SOC6, three years before release of the WPATH medical necessity policy statement:

> *Sex Reassignment is Effective and Medically Indicated in Severe GID.*

> *In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.* (WPATH, 2005, p. 102)

Medical Necessity Policy in the SOC 7

Published three years after the original WPATH medical necessity policy statement, the 7th Version of the WPATH Standards of Care (2011B) made frequent reference to the principle of medical necessity for gender-affirming care (pp. 5, 8, 33, 54, 55, 58, 64, and 97, among others). In the chapter, "Overview of Therapeutic Approaches for Gender Dysphoria," the SOC7 states: "Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people." (p. 8)

The chapter, "Assessment and Treatment of Children and Adolescents with Gender Dysphoria," included a new section which, for the first time, acknowledged "Risks of Withholding Medical Treatment for Adolescents"--

> *Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence, withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.* (page 21)

To WPATH's credit, the SOC7 brought forward progress in policies that acknowledged the medical necessity of suppression of incongruent puberty and affirming hormonal and surgical care (Winters, 2011). These included recognition of informed consent protocols for hormonal care (WPATH, 2011, pp. 35-36), expanded guidance on puberty delaying care for gender incongruent adolescents (pp. 18-20), and removal of arbitrary delays of three months before hormonal care, pending mandatory psychotherapy or "real life experience," from prior SOC Versions (p. 34).

However, the SOC7 retained and introduced barriers to care that contradicted WPATH's long-held medical necessity principle. For example, access to hormonal care and all surgical procedures was obstructed unless diagnosed mental health conditions were "well controlled" (pp. 34, 59, 60, 104, 105, 106). Ambiguous language of "well controlled," with no specific relevance to affirming medical care, created insurmountable, paradoxical barriers for individuals traumatized by denial of affirming care. Moreover, capricious age-of-majority restrictions on confirming surgical care (pp. 21, 60) prioritized political vagaries over medical necessity.

While the SOC7 was far from consistent with the WPATH medical necessity principle, it furthered progress in acknowledging the medical necessity of affirming and confirming care. The SOC7 brought optimism for more progress and unambiguous closure on this issue by release of the SOC8, more than a decade later.

Medical Necessity Policy in the SOC 8

Version 8 of the WPATH *Standards of Care for the Health of Transgender and Gender Diverse People* (2022) describes the medical necessity of gender-affirming care, for those TGD individuals who need it. However, it obfuscates the principle with contradiction and compromise. The SOC8 falls short of providing clarity on this fundamental ethical issue.

The cornerstone expression of the medical necessity principle in the SOC8 is Statement 2.1, in the chapter, Global Applicability:

> *Statement 2.1 We recommend health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people.*
>
> *Medical necessity is a term common to health care coverage and insurance policies globally. A common definition of medical necessity as used by insurers or insurance companies is "Health care services that a physician and/or health care professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease." The treating HCP asserts and documents that a proposed treatment is medically necessary for treatment of the condition.* (p. 16)

This is a positive restatement of the WPATH medical necessity principle. The supporting text of Statement 2.1 describes, "medically necessary clinical interventions" for gender incongruence, as well as "benefits in quality of life and well-being of gender-affirming treatments" (pp. 17-18). Like the WPATH public policy (2016), Statement 2.1 repeats that affirming treatments are "not considered experimental, cosmetic, or for the mere convenience of a patient;" are "safe and effective at reducing gender incongruence and gender dysphoria;" and should be provided without exclusions by health care systems (p. 18).

To the credit of its authors, Statement 2.1 is cited liberally throughout the SOC8 (pp. 31, 45, 50, 81, 88, 93, 194, 110, 125, 128, 143, 156, 171). However, one reference to Statement 2.1 in Chapter 7, Children, is misleading and requires clarification: "This chapter describes aspects of medical [sic]

necessary care intended to promote the well-being and gender-related needs of children (see medically necessary statement in the Global Applicability chapter, Statement 2.1).” (p. 67)

In the SOC8 and prior versions, “childhood” refers to prepubertal youth, when no somatic medical treatments related to gender incongruence are available or recommended.

The current WPATH position statement on medical necessity (2016) is listed in the Reference section of the SOC8 (p. 245), but, inexplicably, no in-text citations can be found with Statement 2.1 or anywhere in the document. Given the historical importance of the WPATH medical necessity policy, this omission merits correction in the SOC8.

The following table lists beneficial references in the SOC8 to Statement 2.1, which defines the principle of medical necessity of gender-affirming care for the document, and other explicit and implicit endorsements of the medical necessity principle:

Table 1: SOC8 Endorsements of the Medical Necessity Principle

SOC8 Statement 2.1 Defining Medical Necessity Principle
Ch. 2, Global Appl., St. 2.1, p. 16 We recommend health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people.
Ch. 2, Global, St. 2.1, p. 17 gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions.
Ch. 2, Global, St. 2.1, p. 18 There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments ...they are not considered experimental, cosmetic, or for the mere convenience of a patient ...They are safe and effective at reducing gender incongruence and gender dysphoria ...WPATH urges health care systems to provide these medically necessary treatments and eliminate any exclusions. ...Medically necessary gender-affirming interventions are discussed in SOC-8.
SOC8 Explicit Endorsements of Medical Necessity Principle
Introduction, p.5 Healthcare systems should provide medically necessary gender-affirming health care for TGD people.
Introduction, p. 7 the medical necessity of treatment and care is clearly recognized for [people] who experience dissonance between their sex assigned at birth and their gender identity. ...in some countries these diagnoses may facilitate access to medically necessary health care...
Introduction, p. 8 for many individuals, [non-prescribed hormonal therapy] is the only means of acquiring medically necessary gender-affirming treatment that is otherwise inaccessible.
Ch. 5, Adults, p. 31 This chapter provides guidance for the assessment of transgender and gender diverse (TGD) adults who are requesting medically necessary gender-affirming medical and/or surgical treatments (GAMSTs) to better align their body with their gender identity.

Ch. 5, Adults, p. 32 Access to assessment and treatment for TGD people seeking GAMSTs is critical given the clear medical necessity of these interventions and the profound benefits they offer to TGD people.
Ch. 5, Adults, St. 5.7, p. 41 The existence of these rare requests [to detransition] must not be used as a justification to interrupt critical, medically necessary care, including hormone and surgical treatments, for the vast majority of TGD adults.
Ch. 8, Nonbinary, p. 81 Some nonbinary people seek gender-affirming care to alleviate gender dysphoria or incongruence and increase body satisfaction through medically necessary interventions
Ch. 8, Eunuchs, p. 88 The 8th version of the Standards of Care (SOC) includes a discussion of eunuch individuals because of their unique presentation and their need for medically necessary gender-affirming care.
Ch. 11, Institutional, St. 11.3, p. 104 People should have access to these medically necessary treatments irrespective of their housing situation within an institution.
Ch. 11, Institutional, St. 11.3, p. 106 As with all medically necessary health care, access to gender-affirming hormone therapies should be provided in a timely fashion when indicated
Ch. 12, Hormone, p. 110 [TGD] persons may require medically necessary [GAHT] to achieve changes consistent with their embodiment goals, gender identity, or both. ...Ever since the first [WPATH SOC] was published in 1979...GAHT has been accepted as medically necessary. ...In these cases [of the early stages of puberty], pubertal suppression is considered medically necessary.
Ch. 12, Hormone, St. 12.4, p. 114 We recognize even though GnRHas are a medically necessary treatment, they may not be available for eligible adolescents...Therefore, other approaches should be considered in these cases.
Ch. 13, Surgery, p. 128 Medically necessary gender-affirmation surgery (GAS) refers to a constellation of procedures designed to align a person's body with their gender identity.
Ch. 15, Primary Care, p. 143 Whether TGD patients receive medically necessary gender-affirming hormone therapy (GAHT) from a specialist, e.g., an endocrinologist, or a PCP may depend on the availability of knowledgeable and welcoming providers...
Ch. 16, Reproductive, p. 156 Medically necessary gender-affirming hormonal treatments (GAHTs) and surgical interventions that alter reproductive anatomy or function may limit future reproductive options to varying degrees.
SOC8 Implicit Endorsements of Medical Necessity Principle
Ch. 5, Adults, St. 5.1.a, p. 33 Avoiding unnecessary delays in care is critically important.
Ch. 5, Adults, St. 5.1.d, p. 34 The presence of psychiatric illness or mental health symptoms do not pose a barrier to GAMSTs unless the psychiatric illness or mental health symptoms affect the TGD person's capacity to consent to the specific treatment being requested or affect their ability to receive treatment. This is especially important because GAMSTs have been found to reduce mental health symptomatology for TGD people.
Ch. 5, Adults, St. 5.3.b, p. 36 There is evidence the use of rigid assessment tools for "transition readiness" may reduce access to care and are not always in the best interest of the TGD person

Ch. 5, Adults, St. 5.3.c, p. 37 There is no evidence to suggest a benefit of withholding GAMSTs from TGD people who have gender incongruence simply on the basis that they have a mental health or neurodevelopmental condition.
Ch. 5, Adults, St. 5.3.d, p. 37 Treatment for mental health problems can and should occur in conjunction with GAMSTs when medical transition is needed. It is vital gender-affirming care is not impeded unless, in some extremely rare cases, there is robust evidence that doing so is necessary to prevent significant decompensation with a risk of harm to self or others. In those cases, it is also important to consider the risks delaying GAMSTs poses to a TGD person's mental and physical health
Ch. 5, Adults, St. 5.3.d, p. 37 Delaying access to GAMSTs due to the presence of mental health problems may exacerbate symptoms.
Ch. 6, Adolescents, p. 45 these gaps [in scientific understanding] should not leave the TGD adolescent without important and necessary care.
Ch. 12, Hormone, St. 12.21, p. 126 Withholding hormone therapy based on the presence of depression or suicidality may cause harm. ...the practice of withholding hormone therapy until these symptoms [of depression and anxiety] are treated with traditional psychiatry is considered to have iatrogenic effects.
Ch. 12, Hormone, St. 12.21, p. 127 If psychiatric treatment is indicated, it can be started or adjusted concurrently without discontinuing hormone therapy.
Ch. 15, Primary Care, St. 15.5, p. 149 Although age itself is not an absolute contraindication or limitation to gender-affirming medical or surgical interventions, TGD elders may not be aware of the current range of social, medical or surgical options...
Ch. 18, Mental Health, p. 171-172 Addressing mental illness and substance use disorders is important but should not be a barrier to transition-related care. Rather, these interventions to address mental health and substance use disorders can facilitate successful outcomes from transition-related care, which can improve quality of life.
Ch. 18, Mental Health, St. 18.2, p. 172-173 The benefits of mental health treatments that may delay surgery should be weighed against the risks of delaying surgery and should include an assessment of the impact on the patients' mental health delays may cause in addressing gender dysphoria.

Contradictions to Medical Necessity in the SOC 8

Unfortunately, support of WPATH's long-established medical necessity principle in the SOC8 is frequently undermined, or even directly contradicted, by conflicting Statements of Recommendation and supporting text. Some egregious examples are listed in Table 2. This is not an exhaustive list.

Table 2: SOC8 Contradictions to the Medical Necessity Principle

SOC8 Contradictions to Medical Necessity Principle and Statement 2.1	Remarks
Ch. 5, Adults, St. 5.3.c, p. 36 Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.	Statement 5.3.c presumes, without citation, scientifically unsupported stereotypes that gender diversity is caused by underlying mental illness. It undermines the WPATH medical necessity principle by suggesting that affirming care be delayed indefinitely, pending a psychotherapy fishing expedition for behavioral "causes" of gender incongruence. Statement 5.3.c is contradicted by its own supporting text (Table 1).
Ch. 5, Adults, St. 5.5, p. 40 The authors posited when clients are adequately prepared and assessed under the care of a multidisciplinary team, a second independent assessment is unnecessary.	This sentence incorrectly implies that a second, independent comprehensive bio-psycho-social… assessment (with consequential delay of medically necessary care) is necessary for adults who select their own affirming health professionals, outside of a centralized "multidisciplinary team" or without third-party mental health referral. It is contradicted by the immediately preceding sentence, describing "paternalism" and "potential breach of the autonomy" in health care systems.
Ch. 6, Adolescents, pp. 45-46 A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments (GAMSTs) (see medically necessary statement in the Global chapter, Statement 2.1), over time.	This section undermines the WPATH medical necessity principle and casts unfounded fear, uncertainty, and doubt on two decades of clinical history of affirming adolescent puberty suppression and hormonal care. It fails to consider the social and ethical limitations of research on a persecuted, closeted class of human beings. It relies on a questionable citation on detransition by (Littman, 2021), while omitting key longitudinal work (Olson, et al., 2022) and study of provider attitudes and fears (MacKinnon, Ashley, et al., 2021). This section asserts a double-standard for TGD care, that would not be appropriate for cisgender adolescents needing hormonal treatments.
Ch. 6, Adolescents, St. 6.3, p. 50 comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care,...[comprehensive biopsychosocial] assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones, surgeries).	**Statement 6.3** deprioritizes medical necessity of affirming care, instead asserting that medical care for all adolescents should be delayed, pending compulsory, protracted MH assessment—regardless of whether specialized MH services were indicated by evidence. It directly contradicts guidance on p. 45 that "gaps [in understanding] should not leave the TGD adolescent without important and necessary care."

Ch. 6, Adolescents, St. 6.3, p. 50 MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here.	This sentence specifies that protracted "comprehensive biopsychosocial assessment of adolescents" be referred to a third-party MH specialist, only because they are TGD
Ch. 6, Adolescents, St. 6.3, p. 51 There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.	This paragraph instructs HCPs to disregard the medical necessity of affirming care for adolescents unless they are referred for specialized, long-term MH care and subjected to a compulsory, protracted MH assessment process. The last sentence is a "denying the antecedent" logical fallacy, asserting a hysterical, frightening conclusion for an inverse condition for which the authors offer no data. This directly contradicts guidance on p. 45 of the same chapter (Table 1).
Ch. 6, Adolescents, St. 6.11, p. 58 cases in which the parent(s)/caregiver(s)' questions or concerns are particularly helpful in informing treatment decisions and plans...situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept.	Lacking citations, this paragraph is another uncritical, back-door endorsement of the unfounded axioms of "rapid-onset gender dysphoria" and "social contagion" (Littman, 2018). It undermines the WPATH medical necessity principle for TGD adolescents who cannot safely come out of the closet to their families early in childhood. Moreover, it fails to consider the global political weaponization, of Littman's false stereotypes, against affirming TGD health care (Winters, 2022; Ashley 2020).
Ch. 6, Adolescents, St. 6.12b, p. 61 Critically, these findings of low regret can only currently be applied to youth who have demonstrated sustained gender incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).	**Statement 6.12b** undermines the WPATH medical necessity principle for TGD adolescents who cannot safely come out of the closet to their families or communicate their gender incongruence or medical needs early in childhood. It casts unsupported fear of detransition, outside of long-term, iterative MH assessment. It offers no evidence of disproportionate detransition rates for adolescents receiving care under informed consent/harm reduction model protocols (SOC7, pp. 35-36), where intake assessment found no reason for specialized, third-party, MH therapy.
Ch. 6, Adolescents, St. 6.12d, p. 62 Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments… A young person's mental health challenges may impact their conceptualization of their gender development history and gender identity-related needs...	These two sentences conflate correlation with causality and are paradoxical, suggesting without evidence that gender diversity is caused by mental disorder, which is caused by family rejection of gender diversity, which is caused by mental disorder, and so on. This serves undermines the medical necessity of puberty suppression or hormonal care care for all adolescents.
Ch 13, Surgery, St. 13.7, p. 133 We recommend surgeons consider gender-affirming surgical interventions for eligible transgender and gender diverse adolescents when there is evidence a multidisciplinary approach that includes mental health and medical professionals has been involved in the decision-making process.	This statement subordinates the medical necessity of confirming surgical care to inflexible gatekeeping by mental health clinicians. In some cases, a trusted, long-term medical provider, qualified in TGD care, may be better situated to perform appropriate assessment. This statement also contradicts Statement 18.2 text in the Mental Health chapter: "The benefits of mental health treatments that may delay surgery should be weighed against the risks of delaying surgery and should include an assessment of the impact on the patients' mental health delays may cause in addressing gender dysphoria." (p. 172)

The assertions typified by examples in Table 2 are not problematic because they require diagnostic assessment. These declarations in the SOC8 are objectionable because they single out Trans and Gender Diverse individuals for disparate deferral of medically necessary care, pending indefinite mental health assessment/treatment, simply because they are Trans or Gender Diverse. Indeed medical assessment and some form of diagnostic coding are ubiquitous in clinical and hospital practice around the world (excepting preventative care and well-care), and they are often needed to establish individual medical necessity for all patients. Intake assessment commonly includes psycho-social screening, with referral to specialized mental health care only when indicated.

In contrast, Statement 6.3 in the Adolescents chapter requires that medically necessary suppression of incongruent puberty or affirming hormonal treatment be delayed, preempted by completion of compulsory "comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns" (p. 50). This is to be administered by a third-party mental health provider (p. 50), rather than a qualified medical practitioner or clinic that might have years of prior familiarity with the patient. It further suggests invasive (and often offensive) "psychometrically validated psychosocial and gender measures" (p. 51). The latter place a further burden of proof upon TGD youth to repeatedly demonstrate their competence and authentic selves. In contrast, adolescents of cisgender privilege would never be subjected to delay of medically necessary endocrine treatment, pending long-term psychological examination, only because they are cisgender. The double standard is unabashed.

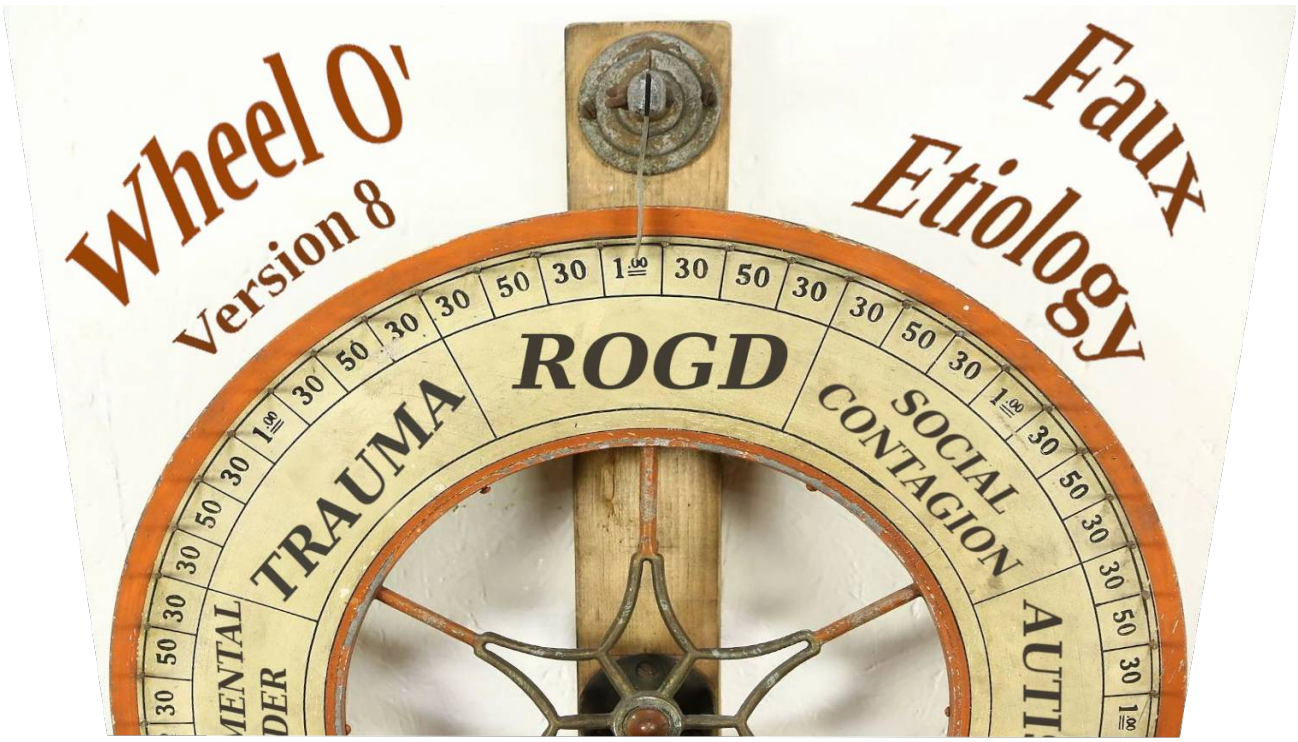
These declarations are contradicted by affirming text within the same chapter and in the Adults and Mental Health chapter:

> *While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care. (p. 45)*
>
> *There is evidence the use of rigid assessment tools for "transition readiness" may reduce access to care and are not always in the best interest of the TGD person. (p. 36)*
>
> *individuals should not be referred for mental health treatment exclusively on the basis of a transgender identity. (p. 117)*

The medical necessity of affirming care is a long-settled principle of ethical practice and is no longer a legitimate topic of debate. It is frequently restated and endorsed within the SOC8 (Table 1). Yet other statements and text of the SOC8 are preoccupied with relitigating this bedrock WPATH principle and turning back the clock on access to affirming and confirming treatments (Table 2).

As a consequence, contradictions to the medical necessity principle in the SOC8 will be scrutinized and weaponized by those opposed to TGD health care. Trans and Gender Diverse people needing care, along with their affirming providers, will face additional barriers from transmisist governments and health systems. Clarity, not ambivalence, on the medical necessity of gender affirming treatments is urgently needed in the SOC8.

Depsychopathologization of Gender Diversity



The principle of depsychopathologization of Transgender and Gender Diverse people means removal of gender diverse identities and expressions from mental disorder classifications and dispelling false stereotypes historically based on those nosologies. Depsychopathologization impacts health and wellbeing of TGD people in at least three ways (Winter, Diamond, et al., 2016):

> *(1) the view that transgender people are mentally disordered is an accident of history rather than one founded on scientific evidence…*
> *(2) The psychopathologisation of gender incongruence therefore leaves transgender people stigmatized. The stigma is particularly pernicious since it is transgender people's identities that are pathologised…*
> *(3) psychopathologisation can undermine transgender people's claims for recognition in their affirmed gender. The view that a transgender woman's identity is a mentally disordered one implies that she is a mentally disordered man. The transgender man is, by implication, likely to be seen as a mentally disordered woman.… (p. 393)*

Public policy statements that asserted international professional consensus on principles of medical necessity of gender-affirming care (WPATH, 2008; 2016) and depsychopathologization of human

gender diversity (2010) were key milestones in WPATH's evolution toward respectful, affirming treatment of TGD people. These bedrock principles of ethical professional practice were prominently stated in the Seventh SOC Version (WPATH, 2011), even though their implementation in the SOC7 fell short of consistent or respectful.

WPATH Policy Statement on Depsychopathologization

More than a decade ago, WPATH released a Depsychopathologisation policy statement, urging that human gender diversity, including non-birth-assigned gender identities and expressions, is not mental disorder:

> *The WPATH Board of Directors strongly urges the depsychopathologisation of gender variance worldwide. 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 which should not be judged as inherently pathological or negative. The psychopathologlisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalisation and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people."* (WPATH, 2010)

The current SOC8 references the (2010) WPATH depsychopathologization statement. Additionally, WPATH has reaffirmed this seminal principle in numerous other public policy statements and papers (2010B, 2014, 2016B, 2019B). Typical among these:

> *Transgender and Gender-Diverse Youth Diversity in gender expression and variations in gender identity represent normative developmental processes for children and adolescents and are not inherently pathological aspects of the human experience.* (2019B)

> *At all times, it is important to account for and critically question existing power inequalities in one's clinical practice, encounters, and writing, so as to join trans-health care users in dismantling pathologizing structures.* (2016B)

WPATH Policy Statement on "ROGD" Pseudo-science

In 2018, a wave of transmisist publicity and political outrage followed publication, editor apology, and re-publication of a scientifically specious article in *PLOS One* (Littman, 2018) about Trans and Gender Diverse adolescents. From a chain-referral sampling survey of online anti-trans hate group members, the author mischaracterized coming out as TGD in adolescence as "rapid-onset gender dysphoria" and

a transmissible "social contagion" of mental illness (Serano, 2018; Restar, 2019; Ashley, 2018; 2020; Winters, 2022). No TGD adolescents were directly interviewed or surveyed in Littman's survey.

WPATH (2018) responded with a cogent public position statement that refuted the faux "ROGD" diagnostic term and renounced psychopathologization, false stereotyping, and fear-mongering of TGD youth and their access to appropriate, affirming care:

> *The term "Rapid Onset Gender Dysphoria (ROGD)" is not a medical entity recognized by any major professional association, nor is it listed as a subtype or classification in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD). Therefore, it constitutes nothing more than an acronym created to describe a proposed clinical phenomenon that may or may not warrant further peer-reviewed scientific investigation.*
>
> *... adolescent gender identity development and the factors influencing the timing of anyone's gender declaration are multifactorial and that all persons—especially adolescents—are deserving of gender-affirmative evidence-based care that adheres to the latest standards of care and clinical guidelines.*
>
> *WPATH also urges restraint from the use of any term—whether or not formally recognized as a medical entity—to instill fear about the possibility that an adolescent may or may not be transgender with the a priori goal of limiting consideration of all appropriate treatment options in accordance with the aforementioned standards of care and clinical guidelines.*

Depsychopathologization Policies by Other Health Authorities

A year before WPATH released its depsychopathologization policy statement, the American Psychological Association Task Force on Gender Identity and Gender Variance questioned the prevailing orthodoxy that had long equated gender diversity with mental illness:

> *Rather than continuing to pursue causal factors, comorbidity, psychopathology, and personality differences, researchers began to focus on the experiences of gay and lesbian people and asked the questions that were most relevant to their lives.* (2009, p. 26)
>
> *The fact that sex reassignment can, in theory, only be accessed with a referral from a mental health professional has been criticized by some members of the transgender community as unnecessarily pathologizing.* (p. 33)

Six years later, the American Psychological Association released TGD practice guidelines that cited the WPATH depsychopathologization policy and noted that assumptions of psychopathology in gender diversity are discriminatory:

> *A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological.* (2015, p. 835)
>
> *Discrimination can include assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression.* (p. 838)

In the Rationale for Proposed Revisions for the 5th Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013A), the American Psychiatric Association announced a change in the title of diagnostic categories associated with TGD care, from "Gender Identity Disorder" to "Gender Incongruence." This was intended to lessen stigmatization of diagnosing gender identities, per se, as mentally "disordered," by placing the diagnostic focus on incongruence experienced by individuals in need of care:

> *It is proposed that the name gender identity disorder (GID) be replaced by "Gender Incongruence" (GI) because the latter is a descriptive term that better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender (usually at birth) (Meyer-Bahlburg, 2009a; Winters, 2005). In a recent survey that we conducted among consumer organizations for transgendered people (Vance et al., in press), many very clearly indicated their rejection of the GID term because, in their view, it contributes to the stigmatization of their condition.* (APA, 2010)

The APA eventually chose "Gender Dysphoria," rather than "incongruence," for the *DSM-5*. They clarified that gender nonconformity, per se, is no longer considered to be mental disorder:

> *DSM-5 aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender. It replaces the diagnostic name "gender identity disorder" with "gender dysphoria," as well as makes other important clarifications in the criteria. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.*
>
> *...Part of removing stigma is about choosing the right words. Replacing "disorder" with "dysphoria" in the diagnostic label is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is "disordered."* (APA, 2013B)

It is important to note that the term, "gender dysphoria," has two meanings in medical and mental health contexts (Winters, 2018B). It was originally defined by Fisk (1979) in its plain-language context of distress with one's physical sex characteristics or birth-assigned social roles. However, the term remains anachronistic and lacks nuance to describe the necessity of care for Gender Diverse people. The second meaning is a label of mental disorder in the *DSM-5*, whose placement in the APA's *Manual of Mental Disorders* still contradicts its utility for adult and adolescent access to somatic medical and surgical treatments. Shifting the diagnostic focus away from the false stereotype of "disordered" gender identity, the "gender dysphoria" title was an incremental, though incomplete, acknowledgment of the depsychopathologization principle by the APA (Winters, 2011; 2013). Further changes by the APA to Gender Dysphoria categories in the Text Revision of the *DSM-5* (2022) were minor terminology updates, such as "experienced gender" and "gender affirming medical procedures" (APA, 2022B).

To date, the most significant embodiment of depsychopathologization of gender diversity was published by the World Health Organization in the 11th Revision of the *International Statistical Classification of Diseases and Related Health Problems, ICD-11* (WHO, 2019). It is a worldwide diagnostic manual for both physical medical conditions and mental conditions.

> *The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health believes it is now appropriate to abandon a psychopathological model of transgender people based on 1940s conceptualizations of sexual deviance and to move towards a model that is (1) more reflective of current scientific evidence and best practices; (2) more responsive to the needs, experience, and human rights of this vulnerable population; and (3) more supportive of the provision of accessible and high-quality healthcare services.* (Drescher, Cohen-Kettenis, & Winter, 2012)

Diagnostic codings related to TGD care in the *ICD-11* were renamed, Gender Incongruence (the term previously considered for the *DSM-5*), and removed entirely from Mental and Behavioural Disorders chapter (previously known as F-Codes):

> *HA60 Gender incongruence of adolescence or adulthood*
>
> *Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.* (2019)

The Gender Incongruence codings were re-categorized in a new, non-psychiatric chapter in the *ICD-11*, titled, "Certain conditions related to sexual health." WHO also eliminated victimless sexual

paraphilia categories from the manual, including F65.1, Transvestic Fetishism. Another archaic, defamatory diagnosis, F64.1, Dual-role Transvestism, was also eliminated from the *ICD*.

The WPATH depsychopathologization principle, debunking socially punitive and scientifically capricious stereotypes of mental disorder about Trans and Gender Diverse people, was established as ethical health practice long before publication of the SOC8 in 2022. It was acknowledged by the American Psychological Association and the American Psychiatric Association and operationalized as global health policy by the World Health Association.

Depsychopathologization Policy in Early SOC Versions

Early versions of HBIGDA/WPATH Standards of Care more closely resembled blunt instruments of denial of medically necessary affirming care than actual standards for provision of care. The original SOC1 (HBIGDA, 1979, pp. 1-2) set an enduring precedent for indefinite, arbitrary deferral of affirming medical treatments, pending protracted psychological "evaluation" and assessment. "Minimal requirements" and "minimal criteria" in the SOC1 referred to lower bounds of delay for access to care, with little regard for the consequences of prolonged suffering. Health care professionals were urged to double or even triple those delays:

> *[Definition] 3.1 Standards of care. The Standards of care, as listed below, are minimal requirements and are not to be construed as optimal standards of care. It is recommended that professionals involved in the management of sex-reassignment cases use the following as minimal criteria for the evaluation of their work. It should be noted that some experts on gender identity recommend that the time parameters listed below should be doubled, or tripled.* (WPATH, 1979, pp. 1-2)

The SOC1 and other early versions stereotyped TGD individuals, not merely as mentally disordered, but with diminished intellect. HBIGDA required a minimum of three months of psychotherapy before access to affirming hormonal and non-genital surgical care and six months before access to genital surgeries—whether or not there was any evidence for referral to mental health specialty care. They went so far as to recommend IQ testing, before granting access to affirming or confirming treatments.

> *4.3.3. Standard 3. The psychiatrist or psychologist making the recommendation in favor of hormonal and non-genital (surgical) sex-reassignment shall have known the patient in a psychotherapeutic relationship, for at least 3 months prior to making said recommendation. The psychiatrist or psychologist making the recommendation in favor of genital (surgical) sex-reassignment shall have known the patient, in a psychotherapeutic relationship for at least 6 months prior to making said recommendation. That psychiatrist or psychologist should have access to the results of the psychometric testing (including IQ testing of the patient) when such testing is clinically indicated.* (1979, p. 4)

Unfounded stereotypes of intrinsic TGD psychopathology and mental infirmary had enduring consequences in early HBIGDA/WPATH Standards of Care. Access to both hormonal and surgical care were further delayed by oppressive "real life experience" social role requirements (1979, p. 4). Still more delay of affirming care was mandated for individuals with coexisting mental health conditions. This policy disallowed concurrent affirming care and mental health support and disregarded harm inflicted by denial of affirming medical care:

> *4.7.2. Principle 14. The patient having a psychiatric diagnosis (i.e., schizophrenia) in addition to a diagnosis or transsexualism should first be treated by procedures commonly accepted as appropriate for such non-transsexual psychiatric diagnoses.* (1979, p. 4)

Publication of the HBIGDA SOC5 and 6 (1998, 2005) brought the beginnings of critical scrutiny of these psychopathology stereotypes. A bold-font section heading in the SOC5, "The Gender Identity Disorders are Mental Disorders" (p. 16), was revised in the SOC6 to, "Are Gender Identity Disorders Mental Disorders?" (2005, p. 10). Mandatory psychotherapy requirements were dropped in the SOC5 for adults seeking affirming care:

> *Psychotherapy is not an absolute requirement for triadic therapy.*
> *1. Individual programs vary to the extent that they perceive the need for psychotherapy.*
> *2. When the mental health professional's initial assessment leads to a recommendation for psychotherapy, the clinician should specify the goals of treatment, estimate its frequency and duration.*
> *3. The SOC committee is wary of insistence on some minimum number of psychotherapy sessions prior to the real life experience, hormones, or surgery but expects individual programs to set these.* (1998, p. 8)

Depsychopathologization Policy in the SOC 7

The WPATH Policy Statement on Depsychopathologization (2010) was prominently cited in the 7th Version of the Standards of Care (2011B), published the following year:

> *Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology*
>
> *WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide. This statement 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."* (p. 4)

The SOC7 brought forward progress in policies that acknowledged both depsychopathologization and medical necessity principles (Winters, 2011A). These included recognition of informed consent protocols for hormonal care (WPATH, 2011, pp. 35-36), clarified guidance on puberty suppression care for gender incongruent adolescents (pp. 18-20), and removal of arbitrary delays of three months before endocrine care—pending mandatory psychotherapy or "real life experience" (p. 34).

However, the SOC7 retained barriers to care that contradicted both of WPATH's depsychopathologication and medical necessity principles. For example, access to hormonal care and surgical procedures was obstructed unless diagnosed mental health conditions were "well controlled" (pp. 34, 59, 60, 104, 105, 106). Moreover, capricious age-of-majority restrictions on confirming surgical care (pp. 21, 60) prioritized political vagaries over medical necessity.

In many ways, the 7th Version Standard of Care did not consistently adhere to the WPATH depsychopathologization policy. However, the SOC7 brought optimism for continued progress and clarity on this principle of ethical practice by release of the SOC8.

Depsychopathologization Policy in the SOC 8

Like the SOC7, Version 8 of the WPATH *Standards of Care for the Health of Transgender and Gender Diverse People* (2022) has fallen short of clarity and closure on the principle of depsychopathologization of gender diversity and resulting barriers to affirming care. Instead, it seems to further cloud these issues with contradiction and compromise.

Inexplicably, the WPATH Policy Statement on Depsychopathologization (2010) is not directly cited in the SOC8. It does not appear in the References section or in-text citations. Given the historical importance of this key WPATH policy on the ethical treatment of Trans and Gender Diverse individuals, this omission merits timely correction in the SOC8.

However, Chapter 2, "Global Applicability," cites later descriptions of the depsychopathologization principle in the *DSM-5* (APA, 2013A) and *ICD-11* (WHO, 2019):

> *Mainstream global medicine no longer classifies TGD identities as a mental disorder…*
>
> *Mainstream global medicine no longer classifies TGD identities as a mental disorder. In the Diagnostic and Statistical Manual Version 5 (DSM-5) from the American Psychiatric Association, the diagnosis of Gender Dysphoria focuses on any distress and discomfort that accompanies being TGD, rather than on the gender identity itself...In the International Classification of Diseases, Version 11 (ICD-11)...the Gender Incongruence diagnosis is placed in a chapter on sexual health and focuses on the person's experienced identity and any need for gender-affirming treatment that might stem from that identity. Such developments, involving a depathologization (or more precisely a de-psychopathologization) of transgender identities, are fundamentally important on a number of grounds.* (WPATH, 2022, p. 15)

The principle of depsychopathologization of gender diversity is re-stated a number of times in the 8th Version, WPATH Standards of Care (2022, pp. 15, 59, 33, 117). The following table lists examples of explicit and implicit endorsements of the depsychopathologization principle in the SOC8. These include guidance that access to affirming medical care should not be withheld only because of co-occurring mental health or neuro-diverse conditions. This tabular listing may be useful to TGD individuals and health care professionals who face obstacles based on false stereotypes that equate gender diversity with psychopathology:

Table 3: SOC8 Endorsements of the Depsychopathologization Principle

SOC8 Explicit References to the Depsychopathologization Principle
Ch. 2, Global, p.15 Mainstream global medicine no longer classifies TGD identities as a mental disorder...developments [in the DSM-5 and ICD-11], involving a depathologization (or more precisely a de-psychopathologization) of transgender identities, are fundamentally important on a number of grounds. In the field of health care, they may have helped support a care model that emphasizes patients' active participation in decision-making about their own health care...
Ch. 6, Adolescents, St. 6.12a, p. 59 The most recent versions of these two systems, the DSM-5 and the ICD-11, reflect a long history of reconceptualizing and de-psychopathologizing gender-related diagnoses... Compared with the ICD 10th edition, the gender incongruence classification was moved from the Mental Health chapter to the Conditions Related to Sexual Health chapter in the ICD-11.
SOC8 Implicit Endorsements of the Depsychopathologization Principle
Introduction, p. 7 WPATH strongly recommends against any use of reparative or conversion therapy (see statements 6.5 and 18.10).
Ch. 5, Adults, p. 31 Some TGD people may need a comparatively brief assessment process for GAMSTs.
Ch. 5, Adults, St. 5.1.c, p. 33 Gender diversity is a natural variation in people and is not inherently pathological. ...The need to include an HCP with some expertise in mental health does not require the inclusion of a psychologist, psychiatrist, or social worker in each assessment.
Ch. 5, Adults, St. 5.1.d, p. 34 The presence of psychiatric illness or mental health symptoms do not pose a barrier to GAMSTs unless the psychiatric illness or mental health symptoms affect the TGD person's capacity to consent to the specific treatment being requested or affect their ability to receive treatment. This is especially important because GAMSTs have been found to reduce mental health symptomatology for TGD people.
Ch. 5, Adults, St. 5.3.b, p. 36 There is evidence the use of rigid assessment tools for "transition readiness" may reduce access to care and are not always in the best interest of the TGD person
Ch. 5, Adults, St. 5.3.c, p. 37 There is no evidence to suggest a benefit of withholding GAMSTs from TGD people who have gender incongruence simply on the basis that they have a mental health or neurodevelopmental condition.

Ch. 5, Adults, St. 5.3.d, p. 37 Treatment for mental health problems can and should occur in conjunction with GAMSTs when medical transition is needed. It is vital gender-affirming care is not impeded unless, in some extremely rare cases, there is robust evidence that doing so is necessary to prevent significant decompensation with a risk of harm to self or others. In those cases, it is also important to consider the risks delaying GAMSTs poses to a TGD person's mental and physical health
Ch. 5, Adults, St. 5.3.d, p. 37 Delaying access to GAMSTs due to the presence of mental health problems may exacerbate symptoms.
Ch. 6, Adolescents, p. 45 these gaps [in scientific understanding] should not leave the TGD adolescent without important and necessary care.
Ch. 6, Adolescents, St. 6.5, p. 53 We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth. ...Conversion/reparative therapy has been linked to increased anxiety, depression, suicidal ideation, suicide attempts, and health care avoidance...efforts undertaken a priori to change a person's identity are clinically and ethically unsound. We recommend against any type of conversion or attempts to change a person's gender identity...
Ch. 7, Children, p. 67 conversion therapies for gender diversity in children (i.e., any "therapeutic" attempts to compel a gender diverse child through words, actions, or both to identify with, or behave in accordance with, the gender associated with the sex assigned at birth are harmful and we repudiate their use.
Ch. 7, Children, St. 7.2, p. 70 Gender diversity is not a mental health disorder; *(see contradictory concerns with this compound sentence in 7.2, Table 4)*
Ch. 7, Children, St. 7.13, p. 77 not all gender diverse children wish to explore their gender. Cisgender children are not expected to undertake this exploration, and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing, intrusive and/or cisnormative. *(see contradictory concerns with 7.13 in Table 4)*
Ch. 12, Hormone, St. 12.8, p. 117 Providers should keep in mind being transgender or questioning one's gender does not constitute pathology or a disorder. Therefore, individuals should not be referred for mental health treatment exclusively on the basis of a transgender identity.
Ch. 12, Hormone, St. 12.21, p. 126 Withholding hormone therapy based on the presence of depression or suicidality may cause harm. ...the practice of withholding hormone therapy until these symptoms [of depression and anxiety] are treated with traditional psychiatry is considered to have iatrogenic effects.
Ch. 12, Hormone, St. 12.21, p. 127 If psychiatric treatment is indicated, it can be started or adjusted concurrently without discontinuing hormone therapy.
Ch. 18, Mental Health, p. 171-172 Addressing mental illness and substance use disorders is important but should not be a barrier to transition-related care. Rather, these interventions to address mental health and substance use disorders can facilitate successful outcomes from transition-related care, which can improve quality of life.
Ch. 18, Mental Health, St. 18.2, p. 172-173 The benefits of mental health treatments that may delay surgery should be weighed against the risks of delaying surgery and should include an assessment of the impact on the patients' mental health delays may cause in addressing gender dysphoria.

Ch. 18, Mental Health, St. 18.9, p. 175 We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.
Ch. 18, Mental Health, St. 18.10 p. 176 We recommend "reparative" and "conversion" therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered. ..."conversion therapy" has not been shown to be effective. In addition, there are numerous potential harms.

Contradictions to Depsychopathologization in the SOC 8

Unfortunately, endorsements and corollaries of WPATH's depsychopathologization policy in the SOC8 are undermined, even directly contradicted, by regressive, conflicting Statements of Recommendation and supporting text. WPATH's ambivalence on the depsychopathologization principle is harmful and easily weaponized against all TGD health care. Some examples of false stereotypes of TGD psychopathology in the SOC8 are listed in Table 4. This is not an exhaustive list.

Table 4: SOC8 Contradictions to the Depsychopathologization Principle

SOC8 Contradictions to Depsychopathologization Principle	Remarks
Ch. 5, Adults, St. 5.3.c, p. 36 Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.	Statement 5.3.c presumes, without citation, scientifically unsupported stereotypes that gender diversity is caused by underlying mental illness. It undermines the WPATH depsychopathologization and medical necessity principles by asserting that affirming care be delayed indefinitely, pending a psychotherapy fishing expedition for behavioral "causes" of gender incongruence. Statement 5.3.c is further contradicted by its own supporting text (Table 3).
Ch. 5, Adults, St. 5.5, p. 40 The authors posited when clients are adequately prepared and assessed under the care of a multidisciplinary team, a second independent assessment is unnecessary.	This sentence incorrectly implies that a second, independent comprehensive bio-psycho-social… assessment (with consequential delay of medically necessary care) is necessary for adults who select their own affirming health professionals, outside of a centralized "multidisciplinary team" or without third-party mental health referral. It is contradicted by the immediately preceding sentence, describing "paternalism" and "potential breach of the autonomy" in health care systems.
Ch. 6, Adolescents, p. 45 For a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider	This sentence is an endorsement of the scientifically bankrupt "rapid-onset gender dysphoria" (ROGD) and "social contagion" myths about Gender Diverse youth. They spreads political panic about fictitious mental "contagion" that turns cisgender kids Trans, through social media and school groups.

Ch. 6, Adolescents, St. 6.3, p. 50 comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care...MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here...The assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones, surgeries).	This statement presumes inherent TGD psychopathology and is reminiscent of compulsory long-term psychotherapy requirements in the SOC1 through SOC4. It demands that medical care for all adolescents should be delayed, pending completion of compulsory, protracted MH assessment. Referral to specialized MH services is doctrinal for all TGD adolescents, simply because they are TGD. It contradicts guidance in the same chapter that "gaps [in understanding] should not leave the TGD adolescent without important and necessary care" (Table 3, p. 45), as well as affirming guidance on (Table 3, pp. 117, 127, and 175).
Ch. 6, Adolescents, St. 6.3, p. 51 There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.	This statement is a denying-the-antecedent logical fallacy, asserting a hysterical,frightening conclusion for an inverse condition, for which the authors offer no data. It presumes inherent psychopathology of all TGD youth, projects unsupported fear, and compels long-term psychotherapy that is prerequisite to affirming medical care. This contradicts guidance on p. 45 of the same chapter (Table 3).
Ch. 6, Adolescents, St. 6.3, p. 53 It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression.	This text presumes unsupported stereotypes that gender diversity is caused by underlying mental illness. Compulsory "gender exploration" fishing expeditions for behavioral "causes" or "etiologies" of gender incongruence are contrary to the depsychopathologization principle. Unless freely initiated and led by the TGD youth, these practices can be covertly punitive and have been proposed by disaffirming policymakers as a "loophole" to prohibitions on gender-conversion practices (Winters, 2022B).
Ch. 6, Adolescents, St. 6.11, p. 58 cases in which the parent(s)/caregiver(s)' questions or concerns are particularly helpful in informing treatment decisions and plans...situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept.	Lacking citations, this paragraph is a back-door endorsement of unsupported myths of "rapid-onset gender dysphoria"(ROGD) and "social contagion." These are recent variations of psychopathological stereotypes of TGD youth that have been perpetuated for generations. The "ROGD" myth conflates closeted circumstance with cisgender status. It misrepresents coming out in adolescence as "rapid onset;" and it casts political panic about fictitious mental contagion that turns cisgender kids Trans, through social media and school groups.
Ch. 6, Adolescents, St. 6.12b, p. 61 Critically, these findings of low regret can only currently be applied to youth who have demonstrated sustained gender incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).	This statement is a denying-the-antecedent logical fallacy, asserting a hysterical, frightening conclusion for an inverse condition. The authors offer no evidence of disproportionate detransition rates for adolescents receiving care under affirming protocols. It presumes inherent psychopathology of all TGD youth and casts unsupported fear of regret. "Iterative" long-term psychological interrogation of a TGD adolescent's identity, in lieu of medically necessary care, contradicts guidance on p. 45 of the same chapter (Table 3).

Ch. 6, Adolescents, St. 6.12d, p. 62 Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments… A young person's mental health challenges may impact their conceptualization of their gender development history and gender identity-related needs...	These two sentences conflate correlation with causality in a paradox —suggesting without evidence that gender diversity is caused by mental disorder, which is caused by family rejection of gender diversity, which is caused by mental disorder, and so on. This is a twisted form of the psychopathologization stereotype.
Ch. 7, Children, St. 7.2, p. 70 we know mental health can be adversely impacted for gender diverse children (e.g., through gender minority stress) that may benefit from exploration and support; therefore, mental health expertise is highly recommended.	This sentence psychopathologizes all Gender Diverse, prepubescent children. It casts doubt on the validity of their gender identities and calls for scrutiny ("exploration") of their identities through psychotherapy, regardless of how consistent and stable they may be in their affirmed genders. This passage is self-contradicted within the very same compound sentence (Table 3) .
Ch. 7, Children, St. 7.13, p. 76 We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.	This statement ambiguously implies compulsory "gender exploration" psychotherapy for TGD youth, throughout prepubescent childhood. It presumes unfounded stereotypes of psychopathology and gaslights the identities of TGD children, who may be long-established and well-adjusted in their authentic social gender roles. Unless freely initiated and led by the TGD youth, these practices can be covertly punitive. 7.13 is contradicted within its own supporting text (Table 3).
Ch 13, Surgery, St. 13.7, p. 133 We recommend surgeons consider gender-affirming surgical interventions for eligible transgender and gender diverse adolescents when there is evidence a multidisciplinary approach that includes mental health and medical professionals has been involved in the decision-making process.	This statement demands compulsory, long-term psychotherapy that is prerequisite to access for confirming surgical care. It rests on the stereotype of intrinsic psychopathology of TGD adolescents. In some cases, a trusted, long-term medical provider, qualified in TGD care, may be better situated to perform appropriate assessment. This statement also contradicts Statement 18.2 text in the Mental Health chapter (Table 3)

A Double Standard of Psycho-Gatekeeping

The examples of psychopathological stereotyping of gender diversity in Table 4 are not problematic because they require diagnostic assessment. They are problematic because they single out Trans and Gender Diverse people for social stigma, compulsory long-term mental health specialty referral, and vastly disparate barriers to affirming hormonal and surgical care—simply because they are TGD and therefore presumed, without evidence, to be mentally ill.

Medical assessment and some form of diagnostic and billing coding are often useful to establish medical necessity and prioritization of resources in health care systems worldwide. Intake assessment in cisgender settings commonly includes psychosocial screening, with referral to specialized mental health care only when indicated by evidence. In contrast, regressive parts of the SOC8 recommend automatic referral of TGD children, adolescents, and adults to specialized mental health clinicians, simply because of gender diversity (Table 4, pp. 40, 50, 70, 133).

For example, Statement 6.3 in the Adolescents chapter of the SOC8 requires deferral of medically necessary suppression of incongruent puberty and affirming hormonal treatments, pending completion of indefinite "comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns" (p. 50). Referral to a third-party mental health provider (p. 50), rather than intake assessment by a qualified medical practitioner or clinic is recommended—even if the latter might be far more familiar with the client. Statement 6.3 further suggests highly problematic "psychometrically validated psychosocial and gender measures" (p. 51). These burden TGD adolescents to repeatedly demonstrate their competence and validity of their authentic selves. In contrast, cisgender adolescents would never be presumed mentally ill and denied medical care because they are cisgender. The double standard in the SOC8 is stunning, yet it is contradicted by affirming guidance within the same chapter and in the Adults and Mental Health chapters:

> *Some TGD people may need a comparatively brief assessment process for GAMSTs.* (p. 31)
>
> *While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care.* (p. 45)
>
> *There is evidence the use of rigid assessment tools for "transition readiness" may reduce access to care and are not always in the best interest of the TGD person.* (p. 36)
>
> *individuals should not be referred for mental health treatment exclusively on the basis of a transgender identity.* (p. 117)
>
> *We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.* (p. 175)

"ROGD" Hysteria and Mythical Etiologies

WPATH (2018) publicly rejected Lisa Littman's faux diagnostic term of "Rapid-Onset Gender Dysphoria" and discouraged related psychopathologizing stereotypes that "instill fear about the possibility that an adolescent may or may not be transgender" (Littman, 2018). Yet, the SOC8 supports "ROGD" pseudo-science in numerous statements and inferences that gender incongruence is a manifestation of myriad mental and developmental disorders, intellectual deficiency, past trauma, and, (nonsensically) social exposure to the existence of TGD human beings (pp. 36, 45, 53, 58, 62). Most troubling, these portions of the SOC8 suggest that affirming medical care for adolescents and adults should be denied or delayed until long-term psychotherapy is completed to dig up assumed, psychopathological "causes" of gender incongruence. Facing a priori presumption of mental defectiveness from regressive statements and text in the SOC8, TGD adolescents and adults seeking

affirming medical care must bear an unconscionable burden of proof to demonstrate their mental competence and gender identities. This contradicts both the "WPATH De-Psychopathologization Statement" (2010) and the "WPATH position on 'Rapid Onset Gender Dysphoria'" (2018).

For example, Statement 6.11 in the Adolescents Chapter is nearly explicit in endorsing Littman's flawed "ROGD" and "social contagion" stereotypes:

> *...a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept.* (p. 58)

Lacking citations, this text conflates the closet with cisgender status. It misrepresents coming out in adolescence as "rapid onset," and spreads political panic about fictitious mental "contagion" that turns cisgender kids Trans, through social media and school affinity groups. Following Littman's model (2018), this text centers the perceptions of "rapid onset" by disaffirming parents, rather than the lived experiences of TGD adolescents. Compulsory, long-term, psychotherapy fishing expeditions for behavioral "causes" of gender incongruence are recommended in the same chapter (p. 53), as prerequisite to gender-affirming medical care.

The stereotype of psychopathological "etiology" of gender incongruence and the mischaracterization of gender incongruence as confusion are extended to adults in Statement 5.3.c. Here, compulsory psychotherapy is recommended to "identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments" (p. 36).

The SOC8 editors erred by not including the "WPATH position on 'Rapid Onset Gender Dysphoria'" (2018) in its entirety in the new the Standards of Care. Littman's (2018) "ROGD" and "social contagion" stereotypes and WPATH's public response to them are described in the Adolescents Chapter, but in coded, confusing, and poorly edited language:

> *...the findings of the [Littman] study must be considered within the context of significant methodological challenges, including 1) the study surveyed parents and not youth perspectives; and 2) recruitment included parents from community settings in which treatments for gender dysphoria are viewed with scepticism and are criticized*
>
> *...these findings have not been replicated.*
>
> *...caution must be taken to avoid assuming these phenomena occur prematurely in an individual adolescent while relying on information from datasets that may have been ascertained with potential sampling bias.* (WPATH, 2022, p. 45)

While this text weakly notes some of the fundamental flaws in the "ROGD" trope, it reads more like a squabble than a medical standard. It lacks firm guidance on this biased, faux science.

Gender Conversion and Covertly Punitive Psychotherapies

Ethical guidance to prohibit gender-conversion or gender-reparative psychotherapies was first adopted by WPATH in the SOC7:

> *Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.* (2011, p. 16)

The SOC8, in their current form, stop short of the SOC7 ethical prohibition of gender-conversion psychotherapies. However, they repeat recommendations against gender-conversion practice (WPATH, 2022, pp. 7, 53, 67, 176). For example, Statement 18.10 in the Mental Health chapter asserts:

> *We recommend "reparative" and "conversion" therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered.*
>
> *..."conversion therapy" has not been shown to be effective. In addition, there are numerous potential harms.* (p. 176)

However, the SOC8 fail to address deceptive strategies that have been used to circumvent professional and legal restrictions on gender-conversion psychotherapies, by labeling them as "gender exploration therapies" (Winters, 2022B). At its 2016 biennial symposium in Amsterdam, WPATH itself platformed a session by attorney and psychiatrist, Richard Green, and psychologist, Kenneth Zucker, on evasion of laws and policies which prohibited gender-conversion practices (WPATH, 2016C). They proposed a loophole to trans-protective restrictions, by suggesting that punitive gender-conversion therapies simply be relabeled as "identity exploration":

> *So, I asked a lawyer the following: 'The bill says treatment cannot seek to change the gender identity of a patient under 18 years of age but it is OK to engage in identity exploration. What's the difference?' The lawyer had a very detailed analysis: 'No one the fuck knows.'* (Zucker, 2016)

Gender exploration, in its plain-language context, is a positive process of self-discovery; but only when freely initiated and led by the individual. All people, TGD and cisgender, explore our individual places in a gendered society throughout stages of youth, adulthood, and elderhood. However, when "gender exploration" psychotherapies on TGD children, adolescents, and adults are not consensual, but are compulsed by psycho-gatekeeping practices, they can become punitive (Ashley, 2019) and covert forms of gender-conversion (Winters, 2022B) .

The SOC8 contains troubling recommendations for long-term "gender exploration" psychotherapies for TGD children and adolescents (pp. 53, 70, 76). These lack clarification to prevent unethical exploitation of the Green-Zucker loophole to obfuscate punitive or gender-conversion psychotherapies. Compulsory "gender exploration" therapies in the SOC8 are frequently combined with stereotypes that gender incongruence is "caused" by underlying mental illness. For example, Statement 6.3 in the Adolescents chapter states:

> *It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression.* (p. 53)

The absence of a visible, documented goal to "change or promote one particular gender identity or expression" by a psychotherapist is a scant fig leaf of protection from the Green-Zucker loophole or other covert punishment of gender diversity. Moreover, "self-discovery" that is "supported" by compulsory psychotherapy for TGD children and adolescents is not the same as self-initiated and self-led discovery or exploration by TGD children and adolescents. Words and clarity matter.

For TGD children living and thriving in authentic, congruent gender roles, Statement 7.13 in the Children chapter is especially unsettling:

> *We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition*. (p. 76)

This statement implies compulsory "gender exploration" psychotherapy for all TGD youth, throughout prepubescent childhood. It presumes unfounded stereotypes of psychopathology and gaslights the gender identities of TGD children. For those who are long-established and well-adjusted in their authentic social gender roles, continual interrogation of their gender identities by a psychotherapist in a position of power and authority can be punishing.

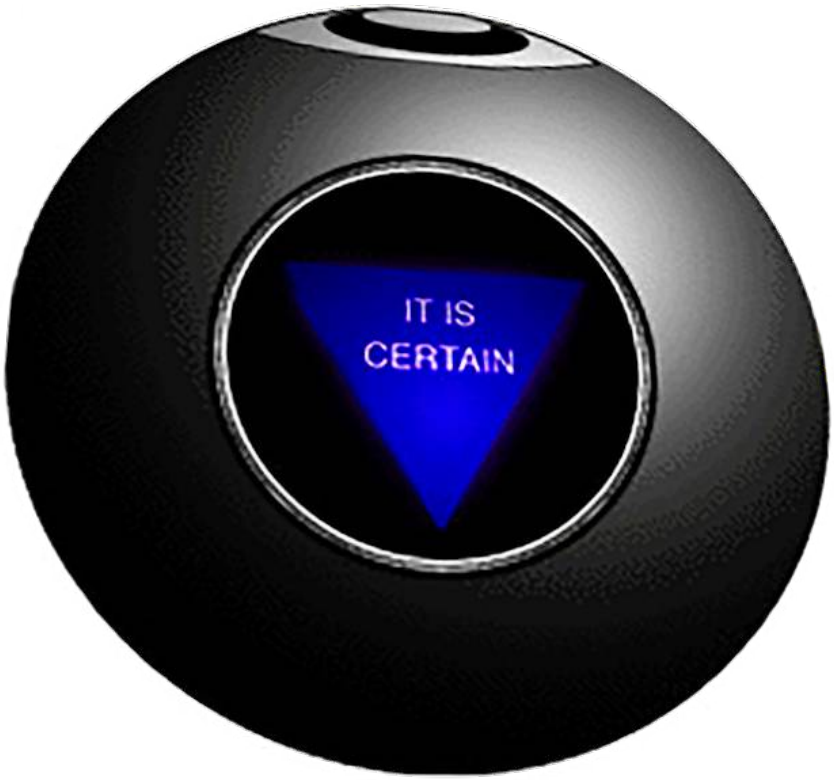
Statement 7.13, however, is refuted within its own supporting text:

> *...not all gender diverse children wish to explore their gender. Cisgender children are not expected to undertake this exploration, and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing, intrusive and/or cisnormative.*

Depsychopathologization of gender diversity is a settled principle of ethical medical practice and is no longer a legitimate topic of debate. It is frequently restated and endorsed within the SOC8 (Table 3). Yet other statements and text of the SOC8 continue to re-litigate this fundamental WPATH principle. This conflict and lack of consensus within WPATH perpetuates false stereotypes and barriers to affirming medical treatments (Table 4).

As a consequence, contradictions to the depsychopathologization principle in the SOC8 will be harvested and weaponized by those opposed to TGD health care. Trans and Gender Diverse people needing care, along with their affirming providers, will face additional barriers from governments and health systems.

Remarks: A Call for Action and Clarity by WPATH Leadership



I have long observed that the WPATH organization and its global Standards of Care have been a battleground between policymakers who see gender expansive people and cultural traditions as a natural dimension of human diversity and those who see gender diversity as a mental sickness to be contained, controlled, or discouraged (Winters, 2008). In spite of this chasm of medical ethics, Standards of Care prior to Version 8 have followed a trend of slow progress toward better understanding and acceptance of gender diversity and more affirming and culturally competent approaches to care. The SOC have gradually evolved from dogmatic denial of medically necessary care, toward the direction of a standard of medical and mental health care for an underserved population. However, this arc of forward-progress seems to have stalled in much of the SOC8—especially in those sections applying to pre-pubertal children and adolescents.

WPATH's regression and ambivalence toward its fundamental principles of medical necessity of gender-affirming care, for those who need it, and depsychopathologization of human gender diversity comes at a critical time in history. The SOC8 has coincided with a virulent rise of global authoritarianism, accompanied by strategic campaigns of disinformation and political extremism that

target Trans and Gender Diverse people and their fundamental human rights, participation in human society, and access to affirming medical care (Williams, 2021). WPATH leadership and SOC editors passed up an opportunity to build standards of Care on WPATH's own established, bedrock ethical principles. Instead, the SOC8 have devolved into a battle royale of contradictory language and compromise with false and biased stereotyping. Health professionals, health systems, and government agencies are left to pick and choose passages from the SOC8 that either support (Tables 1 and 3) or oppose (Tables 2 and 4) affirming health care, with little guidance, context, or nuance.

It is time for the WPATH leadership to finally lay aside false stereotypes of the past and faux science and political extremism of the present. It is time for WPATH to choose, without trepidation, the side of its own ethical principles in Standards of Care and standards of professional conduct.

I recommend that the WPATH leadership place an urgent priority on publication of a corrected SOC8.1 point-revision. These shortcomings must be addressed with consistent, unambiguous cogency on the depsychopathologization of human gender diversity and the medically necessary of affirming and confirming treatments.

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** Revisions of WPATH Standards of Care were traditionally published twice, on the WPATH (formerly HBIGDA) web site and in behavioral journals, including the Journal of Psychology & Human Sexuality, International Journal of Transgenderism, and, most recently, International Journal of Transgender Health. For brevity and accessibility, SOC documents published directly by WPATH are referenced here.*

References with Content Warning

The following references contain material that in the author's opinion may be ideologically biased, in opposition to affirming medical care, civil rights, equality, or participation in human society for Transgender and Gender Diverse people. This content may trigger trauma in TGD readers or those who care about TGD lives.

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