HEALTH AND INSURANCE LAW

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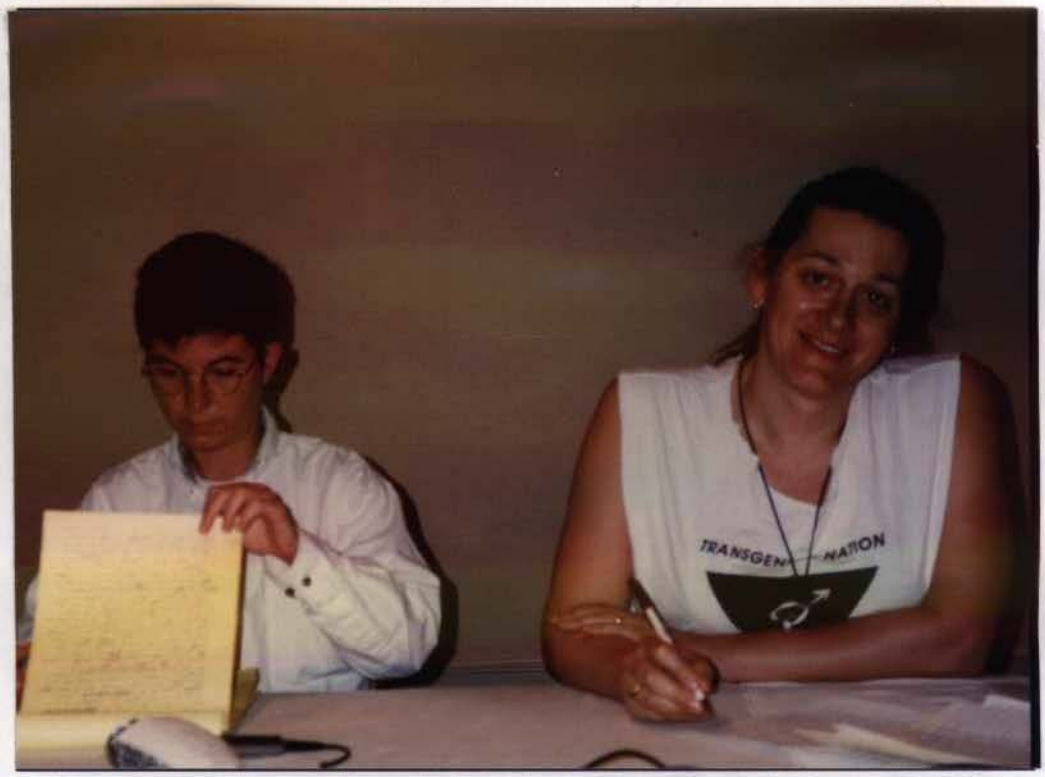
REPORT FROM THE WORKSHOP, HEALTH AND INSURANCE LAW

SHANNON MINTER: Thank you Martine. My name is Shannon Minter and I'm a transsexual man (FTM) and an attorney for the National Center for Lesbian Rights. I'm going to summarize the health law sessions on Thursday and Friday.

Martine really did a brilliant job of using the ICTLEP Health Law Standards as a framework for challenging the very narrow pathologizing model of transgendered identity that's been imposed on us and that's been used to restrict our access to health care. She used ICTLEP standards to articulate instead a different and inclusive multi-etiological model that's more respectful of the diversity of transgender identities and more true to the realities of our lives. It defines transgenderism as medical condition that should be treated on equal terms with any other medical condition. To reach your long-term goal of improving transgender access to health care and improving the quality of that care, Martine stresses the importance of a strategy of solidarity and inclusivity. We really can't accept or settle for a system of access that's based solely on the experiences of just one group within the transgendered community; that's whether that group is male-to-female transsexual at the expense of female-to-male transsexuals; whether it's folks who can afford to pay for treatment at the expense of folks who can't afford to pay for it; whether it's adults at the expense of children and young people. It's an example of using the Health Law Standards to really embody our commitment to solidarity and inclusivity.

The second Health Law Workshop on Friday evening focused on one of the most invisible, disempowered and just objectively vulnerable segments of the transgendered community, and that's children and young people. The panel included myself, Lisa Middleton and Dr. Ted Switzer, and we pretty much covered three topics. First, we summarized the ongoing history of psychiatric abuse of gender nonconforming children and young people. More specifically, how the psychiatric label of gender identity disorder is being used to



(l) Shannon Minter, Attorney, National Center for Lesbian Rights, and (r) Martine Rothblatt, Attorney

authorize and justify that abuse. Second, we discussed how we as a gender community can confront the abuse, and how we can best advocate for young people in our communities. And finally, we discussed how the specific needs of transgendered children and young people fit the larger vision of change that's embodied in the Health Law Standards.

I started out by summarizing a bit of the history of gender identity disorder as it's been applied to children and young people. I began the workshop by describing my work as a legal advocate for lesbian, gay, bisexual and transgender young people who are being abused and discriminated against in the mental health system. To illustrate the continuity and the evolution of the abuse of gender nonconforming children over time -- kind of within the history of modern psychiatry, I shared testimonials from three individuals who were institutionalized and subjected to varying degrees of suffering because of their perceived gender deviance. Those included a transsexual woman who was incarcerated in a mental hospital in 1950 at the age of six years old until she escaped from the hospital in her mid 20's. That was after years of forced electro shock and forced medication. Then more recently, a transgendered lesbian was who was incarcerated in three different mental hospitals from 1981 to 1984 from the age of 14 to 18. She was diagnosed with what was then the new disorder of gender identity disorder because her appearance and behavior was seen as too masculine. Then even more recently, a young bisexual woman who was incarcerated in a residential treatment center in 1993, at the age of 15, again for her perceived gender deviance and her sexual orientation.

I traced the history of gender identity disorder in children from the introduction of GID as a psychiatric diagnosis in DSM-III in 1980, through two subsequent revisions in DSM-IIIR in '87 and then more recently, DSM-IV in 1994. I also summarized the history of attempts to use GID as the diagnostic tool to identify so called prehomosexual and pretranssexual children, and then to use really intrusive behavior modification with the goal of preventing those children from growing up to be gay or transsexual. There are studies now that have shown definitively that the overwhelming majority of children who are diagnosed with and treated for gender identity disorder do in fact grow up to be lesbian, gay, bisexual or transsexual. And although studies have also shown that attempting to eliminate a child's cross gender behavior identification is completely ineffective as a means of preventing adult homosexuality or adult transsexualism, the reality is that contemporary mental health professionals very much continue to view gender nonconformity in children as a deviant pathological condition. And the focus of their treatment continues to be on forcing children to identify with and conform to their assigned gender no matter what damage is caused to that child.

It's also the case that the clinical research in this area continues to be overtly homophobic and even more overtly transphobic and continues to be obsessively focused on achieving adult heterosexuality and gender role conformity. So, with that kind of dismal context as the background, we moved on to address how we can advocate for chidren and youth, how we can stop this abuse. And I briefly discussed the difficulty of advocating for individual young people within the legal system, given the legal presumption that parents have the right to control their children's health care and to dictate the goals of the treatment. But there was a consensus that legal advocates and other advocates must continue to challenge that presumption when the treatment violates the child's human rights and when the treatment causes suffering and damage rather than healing and support. There are limits to parental control.

Then Lisa Middleton gave a really eloquent account of the emotional difficulty even of listening to testimonials of young people who endure psychiatric abuse, because their stories force each of us to confront our own childhood memories and to remember the pain of discovering that we

were outside the dominant norms of gender. And that for us gender was more often going to be a source of pain than of enjoyment. So, as children we only had two paths: Either resist the dominant norms at the cost of certain punishment or possible annihilation, or try and hide our true identities at the cost of losing ourselves and losing our identity. Lisa noted that it's the relentless pressure either to hide on the one hand or to constantly have to defend your identity against constant assault on the other as a child that indeed does make us ill. That's not in the sense of a pathology that's somehow inherent in the transgender identity; but in the sense of just being sick and undermined by the constant insidious trauma -- the daily trauma of being seen and labeled as deviant and having to fight for your identity.

Lisa Middleton, Health and Insurance Law Moderator, ICTLEP

Lisa also cautioned us about the danger of polarizing the transgender community against the entire mental health profession or viewing the entire profession as our enemy. She emphasized what we need to do instead is expose and confront the psychiatric abuse of transgender children, while at the same time trying to communicate with and work with mental health professionals who are genuinely committed to our interest and to our well being. In particular, Lisa emphasized that we really have to encourage and support and build coalitions with lesbian, gay, bisexual, and transgendered people, who are themselves mental health professionals.

And as a gay doctor who has been an advocate for transgendered people for a long time, Dr. Ted Switzer was a good example of what Lisa was talking about, because he was here to describe his work as an ally to the transgender community. And he described several of his own experiences in which he was able to successfully intervene to prevent individual gay and transgendered clients from receiving inappropriate, incompetent or in some cases really abusive treatment. And Dr. Switzer emphasized that type of individual education and advocacy is really crucial. He also emphasized that simply removing GID from the DSM would not eliminate bias or abuse against gender nonconforming children, and that to get the kind of systemic change we're looking for, we have to get to the hearts and minds of individual mental health practitioners on a general basis.

So we emphasize that we need to educate psychiatrists in particular, that transgenderism needs to be understood from a medical or scientific perspective, and to move them away from the pathologizing mental illness model. And he noted that was going to be a serious challenge when it comes to the psychiatric establishment. Then Dr. Switzer's comments were echoed by several people who were workshop participants or audience members who had very positive direct experience of

reaching out to educate health care and health care providers about the reality of transgender people and about the reality of transgendered lives. Both Lisa and Dr. Switzer emphasized the special importance of trying to reach out to the next generation of providers, reaching medical students and ensuring that medical school curriculum includes current updated material about transsexualism and transgendered issues.

In the last topic we moved on to how the particular means and experience of youth and our responsibility to advocate for youth fit into the larger picture; sort of changing the paradigm to our access to health care as embodied in the health law standards. And those standards, as Martine explained, move us away from pathologizing model of transgenderism to a model of equality, dignity and equal access -- really a human rights model that she emphasized. There was a consensus that our long term goal must be to remove gender identity disorder from the DSM by shifting transsexualism and transgenderism from a psychiatric to a medical diagnosis. But, there was also a consensus (and Lisa in particular really articulated this) that we have to pursue this goal very carefully and we have to pursue it in collaboration with providers and that we have to be cautious about not jeopardizing our current access to transgender related health care, as inadequate as that access is, or jeopardizing our current access to reimbursement; again as inadequate as that is. And then we also have to be cautious about not exposing ourselves to new abuses and new forms of exploitation by unscrupulous providers.

Finally, there was a very strong consensus that while we're dealing with all of those challenges and pursuing the long-term goal of changing the whole paradigm of access to health care, that the particular situation and the particular vulnerability of gender nonconforming children and young people is so critical that we can't wait to solve all our larger problems to address what's happening right now to children and young people. And there's no reason to.

So I think the strongest consensus is that we as a community really need to confront the mental health profession and send them the message loud and clear. You have to stop doing this to our kids; this is a really fundamental violation of human rights and human dignity, and you're causing a tremendous amount of damage and suffering. We need to start paying more attention to that issue and putting more resources to protecting the children and young people in our own communities.

MARTINE ROTHBLATT: I will review the multi-etiological approach to the no basis in requiring all transgendered to go through psychotherapy, to have sexual reassignment surgery, or to submit to genetic or neurological proofs of their transgenderism.

In reviewing the Health Law Standards of Care, we clarified that they do not specify surgery or hormones on demand, they do not prohibit discrimination in gender health services based on a marriage or someone's personal appearance. Just because 5 percent of people presenting as transgendered have an underlying psychiatric disorder, it is totally unreasonable, unfair and unethical to require the other 95 percent to submit to the Harry Benjamin psychiatric obstacle course. We found no consensus to make any changes in the Health Law Standards of Care (we will continue to promote them as is).

We are all intersexed to some degree. If that intersexuality is causing distress, we have a right to redress that distress. Redress distress about legal status with a new birth certificate, not new genitals. Redress distress about genitals with sex reassignment surgery, not thousands of dollars on psychiatric therapy. Redress distress about gender appearance with clothing and/or hormones, not psychologists or institutionalization, nor ostracization of the individuals above.

(left to right) Shannon Minter, Attorney, National Center for Lesbian Rights; Lisa Middleton, Health and Insurance Law Moderator, ICTLEP; and Ted Switzer, Physician and winner of the 1996 Transgender Inclusion Award

We can be healthy and still take hormones. Millions of healthy people take all manner of prescription pharmeceuticals, including ones which have a large effect on their body, without a psychologist's permission. We can be healthy and still have genital remodeling surgery. Millions of healthy people have all manner of elective surgery, including ones which have significant risks, without a psychologist's permission. We can be healthy and have a penis with a female legal sex status; or a vagina with a male legal sex status, all without a psychologist's permission. Throughout history, great women have had penises and great men have had vaginas. None of them needed a psychologist's permission slip.

There was useful discussion regarding a psychiatric screening requirement of perhaps 3 to 5 hours or sessions, as a prior condition to receiving transgendered health services. However, there was no consensus on this point, and I believe discussions with transfriendly psychotherapists, such as Kurt Buis, will continue.

The bottom line is that this Fifth Conference strongly supports continuing to promote, distribute and trying to enforce the Health Law Standards of Care. This Fifth Conference strongly believes their tactics are unethical, abusive to transgendered people of all ages, and oppressive to people of gender. We urge this society to revise their standards to bring them into conformance with the Health Law Standards of Care. We further believe the DSM's treatment of people of gender is unethical, abusive to children in particular, and oppressive. We urge the APA to delete all references to GID in DSM and to acknowledge that gender creativity is healthy.

We come to be transgendered from many different paths, backgrounds, causes, etiologies and explanations. You must accept all of your siblings. Don't judge the reality of their experience. It is real. We have a Health Law Standard of Care that defends all of our rights. Defend it. Promote it. Bring HBIGDA and APA into line with it. Our message is simple: gender expression is a human right.

The time has come.