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Nomenclature in the World Professional Association for Transgender Health's *Standards of Care*: Background and Recommendations

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ABSTRACT. This article looks at the history of terminology used in the *Standards of Care for Gender Identity Disorder* (*SOC*), the document guiding much of transgender health care today. We argue that a deeper understanding of how terms and concepts in this set of professional guidelines have evolved over time may foster a more positive relationship between service providers and users by publicly acknowledging tensions that have emerged. The article looks first at the development of the *SOC* in relation to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Disease and Related Health Problems* (*ICD*) and then at the ways that the American and Western European cultural contexts of many of its authors may have unintentionally undermined what we assume to have been the authors' best efforts to produce a document international in scope. We also discuss attempts to address the needs and views of community users and service providers and how this might have affected the language used in previous versions of the *SOC*. Designed to be valuable to service users, for service providers, and particularly for those drafting future editions of the *SOC*, we end with specific recommendations, arguing that in order to develop better language for use in the *SOC*, a more thorough critical examination of the *SOC*'s history and social context(s) is in order.

KEYWORDS. Gender identity disorder, standards of care, transsexualism, professional guidelines, transgender

The document guiding much of transgender health care today, the *Standards of Care for Gender Identity Disorders* (*SOC*), is a product of the social context in which it was produced (Levine et al., 1998; Meyer et al., 2001; Walker et al., 1985, 1990).[1] The words chosen to represent

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[1] Our discussion of the *SOC* will make reference only to Versions 3 to 6. We have been unable to locate copies of Versions 1 and 2. Version 3 (1985) specifies that Version 1 was drafted in February 1979 and was prepared by the same authors as Version 3. Version 2 (1980) presumably had the same authors. We have referenced Version 3 as it was published in the *Archives of Sexual Behavior* (1985); however, we also possess a copy of an originally typewritten draft of Version 3 dated March 9, 1981, which notes that it was the text approved by the HBIGDA membership in March of 1981 (not prepared by the majority of the membership of HBIGDA in January 1980 as is noted on p. 79 of the 1985 version published in the *Archives*).

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contemporary conceptualizations of transgender health have changed over time and in ways that have affected the tone of the *SOC*, including the development of nomenclature used in other related arenas. Because an important part of the history the *SOC* and its terminology is the changing contexts in which the various versions of the *SOC* were created, we argue in this article that a deeper understanding of how terms and concepts have evolved over time may allow a more careful approach to the development of future terminology. Similarly, a deeper historical awareness may also make it possible to formally recognize the ways in which terminology, and the attitudes and approaches represented by that language, have changed through various editions of the *Standards of Care*. It is our hope that such recognition may foster a more positive relationship between service providers and users by publicly acknowledging tensions that have emerged over time.

This article will focus on three significant contexts that have affected the language used in the *SOC*. First, we will look at the development of the *SOC* in relation to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 1980, 1987, 1994; The Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952, 1968) and the *International Classification of Disease and Related Health Problems* (*ICD*; World Health Organization [WHO], 1992) and suggest how some of the nomenclature used in the *SOC* may have resulted from its history as a set of professional guidelines. Second, given the American and Western European cultural contexts of many of its authors, we speculate that this, too, may have influenced the language used, despite what we assume to have been the authors' best efforts to produce a document that was international in scope. Finally, we will address how apparent attempts to address the needs and views of transgendered community users, in addition to those of service providers, might have affected the language used in previous versions of the *SOC*. Thus, this article will provide important background information that we believe will be valuable for service users, for service providers, and particularly for those drafting future editions of the *SOC*. We end with specific recommendations, arguing that

in order to develop better language for use in the *SOC*, a more thorough critical examination of the *SOC*'s history and social context(s) is in order.

THE SOC, THE DSM, AND THE ICD

How the *SOC* has changed over time may be understood partially in relation to changes in American psychiatry and international medicine. This can be illustrated by looking at the relationships between the *SOC* (Levine et al., 1998; Meyer et al., 2001; Walker et al., 1985, 1990), the *DSM* (APA, 1980, 1987, 1994; The Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952, 1968), and the *ICD* (WHO, 1992). All three documents attempt to set uniform standards for medicine that interact with legal, medical, social, and state concerns about how medicine is and should be practiced. All three sets of standards are also "living" documents in that they have been produced and revised over time to reflect changes in medicine and society. The story of the relationship between the three (and the history of the development of each) helps bring into relief what we think may have been some of the motivations behind important changes in the *SOC*, because many versions of the *SOC* have referred to both the *DSM* and the *ICD*.

The *DSM* emerged in the United States in the first half of the 20th century in an attempt to aid in collecting medical statistics and to address communication difficulties among local teaching centers, which had each been using their own diagnostic terminology. In 1927, the New York Academy of Medicine began advocating for the adoption of a nationally accepted standard nomenclature of diseases, a complex process that would span the rest of the 20th century (The Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952). By mid-century, the APA had taken the position that the *ICD-6* relied too heavily "on unproven etiological concepts," and it published the first *DSM* in 1952 as an alternative to the *ICD-6* (First & Tasman, 2004, p. 5).

By 1966, the World Health Organization was having some success in developing standardized nomenclature and diagnoses at the

global level. However, American psychiatrists had objected to earlier versions of the *ICD* for their "unsuitability [for] use in the United States for compiling statistics on the diagnostic characteristics of patients with mental disorders or for indexing medical records in psychiatric treatment facilities" (The Committee on Nomenclature and Statistics of the American Psychiatric Association, 1968, p. xi). Thus, the APA sought to have American clinical practices and data collection interests reflected in the work of the World Health Organization, despite continuing to publish its own *DSM*. The American Psychiatric Association's Committee on Nomenclature and Statistics stated that it wanted its *DSM-II*, which came out in 1968, to reflect "the concept that people of all nations live in one world," and stressed that "from the beginning . . . United States representatives helped to formulate the Section on Mental Disorders in ICD-8" (The Committee on Nomenclature and Statistics of the American Psychiatric Association, 1968, p. vii). This collaboration between the APA and the WHO in the writing of the *ICD-8* reflected, in part, the rising acceptance of psychiatry within general medicine and of American psychiatry on a global level. This kind of simultaneous collaboration and dissonance between American psychiatry and global health experts would also come to play an important part in the Harry Benjamin International Gender Dysphoria Association (HBIGDA) and the *SOC*.

The need for increased dialogue between researchers and clinical practitioners was becoming an issue that would also emerge over the course of *SOC* revisions. The *DSM-I* and *DSM-II* had been developed "almost exclusively by expert consensus," whereas the *DSM-IV* made new claims to authority "based on a systematic review of the then current empirical database" in an attempt to make research and changing diagnostic criteria more applicable to clinical usage within American psychiatry (First & Tasman, 2004, p. 6). The tensions between competing national and international interests, between psychiatrists and other medical practitioners, and the need for increased communication between scientific researchers and clinical practitioners were well established when HBIGDA and the *SOC* entered the picture in the late 1970s.

HBIGDA played an important role in having "gender identity disorder" added to the *DSM-III* in 1980 (Hall, 2005), thereby bringing what had previously been less widely accepted thinking about transsexuals into mainstream psychiatry and opening up new legal and social possibilities for transsexuals in the United States. HBIGDA and the *SOC* had first been conceived at the 5th International Gender Dysphoria Symposium held in 1977, in Norfolk, Virginia, one of several conferences during the 1970s and 1980s where international clinicians and other professionals working on issues facing transpeople[2] shared their ideas and developed an international and interdisciplinary professional community (A. H Devor & Matte, 2007). The HBIGDA founding committee was comprised entirely of Americans, including one transgender activist: Jack Berger, Richard Green, Don Laub, Jude Patton, Charles Reynolds Jr., Paul Walker, and Leo Wollman (H. Devor, 1999). The original *Standards of Care* committee was also formed at that time and included all of the HBIGDA founding committee members with the exception of the lone transgendered-identified founding committee member, Jude Patton. HBIGDA's Articles of Incorporation were subsequently approved in February 1979 at the 6th International Gender Dysphoria Symposium in San Diego, California. HBIGDA was legally incorporated 7 months later in September 1979 (A. H Devor, 2005).

Like the *DSM*, the original and subsequent versions of the *SOC* were based largely on professional consensus and grounded in clinical experience rather than formal research findings. Some argued that by developing standardized terminology, the *SOC* could also pave the way for better data collection and clearer communication among clinicians and scientists in the future. For example, at the Fourth International Conference on Gender Identity, K. Roy Mackenzie made the following argument:

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[2]We use the term *transpeople* purposefully here as a broad umbrella term in common usage in many community settings, recognizing the many debates over appropriate terms and terminology as all raising important points about the need to depathologize and recognize difference among people who may or may not see themselves falling under its purview.

The first step was to make it professionally respectable to even study such material. It is now crucial that the second step be undertaken—the development of more rigorous definitions so that data can be accumulated and compared from the numerous centers involved in case assessment and treatment. . . . Since most investigative gender identity clinics are represented at this meeting, such a move could have immediate and significant impact in ordering data collections. (Mackenzie, 1978, p. 251)

Like the *DSM* and *ICD*, the *SOC* were regularly revised to reflect changes over time. However, the *SOC*, unlike the *DSM* or *ICD*, was primarily intended to be clinical guidelines, rather than to provide diagnostic criteria. The *SOC*'s focus on clinical concerns rather than diagnostic ones may have been the source of some internal inconsistencies within the *SOC*. For example, section 302.5x of the *DSM-III* diagnosis for transsexualism stated that transsexualism was not a valid diagnosis for an intersexed person (APA, 1980). But Version 3 of the *SOC* stated in section 4.3.1 that it followed the *DSM-III* definition, and later in the same section it was noted that the "definition of transsexualism is herein interpreted not to exclude persons who meet the above criteria but who otherwise may . . . be conceptualized and classified," including intersexed people who could also be diagnosed as transsexual and "should first be treated by procedures commonly accepted as appropriate for such medical conditions" (Walker et al., 1985, p. 85). It was not clear, then, whether and how the *SOC* applied to intersexed people.

Following the lead of the *DSM* and *ICD*, early versions of the *SOC*, based on professional consensus and clinical practice, adopted the same pathologizing approach and terminology as was then found in the *DSM* and *ICD*. The *SOC* tended to defer to *DSM* criteria for diagnosis while focusing on its mandate to set treatment guidelines. By 1998, Version 5 of the *SOC* explicitly recognized the shifting language being used in clinical practice, stating that:

"transgendered" began to be used in various ways . . . [to represent] those with unusual gender identities in a value free manner—that is, without a connotation to psychopathology. Some professionals informally use the term to refer to any person with any type of gender problem. Transgendered is not a diagnosis, but professionals find it easier to informally use than GIDNOS [Gender Identity Disorder Not Otherwise Specified], which is. (¶63)

Similarly, Version 5 of the *SOC* explained broadly that "individuals [who] meet specified criteria in one of two official nomenclatures—the *International Classification of Diseases–10* (ICD-10) or the *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition* (DSM-IV) . . . are formally designated as suffering from a gender identity disorder (GID)," (1998, ¶4). The *SOC* then went on to provide only the *ICD-10*'s five specific diagnoses under the spectrum of "gender identity disorders": transsexualism; dual-role transvestism; gender identity disorder of childhood; other gender identity disorders; and gender disorders, unspecified (WHO, 1992). It did not list the *DSM*'s diagnostic categories and gave no explanation for their absence. In any case, it seems clear that the language used to diagnose gender identity disorders came from clinical practice, whereas the *SOC* guidelines suggested a looser flexibility in clinical practice and during a diagnostic phase, particularly concerning the use of the term *transgendered*.

THE SOC'S UNDERLYING AMERICAN CONTEXT

The terminology used in the *SOC* over the years also reflected the sociocultural contexts of its authors, at times conveying important and sometimes subtle subtexts and mixed messages. National and disciplinary biases can inevitably be found in the text in ways that may have been neither visible to, nor intended by, its creators or its users. This was particularly evident in relation to HBIGDA's claim to internationalism. Despite the fact that the organization was called the Harry Benjamin *International* Gender Dysphoria Association, and although members were

not exclusively American, the vast majority of members of HBIGDA have always been closely tied to the United States, whether by training or citizenship. As a result, the language used in the *SOC* did not consistently reflect a fully international or global perspective.

The same introduction to the *SOC*, for example, was used in Versions 1 (1979), 2 (1980), 3 (1985), and 4 (1990). Although we have been unable to obtain copies of *SOC* Versions 1 (1979) or 2 (1980), given that the introduction in Version 4 (1990) begins with the claim, "[a]s of the beginning of 1979" (¶1), we concluded that this was also likely the language used since Version 1. The introduction used between 1979 and 1990, then, referred in the very first sentence to the number of *Americans* "hormonally and surgically sex-reassigned" and in the second sentence discussed those *U.S. citizens* who "consider themselves to be valid candidates for sex reassignment" (Walker et al., 1990, ¶1). The introduction also noted the number of centers in the *Western hemisphere* that offered sex reassignment and proclaimed that "world estimates are not available" (Walker et al., 1990, ¶1).

The membership of HBIGDA, who approved Versions 1, 2, 3, and 4 of the *SOC*, was dominated by Americans and supplemented almost entirely by Western Europeans. It should not be surprising then, that the *SOC* would take American and Western European clinical practices as foundational. The facts that were used to justify the existence of the *SOC* in the introduction were based largely on an American social context. That the introduction was not updated until 1990 illustrates an important part of how this document, which was intended to be international in scope, lacked an adequate research base and retained an overt American and, to a lesser extent, Western European cultural subtext.

By Version 5 (1998), the *SOC* began to explicitly address the previously subtle overemphasis on an American cultural context by including a section called "Cultural Differences in Gender Identity Disorders Throughout the World." This section stated that "even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of the disorder" (¶58). What remained unaddressed, however, was the relationship between the guidance offered in the *SOC* and the myriad expressions of gender diversity being articulated in different global social contexts. Just as creators of the *DSM* had felt that the *ICD* was insufficient for addressing specifically American concerns, it soon became clear that an international document such as the *SOC* could not possibly deal with the particular concerns of all nations comprehensively. This was especially complicated in the area of legal issues, which varied greatly from country to country and were always highly pertinent to transgender health care.

Though the potential or actual legal problems of clinicians dealing with transsexual people in the United States and Europe had long been cause for concern at meetings and in professional publications, by the 1980s a few countries began developing their own national standards to address their particular legal, medical, and social systems. These national standards reflected a changing global sociocultural landscape and a new set of contexts in which the *SOC* was used, read, and interpreted. For example, Italy developed the *Italian Standards of Care for Sex Reassignment in Gender Identity Disorder* (*DSM IV 302.85*; Ravenna, 1998), and Germany created the *German Standards for the Treatment and Diagnostic Assessment of Transsexuals* (Becker et al., 1998), both clearly articulating the relationship between legal and medical authority in those two countries. In Malaysia, Islamic law was newly interpreted and a *fatwa* declared in 1983 by the Conference of Rulers forbidding sex reassignment surgery for Muslims (Koon, 2002). In the same year, the Ayatollah Ruhollah Khomeini issued a ruling permitting sex-change operations to take place in Iran (Mangez, 2005). Thus, though those who wrote and authorized the *SOC* had begun to recognize "cultural differences in gender identity disorders," they seemed unable to fully address the ways in which HBIGDA was itself culturally embedded and constructed, or how this influenced the ways in which the *Standards of Care* were framed and could be used.

LEGITIMIZING WORKING WITH TRANSPEOPLE

It seems likely that, in part, the language in earlier versions of the *SOC* reflected a desire among HBIGDA members to safeguard the professional stature of those who worked in the field of transgenderism. When HBIGDA was first formed and the early versions of the *SOC* were first developed, many professionals serving transgendered clients were in much more precarious professional positions than they are today: isolated from their peers, often facing legal challenges, and generally lacking social approval and support. One of the ways that they could develop legitimacy and social support in the Western world was by using the language of psychiatry and science.

Among the most effective language available for the purpose of professional legitimization were medical and legal terms, some of which would now be considered by many people to be pathologizing or otherwise offensive. For example, a specific focus on *disorders* was an important part of justifying *treatment*, but many transpeople have objected to the notion that their gender variance be considered a mental illness.

The title of the *SOC* itself sends a very strong message about the purpose of the document when it uses the language "gender identity disorders." It seems to us that there are many people who would benefit from making use of these *Standards of Care* who would neither recognize themselves nor the people in their care in this terminology. Similarly, the entire document appears to be directed to the care of transsexual persons despite the occasional mention of people who are troubled by other types of gender issues. More inclusive and less pathologizing language would increase the effectiveness of the *SOC*.

By the turn of the 21st century, a combined desire for national specificity and growing user group mobilization lead to further development of specific alternatives to the *SOC* and its emphasis on "disorders." A notable example of this trend are the *Health Law Standards of Care for Transsexualism*, adopted in 1993 at the Second International Conference on Law and Employment Policy, an event organized mainly by lawyers, many of whom were also themselves transgendered (International Conference on Transgender Law and Employment Policy [ICTLEP], 1997). Although the *Health Law Standards* were also developed largely in an American context, many alternatives to the *SOC* have focused on social, medical, and legal concerns in other locales. Two of the most extensive national sets of standards to address both service users and professional service providers have come from the United Kingdom. For example, *The Guidelines for Health Organisations Commissioning Treatment Services for Individuals Experiencing Gender Dysphoria and Transsexualism* were published in 2005 by the Parliamentary Forum on Transsexualism. The forum that developed these guidelines was established in 1994 "to facilitate co-operation between all the stakeholders in the social integration, destigmatisation and care of transsexual people in the UK." It also contributed greatly to the passage of the *UK Gender Recognition Act* of 2004 (Jones, 2005). Another significant contribution is the draft *Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria*, developed through a broad process of consultation and circulated for public comment late in 2006 by the UK Royal College of Psychiatrists (RCPsych Intercollegiate SoC Committee, 2006).

On a smaller scale, individual community-based projects and clinics have undertaken to develop guidelines and standards relevant to their own communities. Some examples include the Tom Waddell Clinic in San Francisco, California, in the United States (Tom Waddell Health Centre Transgender Team, 2006); the Vancouver Coastal Health and Transcend Transgender Education Support and Education Society in British Columbia, Canada (Feldman & Goldberg, 2006); and the Sherbourne Health Centre in Toronto, Canada (Raj, 2002). These initiatives have emphasized the importance of a harm reduction model, which suggests that the scope and the pathologizing tone of the *SOC* requires modification in order to be made more relevant to local communities.

Although it may be tempting to think that the kinds of objections that have led to alternative standards and guidelines are relatively new, in fact, transpeople have been expressing their

concerns about professionals' abilities to properly understand and provide care for those who use their services since the founding of HBIGDA. For example, in 1979, Jude Patton told readers of the trans-community newsletter *Renaissance* that at the initial formation of HBIGDA, "a suggestion that a consumer be appointed to the original [SOC] task force committee was voted down" by only one vote. On a more hopeful note, he reported that he had been elected to be a member of the task force commissioned by HBIGDA to produce the second version of the *SOC*, thereby giving "consumers . . . a voice in developing Standards of Care" (Patton, 1979). In retrospect, it would seem that some dissatisfaction with the *SOC* might have been avoided had the original document and subsequent revisions included more information about its origins and the contexts and disputes among which it was produced, particularly in relation into the involvement of service users or trans-community members. As it is, this history of trans involvement with the development of the *SOC* seems to have largely disappeared from community memory.

It was only in Version 5 (1998) that the document itself began to address service users directly when it outlined that the *Standards of Care* could be used by "persons with gender identity disorders, their families, and social institutions . . . to understand the current thinking of professionals" (¶1). This shift to directly addressing service users reflected the increasing presence of a rising (but longstanding) service users' advocacy movement, one that by the late 1990s had achieved greater social power and more autonomy. However, the language of the *SOC* still fell short of directly and comprehensively addressing service users' needs: the document's primary function continued to be the setting of professional standards for assessing eligibility for, and provision of, sex reassignment processes.

Because the authors of the *SOC* attempted to respond to service users' demands for more satisfactory language, a further lack of linguistic and conceptual clarity was introduced by the use of more flexible language such as the term *transgender*. This term was considered to be less offensive to service users because it was seen as less pathologizing, although it was still

often used interchangeably with more specifically clinically diagnostic words such as *gender identity disorder*. Though the *SOC* seemed to be aiming to at least partially address both service users and the professionals who worked with them, and to speak to transgenderism more widely, it also continued to use clinical terms like *candidate* and *eligibility*. Thus, though some linguistic changes had been made, the underlying tone of the document remained clinical and pathologizing.

Section 1 in Version 6 provides a useful tool for examining how the language used in the *SOC* reflects underlying assumptions that, although perhaps neither obvious nor intended, can convey negative messages to potential users of the document. In addition to the already discussed gender identity disorders, words such as *management*, *conditions*, *clinical*, *treatment goals*, and *patient* strongly suggest a sickness model. This tone acts as a barrier to many persons who would benefit from such care because it contributes to their distrust the motivations of those who would provide it.

Along the same lines, the language in the section describing "The Purpose of the Standards of Care" should be adjusted to emphasize the desire to provide care and to improve quality of life for those receiving care. A similar need for a change in tone can be found in the introduction to section 9, which recites a litany of reasons to fear undertaking a "real-life-experience" and ends with the seeming afterthought, "[h]owever, not all changes are negative" (Meyer et al., 2001, ¶82).

The gate-keeping role expected of service providers which is implicit in this language has remained in all versions of the *SOC* to date and is something to which many transpeople, and some service providers, vigorously object. For example, Poxon (2000), in her research on the impact of the *SOC* on therapeutic relationships, found that "therapists most frequently viewed the *SOC* as useful guidelines that protected them personally and professionally, while transsexual clients generally found the *SOC* to be a barrier to receiving hormonal and surgical treatment" (p. 157). Similarly, one psychiatrist has argued that "an alternative to the health-care providers' functioning as gatekeepers is the informed consent model

. . . [which] attempts a role of partnership in care with the patient rather than a role as gatekeeper" (Karasic, 2000, p. 157). Many trans-community activists have also provided insightful critiques of the *SOC*'s pathologizing and gate-keeping tone (for example, see Denny, 2001; MacDonald, 1999). It would seem that the challenge of responding sensitively to the needs of both service users and service providers has yet to be fully met.

RECOMMENDATIONS

The HBIGDA has recently changed its name to World Professional Association for Transgender Health (WPATH), in part reflecting the organization's desire to increase its global visibility and influence. In this context it becomes even more essential that the language of the *SOC* is clearly defined and culturally sensitive. Furthermore, if the WPATH wishes the *SOC* to become more widely accepted and more willingly used, the document must be written in a way that also reflects the concerns and realities of both professional and transgendered consumers; Petersen and Dickey (1995), for example, noted that only 5 out of 19 clinics reviewed in their work adhered to the *SOC* in their entirety.

We therefore recommend that the following steps be undertaken by the next *SOC* committee in order to make the *SOC* more widely accepted and more effectively utilized. We also provide only a few examples of the kinds of nomenclature and more general language issues that we think the *SOC* committee would do well to address in the next revision.

1. We recommend that revisions be undertaken at regular intervals, ideally at every five years, and that before each revision the *SOC* committee carefully review all published critiques and commentaries on the *SOC*.
2. We recommend that the entire *SOC* be submitted to a series of consultations with a range of relevant groups from a variety of nations for input concerning:

   a. the scope of topics that should be covered in the *SOC*,

   b. the overall tone of the document,
   c. content suggestions,
   d. specific language usage, and
   e. recommendations for additional consultations.

3. We recommend that revisions undertaken after such a series of consultations should be reviewed by leading expert members of a full range of user groups for endorsement prior to official publication of a revised *SOC*. Information concerning who was consulted for each revision should be included with each issuance of the *SOC*.
4. We recommend that the *SOC* committee extend and clarify the intention that this document is meant to apply to the full range of people with transgendered experiences and adjust the content accordingly throughout, including provisions for the health care needs of transgendered people for whom the traditional "triadic sequence" is not the most suitable.
5. Efforts should be made to make the *SOC* a more internationally applicable document.

   a. A section defining key terms should be included and a glossary should be provided as an appendix in which all key terms are translated into major world languages. If the SOC are to truly reflect an international consensus and enjoy an international usage, we recommend that all basic terms (e.g., *sex*, *sex identity*, *gender*, *gender identity*, *sexual orientations*, *sex assigned at birth*, *transsexual*, *transgender*, *intersexed*, *disorders of sex development*, *GID*, *sex identity dysphoria*, *body dysphoria*, *sex reassignment*, etc.) should be clearly defined, as well as variants in common usage.
   b. A team of social scientists should be engaged to do an extensive rewrite of the section "Cultural Differences in Gender Identity Variance Throughout the World," including a consideration of historical differences in those cultures.
   c. Each section should be scrutinized for unstated assumptions based on the medical or legal system of a particular country or region. Such sections should be made more

inclusive where possible and in all cases made explicit.

6. The intended relationship of the *SOC* to the *DSM*, the *ICD*, and other complementary or competing standards should be explicitly addressed.
7. We recommend that the language used in the *SOC* should reflect a greater acceptance of significant sex and gender change and variation, and we raise the question of whether it is correct to describe people living successfully in their preferred gender and sex as having an ongoing gender identity disorder.

Throughout the *SOC* the terms *biological males*, *biological females*, and *anatomic sex* are used but never defined. The way in which these terms are used seems to imply that all individuals can be clearly understood to be biologically male or female and that they remain biologically unchanged throughout their entire lifetimes regardless of undergoing hormonal treatments or surgical procedures. This would also seem to imply that there are no underlying biological bases for sex or gender variance and that sex and gender changes are entirely superficial and cosmetic.

Though there is no firm evidence identifying a biological basis for people desiring changes of sex and gender, many professional and laypeople believe that biological mechanisms will eventually be understood. Furthermore, the use of this nomenclature to describe people who feel that their originally assigned sex was assigned in error can have the effect of tethering them to their original sex and gender assignments in a way that undermines the legitimacy of any sex or gender changes they may undergo.

Rather than identifying the two primary populations noted at the end of section 1 as *biological females* and *biological males*, the *SOC* might use more appropriate terms, such as *female-to-male* and *male-to-female*, or *transman* and *transwoman*, thus recognizing both individuals' origins and destinations. We also suggest that the *SOC* should recognize a wider range of potential identities among transgendered people, acknowledging that the concept of binary origins and destinations is not universally applicable, as

in the obvious case of intersexed people, but in the case of others as well. Finally, we recommend that the *SOC* address the full spectrum of transpeople's health care needs across the lifespan, not simply health care related to gender transitions.

SUMMARY AND CONCLUSIONS

This consideration of the nomenclature used in the *Standards of Care* has drawn attention to what we find to be some of its most pressing issues. We have explored three major contexts in which various versions of the *SOC* have been formed. First, we described the *SOC*'s history as a set of medical guidelines in relation to the other two dominant and related guidelines, the *DSM* and *ICD*. Second, we looked at how the continued dominance of Americans and Western Europeans in HBIGDA and on the *SOC* committee may have hindered the full realization of the document's intended international scope. Third, we looked at how the authors of the *SOC* have attempted to address both service providers' and service users' needs and perspectives. Finally, we offered recommendations for future *SOC* revisions.

Each of the three arenas explored here has informed the tone of language used. Our primary recommendation is that future versions of the *SOC* pay more careful attention to the tone and background assumptions implicit in the language used. The most obvious and well-known point is that pathologizing language is offensive to many service users and has created social difficulties that render the document less effective. This is only one example, however, and our other major recommendation is that the authors of future versions of the *Standards of Care* consult more widely with focus groups of both user and professional experts in particular fields in order to adequately address issues of language and intent. Finally, we remind all concerned that transparency enables both trust and accountability.

Overview of Recommendations

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   b. A team of social scientists should be engaged to do an extensive rewrite of the section "Cultural Differences in Gender Identity Variance Throughout the World," including a consideration of historical differences in those cultures.
   c. Each section should be scrutinized for unstated assumptions based on the medical or legal system of a particular country or region. Such sections should be made more inclusive where possible and in all cases made explicit.

6. The intended relationship of the *SOC* to the *DSM*, the *ICD*, and other complementary or competing standards should be explicitly addressed.

7. We recommend that the language used in the *SOC* should reflect a greater acceptance of significant sex and gender change and variation, and we raise the question of whether it is correct to describe people living successfully in their preferred gender and sex as having an ongoing gender identity disorder.

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