

23 September 2007

Clinton W. Anderson, PhD  
Director, Lesbian, Gay, Bisexual, and Transgender Concerns Office  
American Psychological Association: Public Interest Directorate  
750 First Street, NE, Washington DC 20002-4242

Dear Dr. Anderson:

Thank you for the opportunity to address serious concerns about the Final Report of the APA Task Force on Gender Identity, Gender Variance, and Intersex Conditions. I have provided specific page/line citations below, but I want to note five key points at the onset.

### **1. Centre for Addiction and Mental Health (CAMH Clarke Institute)**

Nearly all of the regressive and problematic practices and terminology concerning gender-variant people in the last three decades were developed at “gender clinics,” primarily by psychologists affiliated with Toronto’s CAMH Clarke Institute. The three most problematic are:

- Reparative therapy, especially when directed at gender-nonconforming children
- Sexual taxonomies using problematic terms such as “homosexual transsexual”
- The psychosexual pathology “autogynephilia” coined by Clarke Institute allies

The inclusion of both Kenneth Zucker and Anne Lawrence on the APA Task Force echoes the ideological deck-stacking Dr. Zucker has done as Editor-in-Chief of the *Archives of Sexual Behavior*, which has effectively become the house organ for the Clarke Institute. In fact, one of Dr. Zucker’s upcoming *ASB* issues features the longest article ever published in that journal’s 36-year history, devoted to discrediting key critics of Dr. Zucker and his allies. I am among the chief targets of this criticism. The subversion of both *ASB* and this Task Force is part of a much larger problem of “experts” putting their personal and political interests ahead of the populations they are paid to serve. Dr. Zucker and his allies have attempted to suppress dissent by wielding their gatekeeping power against our community and by taking strategic positions in key professional groups and publications, including APA Division 44. Most peer criticism of Zucker and his allies that has reached the public comes from anonymous and pseudonymous psychologists and sexologists who fear career damage and retribution if they dare speak openly about what Dr. Zucker and his allies at the Clarke Institute are doing in the name of psychology and the APA. As you know, trans people involved in the Task Force have resigned for the reasons described above. Joshua Mira Goldberg, who first made the community aware there even was a Task Force, recently wrote that since “the Task Force had refused to work constructively with trans and intersex community groups throughout their process, I did not wish to lend any credibility to their process by engaging in review of their final draft.” I suspect this letter will be treated in the same manner unless the APA takes a hard look at what is obviously a pervasive and ongoing problem with this Task Force.

## **2. Disease models of gender variance**

This Task Force is on a parallel track with what will undoubtedly be a historically significant debate over “mental illness” diagnoses related to gender variance in the American Psychiatric Association’s DSM-V. Dr. Zucker and his allies are laying the groundwork for arguments in line with their practices and viewpoints, while shutting out opportunities for open debate.

## **3. Sex science**

“Sex science” is as problematic for our community as “race science” is for populations which face race-based discrimination. Dr. Zucker and his allies have deep and long-term ideological ties to sociobiology and anthropometry (especially phallometrics). Because of potential for abuse in these fields of inquiry, methodology must be sound and the publication of findings must be based on carefully gathered data, presented responsibly.

## **4. Prevalence**

Conventional conclusions about prevalence data on gender variance have recently come under question. Taking the subset of transsexualism alone, the most-cited prevalence estimates are based on counts of gender reassignments in European clinics many years ago. Reanalysis of those early reports shows lower bounds on the prevalence to be between 1:1000 and 1:2000, using those reports’ own data. More recent incidence data and alternative methods for estimating indicate that the lower bound on the prevalence of transsexualism is at least 1:500, and possibly higher.

## **5. Task Force name and “disorders of sex development”**

“Intersex Conditions” should be changed to “Intersex Traits.” A disease model of intersex is not unanimously embraced. A trait is merely a characteristic, with no pejorative connotation or denotation, but a condition denotes a state of fitness, especially an ailment or abnormality (like a heart condition). Prominent activists and experts question the proposed term “disorders of sex development” (DSD), which conflates issues of function and cosmesis and implies an “order” based on fundamentally heterosexist notions of phenotypic normativity and reproductive fitness.

I do not know by what means you can compel the Task Force to consider and include important data and references that differ from the Clarke Institute viewpoint. Dr. Bockting seems to have worked to bring some balance, but my last-minute involvement suggests others have already lost the war of attrition waged by Dr. Zucker on this front. I hope my involvement is not another empty gesture toward consensus by the Task Force.

Thank you again for allowing me to comment, and please confirm receipt of this letter.

Sincerely,

Andrea James  
aj@andreaames.com  
213-840-2602

page:line comment

11:17 preferred > proposed (for many this term is not “preferred”)

15:12 missing period

34:04 send > sent

41:07 regarding > regarded

42:20 1991 > 1911

43:09 Jorgenson > Jorgensen

47:14 before “Recent” add

One reanalysis of population-based reports shows lower bounds on the prevalence to be between 1:1000 and 1:2000, using those reports’ own data (Olyslager & Conway, 2007). More recent incidence data and alternative methods for estimating indicate that the lower bound on the prevalence of transsexualism is at least 1:500, and possibly higher (Winter, 2006, Olyslager & Conway, 2007).

In references add

Olyslager, F., & Conway, L. (2007, November). On the calculation of the prevalence of transsexualism. Paper presented at the 20th WPATH International Symposium, Chicago, Illinois.

[note: this is the format used for the same conference reference at 157:19]

Winter, S. (2006). Thai transgenders in focus: Demographics, transitions and identities. *International Journal of Transgenderism*, vol. 9, No. 1, pp. 15-27.

48:02 after citations add

Others propose that theoretical linkage between “transvestic fetishism” and “gender identity disorder” is an artifact from diagnoses proposed and implemented in earlier versions of the DSM (Vitale 2005). Vitale (2001) has suggested Gender Expression Deprivation Anxiety Disorder (GEDAD) as an alternative where sexual behavior is neither cause nor effect of dysphoria.

In references add

Vitale A. M., (2001). Implications of being gender dysphoric: A developmental review. *Gender and Psychoanalysis, An Interdisciplinary Journal*. Volume 6, Spring 2001, Number 2, pp 121-141.

Vitale, A. M. (2005, April). Rethinking the gender identity disorder terminology in the *Diagnostic and Statistical Manual of Mental Disorders IV*. Paper presented at the HBIGDA Conference, Bologna, Italy

[note: this is the format used for the same conference reference at 157:19]

48:05 after citations add

However, the diagnosis of transvestic fetishism has been called into question as an iatrogenic artifact (Moser & Kleinplatz, 2002), part of the larger questioning of the diagnostic category of “paraphilia” (Moser & Kleinplatz, 2003).

In references add

Moser, Charles, & Kleinplatz, Peggy J., (2002). Transvestic fetishism: Psychopathology or iatrogenic artifact? *New Jersey Psychologist*, Vol. 52, No. 2, 2002, pp. 16-17

Moser, Charles, & Kleinplatz, Peggy J., (2003). DSM-IV-TR and the Paraphilias: An argument for removal. Paper presented on May 19, 2003 at the Annual Meeting of the American Psychiatric Association

48:11 “transgender” here and “transsexual” at 48:15 should be consistent.

48:16 Replace “While some” with

Although clinicians and researchers connected with Toronto’s Centre for Addiction and Mental Health and/or publishing in the *Archives of Sexual Behavior*

[This model and terminology is used exclusively in *ASB* and only by people affiliated with or collaborating with CAMH Clarke Institute staff.]

49:04 Correlation does not imply causation – this should be noted.

49:11 defeminization > feminization

51:15 after discrimination, add (James, 2006)

In references add

James, A. (2006). A defining moment in our history: Examining disease models of gender identity. *Gender Medicine*, Vol. 3, pp. S56. Full text available at <http://www.tsroadmap.com/info/gender-identity.pdf>

- 52:06 Opponents of... : this requires citation(s)
- 52:08 Proponents of... : this requires citation(s)
- 62:06 internalized transphobia: this requires a citation, perhaps
- D. F. Morrow & L. Messinger (Eds.), *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual and transgender people*. New York: Columbia University Press.
- 64:12 after care. Add
- Ettner (1999) published a guide for practitioners. Brown and Rounsley (2003) published a broader guide for families, friends, coworkers, and helping professionals.
- in references add
- Brown, M. L. & Rounsley, C. A. (2003) *True Selves: Understanding Transsexualism--For Families, Friends, Coworkers, and Helping Professionals*. Jossey-Bass.
- Ettner, R. (1999). *Gender Loving Care: A Guide to Counseling Gender-Variant Clients*. W.W. Norton & Company
- 65:09 2001) > 2001;
- 65:19 Transgender people: this sentence requires a citation.
- 67:18 This paragraph is very negative and should note it's based on convenience samples.
- 69:01 reports > [remove duplicate word]
- 71:03 thFidelix Colemane > ??
- 71:05 depression > add (Vitale, 2001) [see reference above at 48:02]
- 74:16 This section on children has a marked change in tone and feels the most authoritative, despite providing the least published data.
- 76:18 “[children] with GID” vs. “[children] diagnosed with GID”: Starting here, this section should be revised to reflect the earlier controversy about the diagnosis of GID. Saying “[children] with GID” legitimizes the diagnosis. For example, “[children] with nymphomania” or “[children] with ego-dystonic homosexuality” legitimize those formerly accepted diagnoses. This may appear

to be an insignificant change, but it is important for accurately reflecting the controversy surrounding the diagnosis. Instances occur at:

78:08

78:13

78:19

78:21

78:22

79:02

79:09

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79:20

79:21

80:01

80:02

80:04

80:08

80:12

80:20

80:23 (twice)

81:04

81:07

81:09

81:14

81:18

81:22

82:08

82:14

83:05

83:23

84:02

85:18

86:01

86:22

88:18

89:04

89:08

90:22

92:10

92:18

92:20

93:02

93:04

93:07 (twice)

93:11

93:15

95:02

96:01

96:11

96:19

97:11 (twice)

97:14

98:13

98:15

98:17

98:20

99:13

99:14

- 77:17 strong desire to become a member of the opposite sex > rejection of their assigned sex
- 77:19 belief that he or she should become a member of the other sex > rejection of their assigned sex
- 77:22 natal sex > assigned sex
- 78:15 misclassify their own gender > reject their assigned gender
- 78:19 this sentence needs a citation.
- 81:19 second instance of GID seems wrong – change GID > mental illness?
- 81:22 have a homosexual sexual orientation (i.e., sexual attraction to members of one’s natal sex) > are attracted to members of the same assigned sex
- 82:06 homosexual: starting here, the problematic terms “homosexual” and “same sex” are used. As demonstrated earlier, there are many ways to avoid this language,

which has been considered confusing and derogatory since the early days of Harry Benjamin's practice.

82:10 homosexual

82:11 homosexual

82:15 homosexual

82:19 homosexual

82:21 homosexual

82:23 same-sex

83:01 homosexual

84:04 homosexual

92:13 homosexual

92:15 same-sex

93:17 homoerotic

93:22 internalized homophobia (continues to next page)

83:14 problems > [remove, too pejorative]

86:08 harp > sharp

87:17 This sentence requires a citation

91:10 GID or > [remove, unnecessary]

91:20 (pg. 2002) > fix page number

92:21 natal sex > assigned sex

94:20 opposite sex > sex with which they identify

95:10 disorder > [remove per guidelines on etiology: sexual orientation vs. homosexuality, etc.]

97:02 GID > gender identity

97:03 GID > gender identity

98:02 disorder > [remove per guidelines]

184:09 birth sex > sex assigned at birth  
the other gender > their target gender

184:20 Transsexuals are > Transsexual people are a subset of

184:21 opposite to their birth sex > they identify as.

- 184:21 Biological females > Those people  
 184:22 Biological males > Those people  
 184:24 Transsexuals > Transsexual people
- 185:01 biological ... > people who perform stylized, often exaggerated gender roles, usually as entertainment.  
 185:21 biological males > people assigned as males  
 185:223 females. > females, though recent estimates suggest prevalence as high as 1 in 500.
- 186:01 biologic male > person assigned as male  
 186:09 birth sex > sex assigned at birth  
 186:10 sex reassignment > medical intervention  
 186:31 biological males > people assigned as male
- 187:16 transsexuals > transsexual people  
 187:17 birth sex > assigned sex
- 188:19 Gender-dysphoric males... > Gender-dysphoric people may not always appear stereotypically feminine or masculine, and not all gender-variant people are gender dysphoric. [replace sentences]
- 189:13 www.wpath.org  
 189:14 wpath@wpath.org
- 191:04 Transgender Conditions and Disorder of Sex Development > Transgender and Intersex Traits  
 191:05 transgender conditions and disorders of sex development (also called intersex conditions) > transgender and intersex issues  
 191:13 *Transsexual* can be used as a noun or as an adjective. > *Transsexual* can be used as an adjective; *transsexual people* is sometimes preferred over using *transsexual* as a noun by itself.  
 191:15 Transsexuals > Transsexual people  
 191:23 birth sex > assigned sex
- 192:02 remove lines 02-05 up to “Do not”; this birth sex/biologic sex distinction adds confusion and is not widely accepted outside *Archives of Sexual Behavior* and like-minded publications.  
 192:08 again, this distinction is only made in *Archives of Sexual Behavior* and like-minded publications. Most progressive sexologists reject this terminology. cf. Leiblum SR, Rosen RC (2000). *Principles and Practice of Sex Therapy*, Third Edition. ISBN 1-57230-574-6  
 192:16 Disorders of sex development: This section needs to note that calling intersex traits “disorders of sex development” is controversial and not universally accepted. See Milton Diamond, Variations of Sex Development instead of Disorders of Sex Development, commenting on DSD “consensus statements.”

194:20 disorders of sex development > intersex traits

I urge the Task Force to coordinate with both ISNA and Organization Intersex International on the issues of intersex and DSD. The two advocacy groups have widely differing opinions on intersex issues, both of which should be represented.

<http://www.isna.org>

<http://www.intersexualite.org/>