4 CONCEPTS OF GENDER AND TRANS(SEXUALITY) AFTER THE ACT TO AMEND THE TRANSSEXUAL ACT

4.1 Legal developments with respect to the Transsexual Act in 2011

Soon after the *Bundestag* had passed the Act to amend the Transsexual Act, developments in jurisdiction on the Transsexual Act contributed to another profound shift within the gender regime without however displacing it. This chapter focuses on the Federal Constitutional Court decision on somatic requirements for a revision of gender status as stipulated in ss. 8(1)3 and 8(1)4 TSG and aspects related to this decision.

While the first section of the chapter provides a summary of the Court's deliberations leading to its decision, the second section deals with sexological knowledge the Federal Constitutional Court decided to rely on. Drawing upon relevant press releases by TrIQ e. V., the dgti e. V. and ATME e. V. and Grünberger's comment on the Court decision in the legal journal JZ, the third section addresses trans movement reactions and responses in legal scholarship to the Federal Constitutional Court before finally turning to lower court interpretations in the immediate aftermath of the decision.

The effects of the Federal Constitutional Court decision were twofold. While the initial assignment based on the external genitalia to one of two genders only at birth remains in place, gender is no longer necessarily based on physical grounds at a later point in life (de Silva 2012: 160). At the same, the Court chose to follow dominant sexological opinions that stress psycho-medical authority at the expense of trans self-determination.

4.1.1 The Federal Constitutional Court decision on somatic requirements for a revision of gender status under the Transsexual Act

On 11 Jan. 2011, the Federal Constitutional Court rendered stipulations for permanent sterility and sex-reassigning measures in ss. 8(1)3 and 8(1)4 TSG unconstitutional. The case dealt with the question whether a registered partnership can be denied a lesbian transwoman with a change of first names and without fulfilling the somatic requirements for a revision of gender status, since she has the option of marrying her partner.[1] The Court ruled that,

> [i]t contravenes Art. 2(1) and (2) in conjunction with Art. 1(1) GG, if a transsexual individual meeting the prerequisites demanded in s. 1(1)1 to 3 TSG and wishing to legally secure her same-sex partnership may enter a registered life partnership only after she has according to ss. 8(1)3 and 8(1)4 TSG previously undergone a surgical intervention to change her external characteristics and achieved permanent sterility on the basis of which she has according to civil status law gained recognition in her experienced and lived gender. (BVerfG 2011: head note)

Quoting earlier Federal Constitutional Court decisions, the Court set out from three principles. First, it held that Art. 2(1) in conjunction with Art. 1(1) GG safeguards the personal area of sexuality and sexual self-determination, including an individual's gender identity and sexual orientation (ibid: para 56). Second, the Court referred to the scientifically secured knowledge that a person's gender identity cannot be determined based on the external genitalia at the time of birth only. Rather, it significantly depends on an individual's psychological constitution and self-identified gender (ibid). Third, the Court confirmed that if a transsexual individual experiences a lasting contradiction between his or her gendered understanding of self and the gender he or she was legally clas-

1 | In this particular case, a lesbian transwoman had changed her first names according to s. 1 TSG and was undergoing hormone treatment without however intending to undergo sex reassignment surgery. On 08 Dec. 2005, she and her partner in vain sought to enter a registered life partnership in Berlin. The local court rejected the application, arguing that founding a registered life partnership relies on the same sex of both partners. According to the Court, the applicant did not undergo a sex reassignment operation as a prerequisite specified in s. 8(1)4 TSG for recognition as a woman. As a result, the partners only had the option of getting married. Upon further complaints, the regional court and the highest court in Berlin, the Chamber Court, confirmed the decision. On 28 Dec. 2007, the transwoman, who had in the meantime married her partner, filed a constitutional complaint, claiming that the previous courts had violated her constitutional rights in Art. 2(1) in conjunction with Art. 1(1) GG (BVerfG 2011: paras 41-46).

sified as based on external sex characteristics, human dignity in conjunction with the basic right to the protection of his or her personality demand that a person's self-determination and gender identity be recognised in order to render possible a life accordingly, without his or her identity being exposed due to the contradiction between his or her adapted outer appearance and his or her legal treatment (ibid).

The Court examined two major issues before arriving at its decision. First, it discussed the options marriage as an institution for differently sexed partners and the registered life partnership as an institution for same-sex partners present for homosexual transsexual individuals who have fulfilled the prerequisites stipulated by ss. 1(1)1 to 1(1)3 TSG without having undergone surgery to modify external sex characteristics or to bring about permanent sterility (ibid: paras 57-65). While the Court considered the legislator's concept of distinguishing access to marriage or the registered life partnership on the basis of the individuals' gender status legitimate (ibid: paras 58; 65), it suggested that for a homosexual transsexual individual with a legally recognised change of first names to enter either institution means an encroachment on her right to sexual self-determination (ibid: para 60). In the case of a marriage, the individual is identifiable in a gender role that contradicts her understanding of self (ibid: para 61). Moreover, her transsexuality becomes evident (ibid). Such a situation conflicts with Art. 2(1) in conjunction with Art. 1(1) GG that protects the recognition of a person's gender identity and privacy (ibid). If the homosexual transsexual individual chooses to enter a registered life partnership, he or she is required to undergo surgery to alter external sex characteristics and achieve permanent sterility (ibid: para 60). While the Court conceded that it is legitimate to rely on objectively verifiable prerequisites for entering a registered life partnership (ibid: para 58), unreasonable preconditions for gender recognition conflict with the right to sexual self-determination as understood in Art. 2(1) in conjunction with Art. 1(1) GG (ibid: para 64).

Second, the Court discussed whether ss. 8(1)4 and 8(1)3 TSG constitute unreasonable requirements for gender recognition (ibid: paras 66-77). Arguing that a person's gender can be relevant to the allocation of rights and duties and family attributions, the legislator's concern to accord civil status stability and unambiguity, to prevent biological and legal gender from falling apart and to grant a revision of gender status on the basis of sound grounds is legitimate (ibid: para 60). Therefore, the Court considered prerequisites in cases of transsexuality legitimate, such as e. g. further demands on medical supervision, the individual's outer appearance or the quality of expertise (ibid: paras 67-69). However, the Court held that evidence for the stability of the gender identity and a life in the ›other‹ gender are unreasonable and hence incompatible with Art. 2(1) in conjunction with Art. 1(1) GG, if ss. 8(1)3 and 8(1)4 TSG unconditionally and without exception require surgery to alter the external sex characteristics and bring about sterility (ibid: paras 68; 73).

With regard to s. 8(1)3 TSG, the Court reasoned that surgery that largely removes or reorganises sex characteristics to approximate those of the ›other‹ sex massively encroaches upon the right to physical integrity safeguarded in Art. 2(2) GG (ibid: para 71). Depending on a person's age and health condition, health risks and side effects can be so great that surgery of this magnitude is medically contraindicated (ibid: para 70). In addition, and relying heavily on the 2001 statement by the DGfS, the Court held that sex reassignment surgery is not indicated in every transsexual individual. Rather, it is the consistency of life in the ›other‹ gender and the recognition as such that attests to the stability and irreversibility of a transsexual individual's gender identity (Becker et al. 2001: 261, quoted in BVerfG 2011: para 71). Moreover, the Court noted that the legislator accepted that not all members of a gender entirely possess the ›matching‹ external genitalia. Section 9(3) in conjunction with s. 6(1) TSG e.g. allows a reversal of the decision to be recognised as a member of the ›other‹ sex without a surgery mandate (BVerfG 2011: para 72).

Similarly, the Court held that permanent sterility constitutes an unreasonable prerequisite for recognising a transsexual individual's gender as long as the permanency of the inability to reproduce requires surgical interventions. According to the Court, s. 8(1)3 TSG demands of a transsexual individual to trade the right to physical integrity protected in Art. 2(2) GG for the right to sexual self-determination without reasons that bear sufficient significance to justify such an infringement of basic rights (ibid: paras 73-75). The Court suggested that the legislator pursues a legitimate goal by preventing men from bearing children and women from fathering progeny, because such procedures »would contradict the understanding of gender and would have far-reaching effects on the legal order« (ibid: para 75). However, it presented several reasons that suggest that fears of disrupting widespread notions of gender and gender roles in generational reproduction are generally unfounded. While the Court did not rule out the possibility that transsexual individuals might make use of their respective reproductive capacities, it assumed that – based on Becker's statement (Becker 2004: 162) – the probability for female-to male transsexual individuals is low, since they are »predominantly heterosexual« (BVerfG 2011: 76). Whereas male-to-female transsexual individuals are more likely to procreate offspring, it needs to be considered that hormone treatment at least temporarily leads to sterility (ibid). With reference to the court case in Cologne (cf. OLG Köln 2010: 45 f.), developments in reproductive medicine render futile bans on reproduction, despite the requirement for permanent sterility (BVerfG 2011: para 76). Finally, the Court suggested that in these rare cases s. 11 TSG[2] secures a child's

2 | Section 11 TSG provides that the decision to consider the applicant a member of the ›other‹ sex does not affect the legal relationship between the applicant and his or her children or his or her parents, respectively. It only affects the relationship between the

allocation to a mother and a father (ibid: paras 76 f.). Since the Court decided that ss. 8(1)4 and 8(1)3 TSG were unconstitutional (ibid: para 77), it annulled the decisions of the courts that had previously dealt with this particular case (ibid: 78).

The Federal Constitutional Court decided that the incompatibility of ss. 8(1)3 and 8(1)4 TSG with Art. 2(1) and 2(2) in conjunction with Art. 1(1) GG does not lead to their nullity. Rather, the Court pointed out that the legislator has two options of creating constitutional prerequisites. One would be to develop more specific prerequisites for a legal recognition of a transsexual individual's gender that prove the seriousness of the desire to live in the ›other‹ gender in a way that exceeds the prerequisites laid down in s. 1(1) TSG. The other would be to generate a constitutional legal situation when revising the Transsexual Act (ibid: para 79). The Court declared ss. 8(1)3 and 8(1)4 TSG inapplicable until a new regulation takes effect (ibid: para 80). Since the legislator has so far been unable, if not downright unwilling to revise transsexual law, an individual's gender has, with exception of the initial gender allocation become independent of physical properties.

4.1.2 Sexological knowledge in Federal Constitutional Court reasoning on somatic requirements

The Federal Constitutional Court decision on somatic prerequisites for a revision of gender status once more followed the principle that the legislator may not force an individual to trade one basic right entirely for another as a means for the legislator to pursue its regulatory aims (Grünberger 2011: 369). At the same time, the Court relied on sexological perspectives with contradictory effects on trans self-determination. While the Court continued the route taken in the decision on s. 7(1)3 TSG with regard to somatic measures, hence expanding trans self-determination in this area, it drew upon sexological perspectives that confirm and allow a reinforcement of the primacy of psycho-medical expertise in establishing a case of transsexuality.

The Federal Constitutional Court reiterated that a diagnosis of transsexuality does not necessarily imply somatic measures. Referring to the statement by the DGfS (Becker et al. 2001: 261), Rauchfleisch (2006: 17) and Pichlo (2008: 119; 122), the Court suggested that transsexual individuals require individual solutions in order to live their lives according to their respective experienced gender. Therefore, therapeutic measures may range from no somatic interventions, hormone treatment to extensive sex reassignment surgery (BVerfG 2011: para 36). The Court quoted Becker et al. (2001) and Grünberger (2007) who

applicant and the children adopted after the decision took effect. The same applies to the relationship to these children's descendants.

suggest that in the light of these findings, the requirements defined in ss. 8(1)3 and 8(1)4 TSG are constitutionally problematic (BVerfG 2011: para 36).

With regard to establishing a case of transsexuality, the Federal Constitutional Court's perspective was in line with dominant sexological views that clearly limit self-determination rather than those that consider trans expertise at least equivalent to psycho-medical expertise. The Court for example emphasised the diagnostic significance of the ›real life test‹ as a means to determine whether an individual is able to handle the »change of gender roles« (ibid: para 37). Moreover, in order to satisfy the legislator's demand for the stability and irreversibility of trans individuals' gender identities, the Court confirmed the constitutionality of the assessment process regulated in s. 4(3) TSG (ibid: para 67). In fact, it suggested measures that reinforce psycho-medical gatekeeping and gender stereotypes:

> For this purpose, it [the legislator; insertion mine] may in addition to the conditions in s. 1(1) TSG specify, for example, its demands on the medical supervision of the transsexual individual, his outer appearance or the quality of the assessment. (Ibid)

4.1.3 Trans movement reactions and reactions in legal scholarship to the Federal Constitutional Court decision on somatic measures

Trans organisations with a political agenda and the legal scholar Grünberger welcomed the Federal Constitution Court decision to declare ss. 8(1)3 and 8(1)4 TSG unconstitutional and inapplicable until the legislator creates a new, constitutional regulation (dgti 2015; TrIQ 2005-2015; ATME 2015; Grünberger 2011: 371). However, the reactions differed, depending on whether they took into consideration two further issues the Federal Constitutional Court raised. One of these issues was that the Federal Constitutional Court decision allows the government to devise a regulation that demands of transsexual individuals to adapt their outer appearance to the ›other‹ gender. The second issue revolves around the fact that the Court confirmed psycho-medical diagnostic authority in the legal procedure.

Declaring the surgery and castration requirement for a revision of gender status unconstitutional fulfilled a crucial demand of trans organisations and coincided with opinions in legal scholarship stated since 2011.[3] In its press release on 28 Jan. 2011, TrIQ e. V. for instance hailed the Court decision, arguing that, »it was now possible for transgender individuals to achieve the gender status that corresponds with their gender, regardless of whether they undergo sex reassignment operations or not« (TrIQ 2006-2015). Similarly, the then president

3 | See, for instance, Wielpütz 2012: 228 f. and Grünberger 2011: 371.

of the dgti e. V., Alter, explained that, »[a]t long last, the Federal Constitutional Court gives individuals with a deviating gender identity the right to decide on their bodies themselves« (dgti 2015). More cautiously, ATME e. V. described the Court decision as »an important step« (ATME 2015).

While Alter posed the rhetorical question, »*What remains of the TSG now?*« at the end of her announcement (Alter 2011), ATME e. V., TriQ e. V. and Grünberger either implicitly or explicitly suggested that a lot remains to be done to create a regulation that complies with the Basic Law. ATME e. V. severely criticised the Court for reinforcing the psychopathologisation of transsexual individuals and suggesting that the government may require of transsexual individuals to adapt their outer appearance to stereotypical notions of the respective gender they wished to be recognised as. According to ATME e. V., the latter contravenes the right to develop one's personality freely as guaranteed in Art. 2 GG (ATME 2015).

Similarly, Grünberger suggested that the existing requirements for assessment in s. 4 TSG contribute to paternalism, pathologisation and heteronomy (Grünberger 2011: 370). He pointed out that there are no standards compliant with personal rights and rights to privacy that would allow a decision on whether a person's appearance and behaviour conforms to the respective individual's gender identity (ibid: 369). While TrIQ e. V. did not expressly criticise either of these issues in its press release, the association pointed out that a reform of trans law to the effect of reducing and debureaucratising the procedure was overdue (TrIQ 2006-2015).

4.1.4 Initial lower court interpretations of the Federal Constitutional Court decision on somatic measures

While the Federal Constitutional Court decision suggests that transsexual individuals achieve recognition without having to fulfil the unconstitutional prerequisites stipulated in ss. 8(1)3 and 8(1)4 TSG, various local, regional and higher regional courts initially interpreted the Federal Constitutional Court decision to the effect of staying proceedings for a revision of gender status altogether. The local courts Mannheim (AG Mannheim) and Stuttgart (AG Stuttgart) and the High Regional Court Stuttgart (OLG Stuttgart) are examples of such an interpretation (AG Mannheim 2012; AG Stuttgart, quoted in BVerfG 2011a: para 7; OLG Stuttgart, quoted in ibid: para. 9).

In its fourth guiding principle, the Local Court Mannheim opined that, »[p]ending actions whose decisions depend on unconstitutional (parts of) a section need to be stayed until a constitutionally required new law has been enacted. Anything to the contrary would at best apply, if the Federal Constitutional Court had made concrete orders for the transition period« (AG Mann-

heim 2012).[4] Upon the transperson's complaint against this decision, the High Regional Court Karlsruhe decided that, »[w]ith regard to the Federal Constitutional Court decision on 11 Jan. 2011, [...], it is not permissible to stay the proceedings for the establishment of a revision of gender status (s. 8 TSG) up to a new legal regulation« (OLG Karlsruhe 2012: 67178).

As a result of further appeals against decisions of the Local Court Stuttgart (AG Stuttgart) on 23 May 2011 (quoted in BVerfG 2011a: para 7) and the High Regional Court Stuttgart (quoted in ibid: para 9),[5] the Federal Constitutional Court rendered clear that staying proceedings to revise the civil status violates basic rights protected in Art. 2(1) in conjunction with Art. 1(1) GG, because it unlawfully delays the legal recognition of the complainant's gender identity (ibid: para 15). The Federal Constitutional Court explained that transsexual individuals are constitutionally entitled to be legally recognised according to their gender identity. The purpose of its former decision was to declare ss. 8(1)3 and 8(1)4 TSG unconstitutional and inapplicable until the legislator revises the sections in the not foreseeable future, hence allowing for individuals who do not fulfil the prerequisites to be granted a revision of gender status, regardless of whether the conditions for a change of first names and gender status are the same (ibid: para 16).

In addition, the Federal Constitutional Court reminded the High Regional Court Stuttgart that it had violated the complainant's constitutional rights by addressing her according to the gender assigned at the time of birth, despite the fact that she had been granted a change of first names (ibid: para 17).

4.1.5 Summary: Legal constructions of gender, transsexuality and gender regime in the immediate aftermath of the Act to amend the Transsexual Act

While the gender regime remains in place, the Federal Constitutional Court decision on 11 Jan. 2011 contributed to another shift in the gender binary. Al-

4 | In this particular case, a transman who had obtained a change of first names had applied for a revision of gender status without having undergone sex reassignment surgery (AG Mannheim 2012: para 4). He argued that the Federal Constitutional Court decision on 11 Jan. 2011 had rendered the prerequisites for a change of first names and a revision of gender status equal and that the somatic prerequisites laid down by ss. 8(1)3 and 8(1)4 TSG no longer applied (ibid: para 5).

5 | This case dealt with a transwoman who had successfully applied for a change of first names and was denied the recognition of her gender as a woman in both instances (AG Stuttgart, 23 May 2011 – F 4 UR III 571/2011 and OLG Stuttgart, 07 July 2011 – 8W 206/11), since she had not fulfilled the prerequisites for a revision of gender status demanded in ss. 8(1)3 and 8(1)4 TSG (BVerfG 2011a: paras 2-5).

though gender options remain limited to the categories ›man‹ and ›woman‹, with exception of the initial assignment at birth, the Court severed gender from a physical basis since the removal of the surgery mandate for a revision of gender status in cases of transsexuality. At the same time, determining an individual's gender continues to be based on an external decision at any point of a person's life.

The Federal Constitutional Court granted transsexual individuals the freedom to choose whether to undergo sex reassignment measures or not and homosexual trans individuals the right to choose between entering a marriage or a registered life partnership providing fewer rights. However, the Court decision also reveals that the two socially accepted genders remain the background norm against which transsexual individuals applying for a revision of gender status are measured. The Federal Constitutional Court allowed the legislator to develop more specific requirements for a revision of gender status that prove the seriousness of the transsexual individual's desire to live as the ›other‹ gender. As some scholars and trans lobby organisations point out, any such evidence necessarily emerges from, and contributes to imposing stereotypical notions of legally recognised genders on transsexual individuals.

While s. 4(3) TSG was not the issue of the case the Federal Constitutional Court decided upon on 11 Jan. 2011, based on dominant sexological perspectives, it confirmed and reinforced psycho-medical supervision of transsexual individuals. By implicitly underlining the sexological assumption that transsexual individuals lack self-knowledge, the Court reinforced this paternalistic attitude towards transexual individuals to the detriment of trans self-determination.

4.2 Developments in trans politics from 2011 to 2014

The outcome of the reform process stifled any expectations that the federal government would make any further efforts to amend trans law in the foreseeable future, even less so to the effect that it would take into consideration trans movement demands. Despite government reluctance to seriously engage with issues related to trans legislation, trans organisations continued to press for change.

Based on online sources provided by the dgti e. V., the Nationwide Workgroup Transsexual Law Reform (*Bundesweiter Arbeitskreis TSG-Reform* [BAK TSG-Reform]) and the Trans*Aktiv websites, this chapter deals with three major and distinct political projects that to varying degrees dealt with transsexual law reform in the period between 2011 and 2014. The first chapter outlines the dgti e. V. key issues paper for a reform of the Transsexual Act developed in 2011. The second chapter deals with the catalogue of demands for transsexual law reform published by the BAK TSG-Reform in June 2012. The third chapter out-

lines the Waldschlösschen declaration (*Waldschlösschen Erklärung*)[6] released in 2014. The premises, demands and strategies of each of the three political initiatives will be outlined and contextualised within the tradition of trans politics.

The three projects mentioned above indicate a number of political and structural developments in trans politics. First, the initiatives overall coincided on the issue that a special law is an inappropriate means to solve the problems in current transsexual law. Second, without ceasing to develop concepts for trans law reform, trans organisations and coalitions addressed the general public rather than the federal government. Third, the trans movement sought possibilities for intervention in other areas of the federal state. Fourth, the social movement reinforced attempts at creating cohesion and common demands. Finally, the political projects took a clear stance against identity politics in lobbying activities.

4.2.1 The dgti e. V. key issues paper for a reform of the Transsexual Act

Developed in 2011, the dgti e. V. key issues paper was the first of three major political initiatives aimed at legal change in the post-reform period. The paper formulates general principles upon which new legal regulations should be based.

Premises and parameters

The dgti e. V. set out from non-minoritising and non-identity premises and parameters. First and informed by a social constructionist perspective, the organisation suggested that social and cultural arrangements create the problems sex and gender non-conforming individuals face. According to the dgti e. V., it is the cultural reduction of sexes and social limitations on the development of the personality that damage the individuals the key issues paper was meant to provide for (Alter 2011a).

Second, the association pointed out that any sex/gender entry in the birth register is based on a heteronomous decision made at a time individuals are unable to speak out on behalf of their personalities. As such, the external sex/gender assignment applies to all individuals (ibid). Rather than emphasise the

6 | The declaration is named after the *Akademie Waldschlösschen*. The *Akademie Waldschlösschen* was founded in 1981 (Akademie Waldschlösschen undated) and is rooted in the 1970s West German gay movement (ibid: undated a). The institution is a LGBTIQ educational centre operating nationwide and located close to Göttingen (ibid). Since 2013, the *Akademie Waldschlösschen* has hosted the annual meeting of trans activists representing several trans lobby groups and members of trans support groups from all over the country (Trans*Aktiv undated).

special needs of the target groups, the dgti e. V. focused on systemic and procedural foundations of minoritising.

Third and like the PGG of which the dgti e. V. was a member, the organisation's political project was designed to include individuals whose morphologies do not fit polarised notions of ›male‹ and ›female‹. In contrast to the TrGG, the key issues paper does not subsume ›intersex‹ under ›transgender‹, nor does it define the target groups along the lines of identity. Instead, the dgti e. V. developed the set of principles to provide for individuals with ›ambiguous‹ sex characteristics and individuals whose respective gender identity differs from the sex/gender assigned at birth (ibid), hence acknowledging and providing for an indefinite number of sexed individuals and gender identities.

Fourth, the dgti e. V. stated that the Transsexual Act from the very outset did not comply with the Basic Law. Referring to the seven Federal Constitutional Court decisions on various rules of the Transsexual Act since its enactment in 1981, the association was convinced that no reform of the Transsexual Act would ever secure the abovementioned individuals' basic rights, most notably the rights to self-determination, physical integrity and the free development of one's personality (ibid).

Key issues for a new regulation

Based on the aforementioned premises and parameters, the dgti e. V. compiled five key issues. First and arguing that the sex/gender entry and the entry of first names in the birth register are based on a heteronomous decision in an administrative procedure, the dgti e. V. suggests that every individual should be entitled to change this information in an administrative procedure, too. Second, the organisation holds that parents should be entitled to choose gender-neutral first names and forgo a sex/gender entry in the birth register in the event of the birth of a child with ›ambiguous‹ sex characteristics.[7] Third, and on the grounds that only the individual featuring these characteristics has the right to decide upon somatic measures for the sole purpose of producing sex unambiguity, the dgti e. V. proposes to prohibit somatic measures in infants with ›unambiguous‹ sex characteristics to this end. Fourth, and in addition to reiterating trans movement demands for self-determination, the association suggests dispensing with assessment procedures for a change of first names and

7 | However, given that all sex/gender assignments at birth are based on heteronomous decisions, this particular key issue appears inconsistent. Taken to its radical end, a consistent solution would consist of either leaving the sex/gender entry vacant in general or dispensing with this category in the birth register altogether. Moreover, and as and OII-Germany suggests with regard to s. 22(3) PStG, singling out individuals with physical features that do not comply with conventional notions of ›male‹ and ›female‹ risks stigmatisation and discrimination.

a revision of gender status, given that nobody else is exerted to an assessment procedure to verify the initial and external gender assignment, either. Fifth, in the light of the limits of the socially constructed render regime, the dgti e. V. suggests that individuals with ›ambiguous‹ sex characteristics and individuals whose respective gender identity differs from the sex/gender assigned at birth should by law be entitled to social, psychological and somatic measures as a means of rehabilitation (ibid).

In contrast to the PGG, the dgti e. V. did not submit the key issues paper to policy makers. Rather, the organisation decided to publish the paper as an open letter and to collect signatures for its political project (ibid).

4.2.2 The catalogue of demands for transsexual law reform by the Nationwide Workgroup Transsexual Law Reform

Published in June 2012, the catalogue of demands for transsexual law reform[8] was the second major political project initiated and carried out for achieving trans law reform in the period between 2011 and 2014. While the dgti e. V. key issues paper broadly outlines the direction of desired legal reform, the catalogue of demands meticulously elaborates on suggestions for integrating rules regulating trans into existing statutes.

Reasons for founding the Nationwide Workgroup on Transsexual Law Reform and the constitution of the Workgroup

Established in Sept. 2011 for the purpose of developing a consensus among trans organisations with regard to transsexual law reform (BAK TSG-Reform 2012a), the Nationwide Workgroup on Transsexual Law Reform[9] consisted of representatives of more than 30 primarily trans and some intersex groups and organisations and individuals from the whole of Germany (ibid; ibid 2012: 1). Collaboration was open, participatory and decidedly non-party (ibid 2012a).

The Nationwide Workgroup dealt with the issue of transsexual law reform for two reasons. First and similar to the dgti e. V., the Workgroup considered the Transsexual Act to contain rules that collide with trans individuals' dignity and right to self-determination, despite several Federal Constitutional Court decisions that rendered a significant number of rules of the Act inapplicable.

8 | The catalogue of demands for transsexual law reform will be referred to as the catalogue of demands in this chapter.

9 | The Nationwide Workgroup Transsexual Law Reform will be referred to as the Nationwide Workgroup or simply the Workgroup in this chapter.

Second, the Workgroup suggested that in other instances, rules of the Transsexual Act had proven to be deficient and provoked discrimination (cf. ibid).[10]

The catalogue of demands for transsexual law reform

Presenting demands, offering a substantial body of reasons and suggestions for implementation, the catalogue of demands structurally resembled the key issues paper on the reform of the Transsexual Act issued in 2009. While the catalogue of demands also tied into the tradition of strictly outsourcing demands on issues related to psycho-medical premises and procedures, the demands were however, compared with those of the abovementioned model, overall more radical with regard to trans law reform.

Demands

The catalogue contained five demands that overall aimed at securing the rights to self-determination, privacy and health and, as the reasons suggest, were motivated by a desire for an inclusion and de-stigmatisation of trans. First, the Nationwide Workgroup demanded to abolish assessment and court proceedings in favour of trans self-determination (BAK TSG-Reform 2012: 1). The Workgroup presented five reasons to support this demand. The Workgroup held that expert reports cannot fulfil the purpose defined in s. 4(3) TSG. Arguing that a gender identity differing from the assigned gender cannot be diagnosed and that third parties cannot predict the stability of an individual's gender identity, the Workgroup concluded that expert reports cannot fulfil the purpose defined in s. 4(3) TSG (ibid: 2). Moreover, the Workgroup claimed that an expert assessment of an individual's gender identity is incompatible with the right to self-determination guaranteed in the Basic Law (ibid). In addition, the Workgroup claimed that implicitly linking the legal options of a change of first names and a revision of gender status to a diagnosis is not justifiable (ibid: 3). According to the Workgroup, the state is moreover not responsible for ›protecting‹ individuals from their respective decisions (ibid). Reiterating the reason put forth by the TGNB and TrIQ e. V. in 2009, there is little reason to believe that individuals will deal frivolously with these legal options due to their profound social effects (ibid). Finally, the Workgroup argued that social issues are unaffected by a change of first names and a revision of gender status, since a person's habitus and the perception of the habitus are more relevant in everyday life. Therefore, there is no need for the legislator to protect society from trans and intersex individuals either (ibid).

10 | The Nationwide Workgroup identified the exclusion of relevant social law regulations (BAK TSG-Reform 2012: 10) and insufficient regulations with regard to the prohibition of disclosure (ibid: 7) as major shortcomings.

Second, and in contrast to the TGNB Workgroup Law, which for reasons of political feasibility dispensed with its favoured suggestion for trans law reform, the Nationwide Workgroup demanded the abolishment of the Transsexual Act and the integration of provisions granting a change of first names and a revision of gender status into existing statutes (ibid: 1). The Nationwide Workgroup presented two reasons to support this demand. The Workgroup argued that special acts are *per se* stigmatising, because they define the respective group of individuals as beyond what is considered ›normal‹ (ibid: 3). Moreover, the Workgroup argued that a special act suggests that all individuals defined as the target group share the same needs. As a result, different individual needs are glossed over, excluding individuals requiring provisions under the special act, if they do not, or only in part correspond with the definition of the target group in the act (ibid).

Third, and like the suggestions put forward by the TGNB Workgroup Law in 2006 and the TGNB and TrIQ e. V. key issues paper in 2009, the Nationwide Workgroup demanded replacing court proceedings for a change of first names and a revision of gender status by an administrative procedure with the respective office responsible for issues related to a person's civil status (ibid: 1). The Workgroup argued that the current rules providing for a change of first names are unreasonable, unnecessarily laborious and provoke discrimination (ibid: 4).

Fourth, the Nationwide Workgroup demanded to extend the prohibition of disclosure and to locate the provisions in the Administrative Offences Act (ibid: 1), arguing that current provisions of the Transsexual Act are insufficient, particularly with regard to the address of individuals with a change of first names only, issuing reports and the private sphere (ibid: 7). The Workgroup argued that considering developments in social networks and relatives, public administration, schools and employers who frequently do not respect trans individuals' decisions, »a normal life is rendered impossible« (ibid: 8). Instead, individuals »living gender diversity« are frequently forced to explain themselves, and the disclosure of a person's former first name and gender history provokes discrimination. The Workgroup held that trans individuals' rights are not only a private matter (ibid).

Fifth, the Nationwide Workgroup demanded that the legislator create a legally binding provision to ensure health insurance assumption of transition-related medical, surgical and other relevant somatic costs (ibid: 1). Arguing that a change of first names and a revision of gender status do not of themselves entitle trans individuals to such measures, the Workgroup suggested that it is the legislator's duty to protect trans individuals' right to privacy and health (ibid: 11). In addition and based on past experiences (ibid: 10), the Workgroup suggested that failing to legally enshrine access to health insurance coverage of somatic measures risks that health insurance companies will not, or only insufficiently take on the costs of sex reassignment measures (ibid: 11).

Suggestions for implementation

The Nationwide Workgroup made a number of recommendations for implementation compliant with the abovementioned demands. The Workgroup suggested amending s. 11 of the Act to change family and first names (*Gesetz zur Änderung von Familien- und Vornamen*; NamÄndG) to include gender identity as an important reason for a change of first names (ibid: 4). The Workgroup drew upon the suggestion made by the TGNB and TrIQ e. V. key issues paper by recommending as a prerequisite for a change of first names that the applicant declares that he or she does not identify with the assigned gender. The Workgroup suggested that the applicant may apply with the register office for either a first name signifying another gender or a gender-neutral first name (ibid) and enjoy all the rights secured in Federal Constitutional Court decisions on rules of the Transsexual Act (ibid: 4 f.).

The Workgroup recommended to integrate regulations for a revision of gender status into the Civil Status Act and subordinate regulations (ibid: 4). Referring to Federal Constitutional Court decisions which had rendered the prerequisites for a change of first names and a revision of gender status identical, the Nationwide Workgroup suggested applying the same procedure for a revision of gender status as stated above (ibid). Moreover, it suggested that while the birth entry could be either male or female, a status should be created for individuals who consider themselves neither male nor female (ibid).[11]

The Nationwide Workgroup included in its recommendations that the applicant's right to self-determination precludes third-party codetermination (ibid). In addition to referring to the Federal Constitutional Court ruling that existing marriages or registered life partnerships remain unaffected by a revision of gender status, the Nationwide Workshop recommended to provide for transforming one legally sanctioned partnership into the other upon application (ibid: 6). Finally and in contrast to the TGNB and TrIQ e. V. key issues paper, the Nationwide Workgroup recommended regulations for a renewed change of first names and revision of gender status without suggesting sanctions or delivering arguments for appeasement purposes (ibid).

With regard to an extension of the prohibition of disclosure, the Nationwide Workgroup recommended to integrate two regulations into the Administrative Offences Act. The first regulation suggests encoding the rules provided in ss. 5(1) and 10(2) TSG in the Administrative Offences Act. According to the aforementioned sections, a person's former first names and gender status may not be disclosed or investigated into without the respective individual's

11 | Members of the Nationwide Workgroup only realised after the publication of the catalogue of demands that the Civil Status Act does not define sex/gender or the number of sexes/genders. Despite intentions to the contrary, the recommendations unnecessarily limit sex/gender options by suggesting three categories.

consent, unless there are reasons or reasons to believe, respectively, that the purpose serves the public interest (ibid: 7). The second regulation sought to limit relatives' right to refer to trans individuals with the former first name and gender status (ibid).

In addition, the Nationwide Workgroup recommended providing for three further regulations in the Civil Status Act in order to secure trans individuals' right to privacy and protection from discrimination. These include a right to reports, documents and certificates featuring the new names in otherwise unchanged documents within an appropriate time and a right to change the first names in personnel files (ibid). The Workgroup recommended including a provision as outlined in s. 11 TSG to the effect that the birth entry of children born to trans individuals prior to a change of first names and a revision of gender status remains unchanged (ibid).

In order to create a legally binding provision to ensure health insurance assumption of transition-related medical and surgical costs, the Workgroup suggested to extend s. 5 in chapter 3 of the fifth volume of the Social Code Book to ensure that, based on a medical indication, health insurance companies are obliged to cover the costs of all necessary somatic interventions, such as hormone therapy, sex reassignment surgery and further measures, such as for example, epilation (ibid: 10). With regard to epilation, the Workgroup suggested to include qualified professionals, such as cosmeticians among the service providers to be covered by health insurance companies (ibid). While the demands addressing a change of first names and a revision of gender status, including the effects, are overall more radical than the suggestions made by the TGNB and TrIQ e. V. in 2009, the demand for cost coverage of sex reassignment measures by health insurance companies necessarily involves a medical indication, thus compromising trans self-determination in the medical realm.

Like the dgti e. V., the Nationwide Workgroup did not submit the catalogue of demands to government officials. Instead, the Workgroup published the paper, including an extensive list of individuals and primarily lesbian, gay, bi, queer and trans organisations as initial signatories (ibid: 2012b) and encouraged further individuals and organisations to follow suit,[12] while rejecting signatures from political parties and their affiliated LGBTI organisations (ibid 2012c).

12 | By 07 Sept. 2015, more than 30 further organisations and groups engaging in the lesbian, gay, trans, queer and feminist spectrum (BAK TSG-Reform 2012c) and 1952 individuals cosigned the catalogue of demands (ibid 2012d).

4.2.3 The Waldschlösschen declaration by the nationwide network Trans*Aktiv

Issued on 24 Aug. 2014, the Waldschlösschen declaration[13] was the third major political project in the period between 2011 and 2014. Unlike the aforementioned initiatives, the declaration does not focus solely on trans law reform, nor does it elaborate on the implementation of its demands. Instead, the declaration served as the prelude to further consolidation and cohesion within the trans movement.

The institutional and political context of the Waldschlösschen declaration

Trans*Aktiv emerged as a nationwide network in 2013 (Trans*Aktiv undated). The network is composed of representatives of several organisations committed to supporting individuals »living gender diversity« (Trans*Aktiv undated a). The broad invitation policy and the overall purpose of the network suggest that it was created to bring together activists and support groups and to serve a broad population that was particularly, but not limited to transsexual, transgender and intersex individuals (ibid). As a summary of the second (ibid) and the invitation to the third annual network meeting reveal, the major purpose of the network was to establish a nationwide umbrella organisation for all participating associations and groups, taking into consideration an intersectional perspective on individuals »living gender diversity« (ibid undated b.)[14]

The Waldschlösschen declaration

Extending the protection of human rights of individuals »living gender diversity« by demanding that all legal, political, healthcare-related and social actions should follow the principles outlined in the Yogyakarta Principles,[15] constitutes

13 | In this chapter, the Waldschlösschen declaration will also be referred to as the declaration.

14 | Indeed, in Aug. 2015, the dgti e. V. announced in a press release that 59 members from the whole of Germany had founded the Federal Association Trans e. V. i. G. (*Bundesverband Trans**; BVT*). The BVT* represents roughly 33 associations, groups and individuals. It functions as a common platform for improving the social situation of trans individuals in Germany and serves as a contact for the federal government (dgti 2015).

15 | In the light of human rights violations towards individuals based on their actual or perceived sexual orientation, a group of human rights experts discussed and published a set of principles in 2006 that apply international human rights law specifically to sexual orientation and gender identity (The Yogyakarta Principles 2013a: 1). The Yogyakarta Principles cover rights to universal enjoyment of human rights, non-discrimination and recognition before the law (principles 1-3); rights to human and personal security

the overarching demand of the Waldschlösschen declaration (Trans*Aktiv 2014). Other than this, the demands compiled in the declaration address legal, political and healthcare-related issues as they relate to trans and range from long-standing general to very specific demands based on recent developments in federal politics and medicine. Overall, the demands focus on political participation, trans self-determination and human rights protection.

Trans*Aktiv formulated four political demands. Among these are the call for recognising and protecting the human rights of asylum seekers facing persecution and threats based on gender identity and/or sexual orientation in their home countries. According to the network, this demand includes full access to medical and surgical interventions during asylum procedures (ibid).[16] Moreover, Trans*Aktiv demanded financial and structural support for umbrella or-

(principles 4-11); economic, social and cultural rights (principles 12-18), rights to expression, opinion and association (principles 19-21); freedom of movement and asylum (principles 22 f.), rights of participation in cultural and family life (principles 24-26); rights of human rights defenders (principle 27); rights of redress and accountability (principles 28 f.) and additional recommendations as they relate to sexual orientation and gender identity (ibid: 2 f.). While the Yogyakarta Principles are not legally binding, they affirm the obligation of states to implement human rights (ibid: 3). For the authoritative version of the Yogyakarta Principles, see the Yogyakarta Principles 2013.

16 | The medical care of asylum seekers is in general precarious. Medical care of asylum seekers is regulated in s. 4 of the Asylum Seekers Benefits Act (*Asylbewerberleistungsgesetz* [AsylbLG]). According to s. 4(1) AsylbLG, an asylum seeker is granted necessary treatment, including medication and dressings, to ensure the recovery or relief of acute diseases and pain. Section 4(2) AsylbLG provides that expectant mothers and women in childbed are granted medical attendance and nursing care, midwife assistance, medication, dressings and remedies. As the nationwide workgroup for refugees PRO ASYL suggests, s. 4 AsylbLG is flawed, since the medical care of asylum seekers is excluded from the regular healthcare system and provides for emergency healthcare only (PRO ASYL 2013: 2). Moreover, the organisation points out that in practice asylum seekers do not obtain sufficient medical care, because frequently staff without medical qualifications decides on access to medical care for asylum seekers in refugee camps, and social welfare offices often deny asylum seekers preventive medical check-ups, if they do not consider them necessary (ibid: 11). Furthermore, the Asylum Seekers Benefits Act disregards the EU Reception Directive 2003/9/EG issued on 27 Jan. 2003. According to Art. 15(2) EU Reception Directive 2003/9/EG, particularly vulnerable asylum seekers should be granted necessary medical or other care. Art. 17 of the directive defines as especially vulnerable persons e. g. minors, unaccompanied minors, disabled individuals, elderly people, pregnant individuals, single parents with minors and individuals who have experienced torture, rape or other severe forms of psychological, physical or sexual abuse (ibid).

ganisations, associations, networks, support groups and all other organisations serving individuals »living gender diversity« (ibid). Sparked by the establishment of the Inter-Ministerial Working Group »Intersexuality/Transsexuality« (*Interministerielle Arbeitsgruppe »Intersexualität/Transsexualität«* [IMAG]) in Sept. 2014,[17] the network demanded the participation of individuals »living gender diversity« in this workgroup as well as in any other political institution, including health-related policy boards, and legislative panels and consultations on measures pertaining to the life situations of the aforementioned individuals (ibid). Finally, Trans*Aktiv demanded that the Magnus Hirschfeld Foundation (*Bundesstiftung Magnus Hirschfeld* [BMH])[18] include gender diversity in its by-

17 | In September 2014, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (*Bundesministerium für Familie, Senioren, Frauen und Jugend* [BMFSFJ]) set up the Inter-Ministerial Working Group »Intersexuality/Transsexuality« for the purposes of finding legislative solutions for the problems trans and intersex individuals encounter and for establishing social diversity in all areas of life (BMFSFJ 2015). The IMAG focuses on issues related to the medical treatment of individuals with sex variations, the expansion and strengthening of counselling, education and prevention, the investigation into required legislative changes and the analysis of transsexual individuals' actual and legal situation (ibid).

18 | The BMH is a federal foundation located in Berlin (BMH 2015). According to the by-laws of the BMH, the purpose of the foundation is to promote education and research, particularly with regard to commemorating the national-socialist persecution of homosexual individuals (s. [1]1), presenting and conducting research on the life and work of Magnus Hirschfeld and homosexual men and women's living environments in Germany (s. [1]2) and countering social discrimination against homosexual men and women in Germany (BMH 2012: 1). The purpose of the BMH and the representation on the boards (cf. ss. 6 and 12 of the by-laws) suggest that the foundation was formally set up with a heavy white, gay, cis bias and a lopsided commemoration of Magnus Hirschfeld and his body of work. The staffing and purpose of the BMH sparked angry protest, particularly by TrIQ e. V. The latter demanded »an end to exclusion, ignorance, outside depictions and supposed inclusion« (TrIQ 2011b) and demanded an appropriate consideration of all LGBTI groups and research interests, including intersectional perspectives and trans and inter representatives on all boards of the foundation (ibid). While the by-laws were not amended, the BMH included one trans individual on the board of trustees and one intersex activist in the advisory committee. Moreover, the current research programme defines as its cornerstones history, diversity and intersectionality and promotes research and the inclusion of issues related to gender diversity in its events as the programme of the First LGBTI Science Congress in Berlin in 2013 attests to (cf. Hirschfeld-Kongress undated). These developments were an effect of intense struggles between trans organisations and the BMH as well as internal struggles.

laws and proportionately represent individuals »living gender diversity« on all boards of its institution (ibid).

With regard to legal reform, the network made two demands. First and like the initiatives portrayed earlier on, the network called for a timely reform of the Transsexual Act, including a change of first names and a revision of gender status without expert reports and court proceedings to the benefit of self-determination or an abolishment of the Transsexual Act altogether. Second, Trans*Aktiv demanded to extend anti-discrimination measures and the protection of privacy rights (ibid).

With regard to healthcare, Trans*Aktiv focused on two issues. The network demanded to secure and improve accessible, comprehensive, needs-oriented and preventive healthcare based on informed consent and without additional assessment by medical advisory bodies to the statutory health insurance companies for all individuals requiring healthcare services due to their gender identity (ibid). In addition, the network demanded that the committee of the Association of the Scientific Medical Societies in Germany (*Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachschaften e. V.* [AWMF])[19] work towards the depathologisation and destigmatisation of trans when revising their medical guidelines.[20]

4.2.4 Summary: Concepts of gender, trans and gender regime in trans politics since the Act to amend the Transsexual Act

The period between 2011 and 2014 witnessed three major trans movement projects. While the political initiatives had in common that they turned away from lobbying for a reform of the Transsexual Act and demanded an integration of rules in existing legislation instead, they set different priorities. While the dgti e. V. devised a broad conceptual framework for future legal regulations, the Nationwide Workgroup for Transsexual Law Reform developed concrete suggestions for implementation. The newly formed network Trans*Aktiv in contrast compiled a broad set of concrete political, legal and healthcare-related demands.

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19 | See chapters 4.3.1-4.3.3 on the AWMF guideline debate on gender dysphoria.

20 | ATME e. V. participated in the first meeting of Trans*Aktiv. The organisation refused to support the declaration. Spokespersons of ATME e. V. objected to the statement that the network trusts trans organisation representatives involved in the AWMF guideline process and supports their work. ATME e. V. claimed that individuals involved in a process based on the concept of ›gender dysphoria‹ or ›gender incongruence‹ do not speak in their name. Moreover, ATME e. V. argued that the trans individuals involved in this particular process do not represent all individuals concerned. Finally, they suggested that future developments on the treatment of transsexual and intersex individuals should be discussed publicly and in a transparent way (ATME 2014).

Disillusioned with the half-hearted, if any, past and present government coalitions' attempts to profoundly reform trans law, the political projects mark two shifts in transpolitical strategy. First, the projects indicate increasing efforts to create cohesion within the trans movement. The tendency towards creating common demands and an umbrella organisation however also suggest an adaptation to liberal-democratic rules that interest groups represent themselves with one voice. Second, the networks reinforced efforts to gain support from, and involve civil society actors. At the same time, the abovementioned networks continued to monitor federal politics for opportunities to bring trans issues back onto the agenda.

Enabled by prior achievements in trans litigation and less pressed to make anticipatory compromises in the light of federal government unwillingness to engage with fundamental trans law reform, trans concepts and demands radicalised. This tendency is expressed in the definitions of the target group and demands for law reform that without exception subscribe to a perspective of (trans) gender diversity and individuality and healthcare demands that base medical and surgical interventions on informed consent only.

The radicalisation of demands in trans politics is also mirrored in the identification of the gender binary, including its institutionalisation and procedures, as the cause of problems. Consequently and in addition to continuing to insist on respecting the basic human rights to self-determination, the free development of one's personality, privacy and health, the political projects reject stigmatisation and minoritisation materialised for instance in special acts and special assessment procedures.

4.3 Developments and debates in sexology on trans(sexuality) from 2011 to 2014

While few issues have been resolved at the time of writing, current debates in sexology indicate four major developments. First, successful social movement struggles for an acceptance of gender and sexual diversity, the appreciation of theoretical developments on gender and international psycho-medical developments on trans prompted sexologists in Germany to reconceptualise trans. Second, a shift in the balance of power between proponents of trans self-determination and defenders of psycho-medical surveillance within the discipline is mirrored in a number of contributions in the current sexological debate on trans. The former not only question central diagnostic instruments employed so far, but question the diagnostics of trans *per se* by any others than trans individuals themselves. Third, the abovementioned developments inspired sexologists to rethink the psycho-medical management of trans and to reinforce their critique of the rigid assessment instructions and practices exercised by advi-

sory bodies of statutory health insurance companies in the process of assuming the costs of sex reassignment treatment. Fourth, voices in sexology emerged that advocate a withdrawal from psycho-medical involvement in the procedures under the Transsexual Act and heavily criticise government inactivity.

This chapter outlines the abovementioned developments as they unfolded from 2011 to 2014. The first section of this chapter deals with the terminology and definitions that have been suggested so far, taking into consideration the concepts that inform them. Thereafter this chapter presents an overview of suggestions for diagnosing and treating gender dysphoria, including the discussion on the necessity and function of psychotherapy as a diagnostic instrument. The third section addresses developments in the psycho-medical management of trans, focusing particularly on the debate on the developing AWMF guidelines on gender dysphoria and on sexologists' responses to the MDS instructions for the assessment of cost coverage for sex reassignment measures in cases of transsexuality. Finally, this chapter takes up the sexological debate on psychologists' and psychiatrists' role under the Transsexual Act, taking into consideration disparate perspectives on psycho-medical engagement in legal proceedings under the Act as well as suggestions for future psycho-medical contributions by those endorsing further involvement in this field.

The analysis of the aforementioned debates mainly draws upon two recent debates in the *Zeitschrift für Sexualforschung*. The first debate emerged in 2013 and mirrors cis and trans contributors' and/or psycho-medical practitioners' demands for a reform of the Transsexual Act. The second debate began in 2014 and engages with clinical and trans demands on the guidelines on gender dysphoria, which are in the process of being created and will replace the German Standards. Additional sources will be an article by Fritz that appeared in the journal *Gestalttherapie Forum für Gestaltperspektiven* (Gestalt Therapy Forum for Gestalt Perspectives) in 2013, the instructions produced by the MDS in 2009 and an article published in 2008 that presents the perspective of the MDK Nordrhein.

The current debates reveal that sexologists nowadays accept as an undisputed fact a plurality of trans individuals with different health care needs, and the debate suggests that the margin between pathologising and depathologising concepts is in the process of shifting towards the latter. Moreover, while some sexologists continue to advocate psycho-medical involvement for diagnostic and assessment purposes in legal proceedings under the Transsexual Act, regardless of whether they endorse pathologising or depathologising concepts of trans, others suggest withdrawing from any diagnostic and assessment operations in psycho-medical and/or legal settings in favour of trans self-determination.

4.3.1 The debate on reconceptualising transsexuality

Reconceptualising transsexuality is part of the current AWMF guideline debate in Germany. This particular part of the sexological debate has so far involved psycho-medical professionals and/or trans community members and feminist sympathisers. While some discursive traditions overlap, psycho-medical and trans contributions to the debate mirror different disciplinary and social contexts. Regardless of these differences, the current reconceptualisation of trans indicates a shift towards the depathologisation of trans, a recognition of gender diversity and, ultimately, calls into question the gender binary.

Major factors contributing to the debate on terminological and conceptual revisions

Psycho-medical contributions were fuelled by three major factors. These were observations of rapidly diversifying clinical manifestations of transsexualism, a multiplicity of trans subjects that defied any clear-cut categorisation and who revealed different health care needs, poststructuralist and social constructionist thought as well as terminological and conceptual revisions of trans by influential Western psycho-medical associations. Trans community contributions to varying degrees drew upon gender and transgender research and to a lesser degree on premises of community-based participatory research.

Since the late 1990s, the growing visibility of various manifestations of trans had already begun to blow the narrow boundaries of psycho-medical classifications, posing theoretical and practical problems. While Vogel's observation that transsexual developments manifest themselves in different ways and can no longer be subsumed under the twelve cardinal symptoms developed in the late 1970s (Vogel 2013: 181) seems overly cautious in the light of the debates on transsexualism throughout the 1990s and early 2000s, Becker's and Nieder and Strauß's observations appear more to the point. The latter state that ›trans‹ constitutes a »plural phenomenon« (Nieder/Strauß 2014: 73), whereas Becker suggests that dichotomous concepts increasingly fail to capture the growing spectrum of gender identity variants, some of which she identifies as

> pregnant transmen; *shemales*, i. e. biological men, who consciously live as ›women with a penis‹; biological men who live as men socially and ›only‹ wish to have the testicles removed; biological women who do not want to live as men socially, but – as their version of gender identity – ›only‹ wish to have their breasts surgically removed; mtfs who want to live as women socially and demand hormone treatment that guarantees the growth of breasts as well as the preservation of erectibility and many more – but also individuals who reject any assignment to a gender [...]. (Becker 2013: 151 f.)

While poststructuralist and social constructionist premises on gender do not necessarily feature consistently in every individual contribution to the current debate, several contributors stress the social dimension of gender, question the gender binary, and some critically address psycho-medical involvement in the construction of transsexualism.

The term ›liquid gender‹,[21] which Sigusch introduced into the sexologist debate »to do semantic justice to cultural change« (Sigusch 2013: 187) is one example of a historically-specific notion of gender. He describes as ›liquid gender‹ individuals »who glide to and fro between the two big cultural genders while being able to live convincingly according to both gender roles« (ibid).

Becker's article entails a self-reflexive perspective on psycho-medical contributions to the construction of transsexuality. While Becker is sceptical of the apparent »immateriality of poststructuralist gender discourse« (Becker 2013: 148),[22] she concedes that deconstructionist perspectives contributed to a critical analysis of transsexuality as a »medical project« (ibid: 147).

Most prominently, deconstructionist axioms feature, albeit inconsistently, in challenges to gender and the gender binary as hegemonic constructions. When contemplating the future role of psychotherapy in the treatment of gender dysphoria, Löwenberg and Ettmeier suggest questioning the gender binary for two reasons. First, they argue that such an approach helps identify gender stereotypes in psychotherapeutic concepts. Second, they suggest that the deconstruction of the gender binary according to which every individual is required to live unambiguously as a ›man‹ or a ›woman‹ necessarily implies a deconstruction of ›trans‹ in the sense that every unambiguous man is expected to become an equally unambiguous woman and vice versa. They conclude that psychotherapy and any other form of treatment need to take into consideration the pluralisation of life-concepts and hence question the binary gender model (Löwenberg/Ettmeier 2014: 49).

Quoting the transwoman Jean Lessenich,[23] Becker affirms the former's suggestion that, »masculinity and femininity are myths, transsexuality, too«

21 | Sigusch's concept of ›liquid gender‹ resembles Bornstein's concept of ›gender fluidity‹. Bornstein developed the concept ›gender fluidity‹ in 1994 to denote subject positions that resist categorisation on either side of the gender binary (cf. Bornstein 1994: 52).

22 | In her critical appraisal of poststructuralism, Becker (2007: 57) suggests that poststructuralist gender discourse has »disembodied« gender differences. »All that is left are language, discourse, symbolic construction and ›undoing gender‹, i. e. the representation, staging and performance of gender.«

23 | Jean Lessenich is the author of *Die transzendierte Frau*.

(Lessenich 2012: 175, quoted in Becker 2013: 154)[24] in her critique of re-essentialising approaches to transsexuality in sexology and the trans movement. Most apodictically, Sigusch suggests that, »here at least, the period of the rule of ›either man or woman‹ as well as of ›a man and a woman‹ is drawing to its dull close« (Sigusch 2013: 187).

Terminological and conceptual revisions in influential Western psychomedical associations finally sparked the debate on the reconceptualisation of trans among sexologists in Germany. In 2011, WPATH published the 7th version of the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.[25] Two years later, the APA produced the DSM-5. The latest version of the Standards of Care and the DSM-5 have in common that they depathologise gender identities and expressions that are not stereotypically associated with one's assigned gender at birth, recognise gender identities that exceed the gender binary, focus on the distress gender dysphoria may cause as a core diagnostic criterion, acknowledge multiple ways of living trans(sexual) lives and individual health care needs and point out to the social and political dimension of health and health impairment.

The depathologisation of gender identities and expressions that are not stereotypically associated with the assigned gender at the time of birth as well as the recognition of gender identities that exceed the gender binary feature in the definitions the abovementioned associations agreed on. As early as in May 2010, WPATH released a statement noting that, »the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and cultural diverse phenomenon [that] should not be judged as inherently pathological or negative« (WPATH 2012: 4). This perspective is reflected in the Standards of Care that suggest that,

24 | Becker's statements are inconsistent. Although she subscribes to the notion that all genders are myths, the consequences for the myths that do not follow the hegemonic ones are not the same. While Becker insists on mandatory psychotherapy for trans individuals prior to somatic interventions (Becker 2013: 156), she does not suggest applying the same measure to cis individuals seeking somatic treatment such as e. g. hormone replacement therapy in postmenopausal cis women or mastectomies in cis men who develop gynaecomasty. While extending the assumption that individuals lack self-knowledge and require psychiatric assistance or surveillance to cis individuals would not be a desirable outcome from a human rights perspective, the question arises why trans and cis individuals should be treated differently with regard to similar issues, if all genders are myths.

25 | The Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People will be referred to as the Standards of Care.

»transsexual, transgender, and gender-nonconforming[26] individuals are not inherently disordered« (ibid: 6). Similarly, the APA describes ›gender identity‹ without any further ascriptions as »a category of social identity«, which »refers to an individual's identification as male, female, or, occasionally, some category other than male or female« (APA 2013: 451).

Both associations distinguish between gender identities and/or gender expressions on the one hand and gender dysphoria on the other. According to WPATH, ›gender dysphoria‹ is »broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)« (WPATH 2012: 2). Replacing ›gender identity disorders‹ with ›gender dysphoria‹,[27] the APA likewise defines ›gender dysphoria‹ as »the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender«, and it is the distress of gender dysphoria rather than an identity that forms the basis for a diagnosis (APA 2013: 453). In line with acknowledging non-binary genders, the APA considers ›gender dysphoria‹ a »multicategory rather than a dichotomy« (APA 2013a: 14), which is expressed in the DSM-5 accordingly: »Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.« (APA 2013: 453) Nor does a particular gender identity necessarily involve a lifelong sense of belonging to one gender as the definition of ›transgender‹ suggests: »*Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender.« (Ibid: 451)

In addition, WPATH and the APA suggest that there are multiple ways of living trans lives, necessitating individualised health care regimens.[28] This applies to any individual experiencing gender dysphoria (cf. APA 2013: 454) as well as to those defined as ›transsexual‹: »*Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or from female to male, which in many, but not all cases involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).«

26 | ›Gender nonconformity‹ is defined as »the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex« (WPATH 2012: 5).

27 | For a compilation of changes from DSM-IV-TR to DSM-5 on issues related to gender dysphoria, see APA 2013a: 14 f.

28 | WPATH e. g. notes that, »[f]or individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which they take place differ from person to person.« (WPATH 2012: 9)

(Ibid: 451) WPATH also considers ways of living trans lives that have until recently been considered unthinkable among sexologists: »Many transgender, transsexual, and gender-nonconforming individuals will want to have children. Because feminizing/masculinizing hormone therapy limits fertility [...], it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs.« (WPATH 2012: 50) Unlike the DSM-IV-TR (APA 2000: 4), the DSM-5 no longer excludes intersex individuals from a diagnosis of gender dysphoria (APA 2013: 453).

Moreover, both associations recognise the impact of social interactions, policies and the legal environment on trans health. WPATH holds that stigma attached to gender nonconformity impinges on trans individuals' health (WPATH 2012: 4). While the APA points out to the adverse effects of prejudice, discrimination and victimisation (APA 2013: 458), WPATH additionally advocates interventions into the public sphere to achieve favourable conditions for trans health:

> WPATH recognises that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms. (WPATH 2012: 1 f.)

Several statements in the revised Standards of Care reveal WPATH's struggle for depathologisation and anti-discrimination, whilst attempting to secure access to health care. While WPATH, like the APA, suggest that some instances of distress due to gender dysphoria may amount to a mental disorder (WPATH 2012: 5), WPATH at the same time cautions that, »[a] disorder is a description of something with which a person might struggle, not a description of the person or the person's identity« (ibid). WPATH notes that, »[t]he existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments« (ibid: 6).

Trans and feminist contributions to the debate on reconceptualising trans draw upon several sources. Among these are queer-feminist thought and results of gender and transgender research and trans activism, insights gained from community-based participatory research and human rights discourse. Trans and feminist contributions have in common that they are informed by research that renders visible multiple genders beyond the gender binary, approaches that question power relations and practices that marginalise genders and sexualities and demand that psycho-medical practitioners critically reflect upon their entanglement in the binary gender regime.

Fritz bases her approach to trans counselling on queer-feminist axioms. Referring to Butler's theorems of ›gender‹ as radically independent of ›sex‹ (Butler 1990: 7) and ›gender‹ as a performative effect of a regulatory regime that polarises and hierarchises genders under constraint (Butler 1997: 17), Fritz applies the effects of taking the gender binary for granted to psychotherapeutic contexts (Fritz 2013: 139).

She argues that psychiatry and psychotherapy with trans individuals during the assessment and therapeutic process mirrors a pronounced subject-object-relationship. As long as experts define norms and their deviations, trans individuals will be degraded to objects and questioned, hence enforcing a hierarchical relationship and leaving little space for exploring gender identity beyond the gender binary (Fritz 2013: 143). Fritz argues that it is »[o]nly reflexion and questioning the binary logic of gender that shed light on concepts of self-determination and human rights discourses« (ibid 2013: 140).

Hamm and Sauer (2014) draw upon transgender studies research in Germany. The authors particularly draw on two strands of transgender studies of which one engages with the broad spectrum of trans identities, lives and concepts. Hamm and Sauer as well as Radix and Eisfeld (2014: 32) point out to the diversity of trans individuals. Hamm and Sauer note that,

> [t]rans individuals are extremely diverse. They have in common that they cannot and/or do not want to occasionally, in part or at all relate to their assigned gender at birth. Trans individuals may identify as the ›other gender‹ within the gender binary or locate themselves between or beyond it or completely refuse a gender assignment. Individuals that live as ›neither nor‹, ›(gender)queer‹, ›non-gender‹ and the like beyond polarity may, but need not necessarily, consider themselves as trans. (Hamm/Sauer 2014: 6)

Hamm and Sauer's perspective also builds upon results of interdisciplinary gender and transgender studies research that examines the conditions and practices that construct certain genders and sexualities as deviant, while the norms and social negotiations minoritisation is based on remain unquestioned. This applies in particular to a body of research that examines how psychiatry and the law have contributed to normative concepts of gender and sexuality and the effects ›gender unambiguity‹ had (and continues to have) on social participation. Hamm and Sauer conclude from the findings of this research that psycho-medical perspectives on trans identities and bodies have contributed to reproducing the heterosexually organised gender binary and sex/gender unambiguity as a prerequisite for social participation (ibid: 6 f.).

Based on these findings, Hamm and Sauer argue that medicine and psychology have so far defined trans as psychological disorders and conducted research in the context of a paradigm of deviation, usually without having considered that ›gender‹ or the ›heteronormative gender binary‹ require an ex-

planation (ibid). Therefore, the authors argue that the ›objectivity‹, ›validity‹ and ›results‹ of binary research designs and interpretations as well as the lack of self-reflexion need to be questioned (ibid).

Based on the critique of psycho-medical premises and research on, and the treatment and management of trans individuals so far, and informed by insights from transgender studies research and trans activism, Hamm and Sauer suggest taking into consideration principles in community-based participatory research and fundamental human rights guaranteed in the Basic Law and the European Convention on Human Rights. With regard to the former, the authors demand that psycho-medical researchers question power relations in their projects and consider the question who profits from such an undertaking (ibid: 8). With regard to human rights, Hamm and Sauer argue that any research, development of guidelines and treatment of trans individuals needs to observe the right to the dignity of every person, which the Federal Constitutional Court defined as the right to individuality (ibid: 14); the right to self-determination, which includes the right to determine one's identity freely and the right to adapt one's body, name and gender status to one's identity (ibid: 11); the right to health, i. e. the right to a humane existence and the free development of one's personality (ibid: 12) and the right to privacy, which – applied to trans individuals – includes the rights to be legally recognised according to one's gender identity and to health insurance coverage of sex reassignment measures (ibid: 13).

Terminology and definitions from 2011 to 2014

The borders between psycho-medical and trans community concepts are not always clear-cut. However, most psycho-medical contributors to the current sexological debate have so far adopted the term ›gender dysphoria‹ (›*Geschlechtsdysphorie*‹), whereas trans community as well as some psycho-mediccal contributors use the term ›trans‹ (›*Trans**‹), including variations of the term, such as ›trans individuals‹ (›*Trans*-Menschen*‹ or ›*Trans*-Personen*‹ or ›*Transgeschlechtlichkeiten*‹).

The use of the term ›gender dysphoria‹ in the current sexological debate is inspired by the terminological shift in the DSM-5 (Strauß/Nieder 2014: 1). While Becker remains cautious of the term, suggesting that the merits and drawbacks remain to be seen (Becker 2013: 152 f.), most psycho-medical contributors to the continuing debate have adopted the term ›gender dysphoria‹.[29] Like the APA, Nieder and Strauß define ›gender dysphoria‹ as the »distress [...] that may result from the incongruence between individual experience and the assigned gender, which is usually based on primary sex characteristics«

29 | See, for instance, Strauß/Nieder 2014, Nieder/Strauß 2014, Löwenberg/Ettmeier 2014 and Vogel 2013.

(Nieder/Strauß 2014: 62). In essence, Vogel's, and Löwenberg and Ettmeier's (2014: 48) definitions are identical. Vogel e. g. defines ›gender dysphoria‹ as the psychological distress caused by the discrepancy between a person's identity and experienced sex (Vogel 2013: 181).

The abovementioned authors welcome the revised terminology for conceptual and pragmatic reasons. Löwenberg and Ettmeier, Vogel as well as Strauß and Nieder positively highlight the depathologising impetus of the term, which allows for a recognition of diverse, non-binary genders (Löwenberg/Ettmeier 2014: 48; Strauß/Nieder 2014: 1f.) as well as the acknowledgement of transsexuality as a heterogeneous, individual and self-defined identity (Vogel 2013: 181). Moreover, the revised terminology avoids any standardisation of gender and renounces gender role stereotypes, since it does not evaluate experienced or expressed gender (Nieder/Strauß 2014: 61; Strauß/Nieder 2014: 1; Vogel 2013: 182). In addition, Nieder and Strauß positively emphasise the inclusion of variations of sex development (Nieder/Strauß 2014: 61; Strauß/Nieder 2014: 2). Finally, Löwenberg and Ettmeier suggest that the term ›gender dysphoria‹ opens up a broader range of therapeutic options and individual solutions (Löwenberg/Ettmeier 2014: 48).

The term ›trans‹ originated from the trans community and has ever since been a decidedly non-pathologising term. All contributors to the sexological debate who occasionally[30] or continuously use the term ›trans‹ define ›trans‹ »as an umbrella term for diverse gender identities« (Fritz 2013: 135) or, more precisely, »for ›transsexual‹, ›trans-identified‹, ›transgender‹ etc. in order to include a multiplicity of self-identities and gendered (non-) localisations« (Hamm/Sauer 2014: 1), or, as Radix and Eisfeld suggest from a U.S. experience, »as an umbrella term [...] that includes those, too, who live beyond the gender binary (e. g. genderqueer, androgynous, bi-gendered and two-spirit) and those not interested in sex reassignment measures« (2014: 32). Nieder and Strauß define ›trans‹ as a category comprised of »individuals whose experienced gender identity does not (or not completely and/or permanently) concur with the gender assigned at birth« (Nieder/Strauß 2014: 59).

4.3.2 Diagnosing gender dysphoria

Reconceptualising trans necessarily involves reconsidering issues related to diagnostics. So far, the current sexological debate has addressed questions of classification, diagnostics and treatment models, in particular with regard to the necessity and function of psychotherapy and, to a lesser degree, further diagnostic instruments, most notably physical examinations and the so-called real life test. While the debate has only just begun and the struggle over trans

30 | See, for instance, Nieder/Strauß 2014.

self-determination remains contested, it indicates a shift towards more ›patient-centred‹, individualised health care and psycho-medical self-reflexivity.

Suggestions for classifying gender dysphoria

A diagnosis of gender dysphoria is contingent upon a classification. The debate on classifying gender dysphoria is marked by considerations on securing health insurance coverage of the costs of sex reassignment surgery and the tension between perspectives that ›other‹ trans and those that consider trans a legitimate gender on a par with any other gender. So far, four suggestions for classifying gender dysphoria have arisen.

The first suggestion opts for classifying gender dysphoria as a mental disorder. Löwenberg and Ettmeier give two reasons for this particular preference. First, they argue that since there are no scientifically verified somatic findings that support a classification of trans as a somatic phenomenon, the psychosocial problem remains paramount.[31] In addition, they point out that there are other ›mental disorders‹ that continue to be classified as mental illnesses, despite the fact that these conditions are demonstrably influenced by somatic factors (Löwenberg/Ettmeier 2014: 50). Second, the authors argue that the distinction between ›transsexuality‹ or ›transidentification‹ as non-pathological identities, respectively, and the clinical term ›gender dysphoria‹ mirrors the depathologising gesture with regard to diverse gender identities, whereas ›gender dysphoria‹, defined as the distress caused by the discrepancy between the assigned and the experienced gender, needs for pragmatic reasons to be understood as a mental disorder (ibid: 48).

31 | Becker agrees with Löwenberg and Ettmeier on the issue of somatic causes of transsexuality (cf. Becker 2013: 153). Apart from the lack of empirical evidence, Becker points out to three further shortcomings of monocausal, somatic aetiological reasoning. First, in her opinion any mono-causal aetiology appears improbable in the light of diverse transsexual developments. Quoting Nieder, Jordan and Richter-Appelt (2011: 218), she suggests that transsexual developments are rather conditioned by an interplay of biological, psychological and social factors in unique and multiple ways (Becker 2013: 154). Second, she anticipates that potential findings in imaging techniques, such as e. g. magnetic resonance imaging, will once more lead to distinctions between ›real‹ and ›unreal‹ transsexual individuals or to reinvoking the notion of the ›wrong body‹. As an effect, these notions will contribute to the homogenisation of transsexual individuals and ignore the complexity of transsexual individuals' situations and perceptions of their respective bodies (ibid: 154 f.). Finally, she argues that insisting on somatic causes of gender re-essentialises the categories ›woman‹, ›man‹ and »transsexual desire« (ibid: 151). However, Becker tends to equate calls for depathologisation with the essentialisation of gender (ibid). When taking into consideration deconstructionist perspectives on gender in trans organisations, such as e. g. in TrIQ e. V. and the TGNB, this does not apply.

The second suggestion considers developing an alternative classification in the ICD-11.[32] Fritz argues that responding to the distress caused by the incongruence between the experienced gender and the body with somatic measures calls into question a classification as a mental disorder. She points out that no other mental disorder is treated with physical interventions and court decisions. Since trans individuals are dependent on medicine and health insurance coverage of sex reassignment measures, and drawing upon the debate that arose during the Transgender Council in 2012, she tentatively suggests creating the classification ›Z‹ for trans individuals (Fritz 2013: 142).[33]

The third suggestion distinguishes between a preferable and a pragmatic or realistic solution. Ideally, Hamm and Sauer advocate a non-pathologising classification in the ICD 11 or a rule in social legislation, respectively that obliges health insurance companies to assume the costs of sex reassignment measures based on prior informed consent. Since neither option currently appears to be practicable in the current legal and political climate, they suggest that individuals involved in treating trans individuals will have to continue to operate with the existing diagnosis of ›gender identity disorders‹, i. e. a mental disorder.

The fourth suggestion is based on the premise that diagnostic categories as they exist in classification systems are in principle inappropriate means to deal with patients of any sort. Güldenring presents two arguments to support her view. First, she holds that subjective feelings cannot be captured using allegedly objective criteria (Güldenring 2013: 170). Second, she argues that, »psychiatric diagnostics measures nonconformity, deviance and the unusu-

32 | The ICD 10 GM is the German modification of the 10th revision of the ICD. In its 2015 version, ›Gender Identity Disorders‹ (›*Störungen der Geschlechtsidentität*‹) (F64) are subsumed in Chapter V ›Mental and Behavioural Disorders (F00-F99)‹ (›*Psychische und Verhaltensstörungen*‹). The most recent ICD 10 GM neatly distinguishes between various ›gender identity disorders‹, e. g. by codifying ›transsexualism‹ (›*Transsexualismus*‹) as F64.0 and ›dual-role transvestism‹ (›*Transvestitismus unter Beibehaltung beider Geschlechtsrollen*‹) as F64.1 (DIMDI 2015). The 11th revision of the International Classification of Diseases will be released in June 2018 (WHO undated).

33 | In a proposal made in June 2013, TGEU made three suggestions for a revision of the ICD 10. First, TGEU suggested to remove all trans-related diagnoses from the mental disorder section ›F‹ in order to avoid psychopathologisation and second, to create a new and separate chapter called ›Gender Incongruence‹ containing the diagnosis ›Gender Incongruence in Adolescence and Adulthood‹ as the only diagnosis to ensure access to health care for all trans individuals who need or seek it. Third, the organisation suggested to abolish the diagnosis ›Gender Identity Disorders in Childhood‹ and rather cover clinical needs of children in XXI (Z) ›Factors Influencing Health Status and Contact with Health Services‹, hence granting pre-pubertal individuals health care without exposing gender-nonconforming children to stigmatisation and discrimination (TGEU 2014: 2-4).

al« (ibid), usually equating the latter with disorders requiring treatment. As a result, a person's individuality is not treated with respect (ibid). The author suggests that rather than define and heteronomously categorise individuals, appropriate diagnostics ought to »respect the special nature of an individual, appreciate his or her desire for expression as an individual note and essential need« and »help the individual to achieve maximum self-determination under the conditions of a frequently limiting environment« (ibid). However, Güldenring remains silent on issues related to health insurance coverage of sex reassignment measures.

Suggestions for diagnostic and treatment models

Reconceptualising trans and gender dysphoria also raises questions about appropriate diagnostic and treatment schemes. The sexological debate in Germany has so far particularly discussed the necessity and function of psychotherapy. In the course of the debate, three models have been presented to date, which are based on different assumptions on trans expertise and have different effects on trans self-determination.

The first model regards psycho-medical diagnostics and psychotherapy as mandatory. Regardless of the critique that has been levied against this particular model from within sexology and, more profoundly, by trans organisations, Becker proposes sticking to this mode of enquiry. She reasons that trans individuals not only harbour contradictory desires. Even more so,

> many transsexuals only arrive at a clear and reflective attitude towards individual somatic measures in the course of a psychotherapy or the diagnostic-therapeutic process, which among other things potentially includes an active disillusionment of too high expectations with regard to operations, a solution for all problems [...]. (Becker 2013: 155)

While she concedes that transsexuality constitutes a self-diagnosis, this does not mean that all ›patients‹ have answered all their questions. Rather, many »patients with a transsexual desire« voluntarily seek physicians and psychologists in the period of self-enquiry, »because they wish to gain more clarity about their individual transsexuality, a competent clarification of their transsexual desire or ›recognition‹ (in a deeper sense) within the intimacy of a psychotherapeutic relationship« (ibid: 156).

While there are to date no reliable data on the number of trans individuals voluntarily seeking psychotherapeutic assistance, such a desire may indeed emerge in some trans individuals (cf. Hamm/Sauer 2014: 16). Becker's model of mandatory diagnostics and psychotherapy however does not explain why individuals who have fulfilled the tasks of self-exploration and enquiries on their own or by other means should have to undergo psychotherapy (cf. ibid: 17), nor

why psychotherapy features as a superior form of enquiry as opposed to e. g. peer support (cf. Seikowski 2007).

The second model suggests mandatory diagnostics and optional psychotherapy for individuals experiencing gender dysphoria and is inspired by the debate on the revision of guidelines in Germany. However, this model appears in two guises. Hamm and Sauer developed their variant of the model against the background of discriminatory experiences trans individuals make in the course of a transition, whereas Löwenberg and Ettmeier's concept is inspired by the latest revision of the Standards of Care. While the formers' variant is motivated by maximising trans self-determination, Löwenberg and Ettmeier focus on the clinical perspective, including thorough diagnostics.

Hamm and Sauer favour either a non-psychopathologising classification or a legal provision that – similar to the Argentinian *Ley de identidad de género*[34] – ensures coverage of medical and surgical sex reassignment measures on demand. However, in the face of the current situation in Germany they suggest in recognition of trans self-determination to reduce the diagnostic process to few appointments. Moreover, they suggest extending diagnostic competency to somatically oriented physicians in order to gain further independence of psy-

34 | On 08 May 2012, the Senate of Argentina approved the *Ley de identidad de género*, an Act that regulates the transition from the assigned gender to another. Section 1 broadly defines that »[a]ll persons have the right a) to the recognition of their gender identity; b) to the free development of their person according to their gender identity« and »c) to be treated according to their gender identity«, particularly with regard to first names, image and sex recorded in documents proving their identity (TGEU 2013). Section 2 defines gender identity in non-pathologising terms and suggests that an individual's gender identity can manifest itself in multiple ways, possibly including, but not limited to, freely chosen medical and surgical means (ibid). Section 3 rules that any person who does not identify with the assigned gender may request an amendment of the recorded sex according to the self-perceived gender identity (ibid).
The concept of self-defined gender identity runs through the entire Act. Section 4 e. g. specifies overall easily accessible requirements for formal gender recognition and in particular provides that, »[i]n no case will it be needed to prove that a surgical procedure for total or partial genital reassignment, hormonal therapies or any other psychological or medical treatment has taken place« (ibid), rendering the right to the recognition of one's gender identity radically independent of psycho-medical interventions and expertise. Moreover, s. 11 provides that access to surgical and/or hormonal treatment to adjust the body to the respective self-perceived gender identity does not require any judicial or administrative authorisation. Rather, the only requirement is the individual's informed consent. In addition, the Act rules that any health insurance company must guarantee the assumption of costs for medical procedures contemplated in the Act (ibid). For the original text in Spanish, see CDI/MECON undated).

chiatrists and psychologists, close gaps in health care provision, reduce waiting time and to relieve heavily frequently specialists (Hamm/Sauer 2014: 22).

Hamm and Sauer reject psychotherapy as a diagnostic instrument for two reasons.[35] First, they argue that in the light of the experiences made under the German Standards,[36] the therapist becomes the decision-maker on legitimate ways of expressing gender identity, and these decisions for most part have relied on a binary concept of gender (ibid: 15). As a result, trans individuals have generated narratives to match the stereotypical expectations of psychiatric gatekeepers. These practices put in question any meaningful psychotherapeutic assistance and preclude the establishment of trustful working relationships (ibid: 16). Second, they point out to the lack of psychotherapeutic or psychiatric diagnostic evidence. According to Hamm and Sauer, proponents of compulsory psychotherapy assume that there are a number of mentally ill transsexual individuals, without however defining the ascriptions ›healthy‹ and ›sick‹. Moreover, they observe that psychological and psychiatric professionals mainly focus on conflictual developments (ibid: 17).

35 | Hamm and Sauer also reject a mandatory ›real life test‹ and invasive questions as diagnostic means. They oppose the former for three reasons. First, requiring a ›real life test‹ exposes trans individuals to discrimination and verbal and physical abuse. Second, individuals are forced to disclose their trans status, which infringes upon their right to privacy. Third, life as a publicly discernible trans individual cannot be compared with the situation of passing as the gender a person identifies with (Hamm/Sauer 2014: 19). The authors suggest that it is for the trans individual to decide whether, when and where to present him- or herself according to his or her gender identity (ibid: 19 f.).
Hamm and Sauer demand banning invasive questions in diagnostic procedures, arguing that invasive enquiries in particular into sexual practices and sexual orientation violate a trans person's privacy. Moreover, the authors consider these and comparable questions inappropriate in a setting marked by unequal power relations and dependency. Furthermore, Hamm and Sauer suggest that they are entirely irrelevant, since trans individuals live diverse sexualities (ibid: 21).

36 | In a study on violence and multiple discrimination, LesMigraS e. V., an intercultural group of lesbian, bisexual migrants, black lesbians and trans individuals working in the area of anti-discrimination and anti-violence in a lesbian counselling centre in Berlin (*Lesbenberatung e. V.*) (LesMigraS 2011), e. g. stated that in addition to discrimination in everyday life, half of the trans individuals interviewed had experienced discrimination at the workplace or in vocational training, and 44.7 % reported having made negative experiences in the area of health care (LesMigraS 2012: 4).

The authors also reject compulsory psychotherapy as a means of treatment for two reasons.[37] First, they suggest that many trans individuals have accomplished all necessary tasks prior to seeking an indication for somatic interventions. Second, they doubt the legitimacy of a prescribed psychotherapy, since such a procedure violates three requirements for psychotherapeutic treatment: Psychotherapy is meant to ameliorate a mental disorder; the patient needs to be motivated, and treatment should involve economic considerations. Hamm and Sauer argue that none of these prerequisites apply in cases of mentally healthy trans individuals (ibid: 17 f.).

The second variant of this model focuses on thorough psychological or psychiatric diagnostics and comprehensive psychological support. Löwenberg and Ettmeier distinguish between a mandatory ›integrative treatment‹ and an optional psychotherapy.[38] Their proposed treatment model suggests that a psychologist, psychiatrist or neurologist should be responsible for the mandatory part of the treatment regimen. This so-called gender specialist is responsible for diagnosing gender dysphoria, conducting the differential diagnostics and coordinating the overall therapeutic scheme (Löwenberg/Ettmeier 2014: 50 f.), such as indicating treatment for potential comorbidities, conveying information on legal and therapeutic options, indicating somatic measures (ibid: 51) and referring the ›patient‹ to suitable colleagues (ibid: 52). According to Löwenberg and Ettmeier, the treatment schedule should provide the option for long-term

37 | However, Hamm and Sauer suggest that optional psychotherapy, which is entirely detached from diagnostics would be desirable and helpful for trans individuals (Hamm/Sauer 2014: 16).

38 | For comparison: In its 7th version of the Standards of Care, WPATH notes that a mental health screening and/or assessment is needed for referral to hormonal and surgical treatment for gender dysphoria (WPATH 2012: 28). Like Löwenberg and Ettmeier, WPATH holds that »psychotherapy – although highly recommended – is not a requirement« (ibid). Rather than outline a mandatory treatment programme, the Standards of Care develop principles that should inform interactions with transsexual, transgender and gender-nonconforming individuals seeking health care: »Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).« (Ibid: 3)

treatment to individuals whose gender dysphoria persists for various reasons, such as for example, with individuals who cannot undergo hormonal and/or surgical measures or whose professional and/or family circumstances do not allow for a social and/or somatic transition (ibid). While Löwenberg and Ettmeier emphasise that any treatment should be patient-centred, seek individual solutions and should not hierarchise various measures or fulfil gatekeeper functions (ibid: 51), they nevertheless point to a problem Hamm and Sauer's model tries to avoid, that is, encroachments on trans self-determination:

> The psychotherapeutic treatment of patients with gender dysphoria will [...] in most cases mean that the therapist is, in spite of all due neutrality, forced to ›participate‹. This happens, for example, when the therapist indicates somatic measures for adjustments to the experienced gender or more or less tacitly supports them or when he delays or impedes potentially helpful somatic measures by presenting objections. (Ibid: 56)

Like Hamm and Sauer, and for the same reasons, Löwenberg and Ettmeier oppose mandatory psychotherapy. Arguing that gender variance may require consultation (ibid: 53), there is no reason for an automatic indication for psychotherapy (ibid: 54). The authors advocate easy access to optional psychotherapy, regardless of whether comorbidities exist or not, arguing that an optional psychotherapy might assist individuals featuring adjustment problems, such as e. g., problems relating to coming out, partnerships or self-acceptance (ibid: 55 f.).

The third model that entered the current sexological debate relies solely on a trans person's informed consent as it is practiced in the Callen-Lorde Community Health Center (CLCHC)[39] in New York City. This particular model values patient autonomy highly and assumes that individuals seeking health care services are capable of self-determination, once they have been informed about the potential and risks of transition-related hormone therapy (Radix/Eisfeld 2014: 34).

The informed consent model was developed for two major reasons. First, the model takes into consideration the specificities of the US American health system, including its effects on trans individuals. Radix and Eisfeld note that since the US lacks a comprehensive health system, a significant number of individuals are not health insured. This applies particularly to trans individuals of which 47 % in 1999 and 2000 were said to be without a health insur-

39 | The CLCHC was founded in 1983 in New York City for providing medical care for gay men's sexual health. The scope of the CLCHC was gradually extended to e. g. provide general medical health care, offer transition-, HIV- and sexual health-related health care for lesbian, gay, bisexual and trans individuals. The CLCHC provides outpatient health care services only and no surgical interventions (Radix/Eisfeld 2014: 34).

ance. Moreover, commercial health insurance companies usually do not cover transition-related interventions, and Medicaid, the statutory health insurance company for low-income individuals, excludes transition-related health care provisions (ibid: 33).

Second, the model responds to the difficulties trans individuals face when consulting psychologists and psychiatric professionals. Like Hamm and Sauer, Radix and Eisfeld observe that only those trans individuals are granted access to sex reassignment measures who adapt themselves to the treatment provider's heteronormative and gender binary bias (ibid). These practices led the CLCHC to doubt the necessity of psychotherapy and psycho-medical indications for sex reassignment treatment (ibid).

Based on these experiences, the CLCHC developed procedures according to the informed consent model »which stress the necessity to provide trans-positive health care«, access to sex-reassignment-related health care provisions and include the entire spectrum of comprehensive health care provision (ibid: 34). While the revised WPATH Standards of Care suggest locating trans health care in the area of mental health (WPATH 2012: 36),[40] the CLCHC situates trans health care in the field of general health (Radix/Eisfeld 2014: 35). Since trans individuals frequently face discrimination in the health care system to the effect of delaying access to preventative health care measures and emergency care, the CLCHC monitors transition-related and general health parameters (ibid: 35 f.).

While in contrast to the USA, most individuals in Germany are health-insured,[41] and whereas health insurance companies are obliged to assume the costs of several medical and surgical sex reassignment measures, the CLCHC model of informed consent is nevertheless relevant to the German debate. Not only do Radix and Eisfeld's as well as Hamm and Sauer's contributions mirror trans individuals' distrust of the psychological and psychiatric disciplines.[42]

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40 | WPATH explains that mental health professionals can play an important role »in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment« (WPATH 2012: 36). At the same time, the organisation suggests that protocols developed in various US community health centres, such as the CLCHC, »are consistent with the guidelines presented in the WPATH *Standards of Care*, version 7. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring protocols to the approach and setting in which these services are provided« (ibid).

41 | Major exceptions are unregistered individuals, usually homeless people and low-income self-employed people.

42 | The strained relationship between trans individuals and sexological practitioners is also expressed by Güldenring: »With the publication of the ›cardinal symptoms‹ on ›transsexuality‹ in 1979, Sigusch et al. (250 ff.) paved the way for the nagging, at times extreme, mistrust between transidentified/transsexual patients and their practitioners

The former also provide data on trans individuals' ability to make informed decisions without psychological or psychiatric diagnostics and, by implication, refute the fear of so-called regretters:

> Making 0.8 % and only three documented cases of reversals, the number of regrets after irreversible measures for physical gender reassignment was low. Complaints with recourse to legal channels were not reported. Since the mentioned rate of 0.8 % corresponds with the rate of 0.5 to 3 % in the WPATH care guidelines, it is fair to say that both models appropriately assess the patients' ability to make suitable and informed decisions with regard to hormone treatment in the course of physical gender reassignment. (Ibid: 39)

Reconsidering principles in diagnostics and treatment with trans individuals

Despite suggesting different diagnostic and treatment models with different implications for trans autonomy, most contributions signal a shift from diagnostics, in particular psychotherapy, as a gatekeeping instrument to a supportive means. Indicators for such a development feature in demands from within and outside the discipline for individualised, patient-centred health care and a more restrained and self-reflexive attitude of psychotherapists and psychiatrists.

Several contributors to the debate suggest providing individualised patient-centred care, which includes respecting a trans individual's identity and individual choice and sequence of measures required to secure »the best possible health and comfort in life« (Güldenring 2013: 170). Löwenberg and Ettmeier, for instance, define as the aim of an ›integrative treatment‹ to find a solution for the health care-seeker »that does justice to his unique identity« (Löwenberg/Ettmeier 2014: 48). Löwenberg and Ettmeier as well as Güldenring agree that valuing a patient's personality and individuality is a condition for a patient-centred approach (Güldenring 2013: 170; Löwenberg/Ettmeier 2014: 55), which includes accepting a concept of life »beyond classical gender roles« (Löwenberg/Ettmeier 2014: 55).

Löwenberg and Ettmeier as well as Hamm and Sauer agree that patient-centred treatment requires somatic and psychotherapeutic therapies according to an

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and left scorched earth in their wake. […] In retrospect, I [Güldenring] understand these ›contemptuous‹ (Richter-Appelt 2012: 253) cardinal symptoms not only as Sigusch, Meyenburg and Reiche's views. The authors were symptom carriers of a deeply seated fear of the phenomenon transidentity/transsexuality, which dominated thought in medicine about gender and commonly allowed for treating trans individuals apodictically and discriminatorily. This fear continues to be expressed nowadays through exclusionary behaviour in medicine and clinical psychology in Germany.« (Güldenring 2013: 166 f.)

individual's needs. The former e. g. suggest that an individual should have the choice of all possible somatic and psychotherapeutic means without hierarchising any one of them (ibid: 51 f.). Similarly, Hamm and Sauer suggest that it should be up to »trans individuals themselves to decide in a dialogue with clinical experts which measures are individually longed for and needed and which ones are not« (Hamm/Sauer 2014: 20). The authors argue that taking into consideration »the diversity of trans, the desire for sex reassignment operations should no longer be a condition for diagnostics and [...] somatic treatment« (ibid: 21).

Contributions to the debate acknowledging the limitations of binary gender concepts in psychology and psychiatry and the demand that psychotherapists and psychiatrists abandon their role as gatekeepers suggest that a process of self-reflexivity has begun in sexology. While the aforementioned authors establish aims of trans health care, Fritz offers a blueprint for encounters at eye level with trans individuals in asymmetrical settings.

Fritz suggests questioning two asymmetrical settings of which one is social and the other therapeutic. The author notes with regard to the former that questions are unilaterally posed to those who do not comply with the norms of the gender binary. In contrast, cis individuals are not required to explain or justify their gender identities:

> We have made ourselves comfortable in the apparent self-conceptions of the gender binary and are not used to questioning ourselves or to being questioned. Questions are posed to those who do not merge with the logic of the gender binary. Questioning oneself is due to their biography a lifelong process in individuals with transidentity issues anyway. The asymmetry in which we operate and which also impacts on our gestalt therapeutic spaces becomes clear here. (Fritz 2013: 146)

The second asymmetry requiring critical interrogation is the power relations, including the role of the psychotherapist in a psychotherapeutic setting. Fritz argues that therapists are part of the dialogue, including who they have become, their self-concepts, attitudes, norms and values. This applies to their gender identity as well as to their client's. All these experiences impact on the therapeutic space (ibid: 145).

Fritz suggests that in order to create conditions for an immediate dialogue, it is necessary to question power relations that condition and limit it. Such a process includes questioning seemingly self-evident facts and allowing for a psychotherapist's insecurity on behalf of him- or herself rather than a false security by unilaterally insisting on interpretative authority. The author argues that such an encounter with trans individuals will transform therapists too, because,

now we are questioned with our logic of binary gender thought and knowledge. Likewise, gender-normative instruments in society, law and in the health system are questioned that stigmatise and question individuals with transidentity issues over and over again (ibid: 146 f.).

4.3.3 Rethinking the psycho-medical management of trans(sexuality)

The debate on reconceptualising transsexuality, suggestions for diagnostic and treatment models and reflexions on the role of professionals involved in trans health care are part of the debate on the AWMF guidelines that are currently being developed. The debate on guideline development includes a renewed critique of the German Standards and trans health care management, in particular of the MDS instructions for assessment (2009) as well as general suggestions for new guidelines and interim results of this process.

The critique of the German Standards in the AWMF guideline debate and recommendations for change

Different assessments of the German Standards notwithstanding,[43] contributors to the debate on the AWMF guidelines univocally agree that the former

43 | While all contributors agree that the German Standards are no longer up to date, if they ever were (cf. Hirschauer 1997: 337), they assess the contribution to trans health care differently. In their critical appraisal of the German Standards, Strauß and Nieder suggest that the German Standards constituted a »milestone«, since the compiled knowledge and scientific findings on transsexuality contributed to a significant improvement of trans health care (Strauß/Nieder 2014: 27). However, other authors disagree with this assessment. Löwenberg and Ettmeier suggest that the authors of the German Standards dismissed the fourth version of the then HBIGDA Standards of Care, despite the fact that they were based on research, because the international standards questioned the necessity of psychotherapy (Löwenberg/Ettmeier 2014: 46 f.). According to Löwenberg and Ettmeier, the merit of the German Standards was at the time however that they recommended psycho-medical professionals to adopt a neutral attitude towards an individual's »transsexual inclination« (ibid: 46). Hamm and Sauer tentatively suggest that the German Standards contributed to the discrimination against, and stigmatisation of trans individuals (Hamm/Sauer 2014: 5). I suggest that Löwenberg and Ettmeier's as well as Hamm and Sauer's assessment are more appropriate. As chapter 4.1.4 suggests, the German Standards were, rather than being the result of any systematic research and evaluation of scientific knowledge or consultations with trans organisations, informed by conservative notions of gender and sexuality, homogenising and unfounded psychopathologising assumptions on transsexuality and driven by the intention to control access to sex reassignment measures. Instead of contributing to the improvement of trans health care,

are outdated and flawed. Sexologists and/or trans individuals that have so far participated in the debate take issue with several conceptual, methodological and functional deficiencies.

Nieder and Strauß as well as Hamm and Sauer identify major conceptual shortcomings. The latter argue that in addition to the pathologisation of transsexuality (Hamm/Sauer 2014: 8), the standardised and limited concept of transsexuality underlying the German Standards not only led to the notion of ›real‹ and ›fake‹ transsexuality, but to the exclusion of several trans individuals requiring trans-specific treatment. The authors recommend to depathologise, destigmatise and de-discriminate trans individuals (ibid), recognise a broad range of trans identities and living circumstances and diverse health care needs[44] as well as to grant maximum self-determination[45] (Nieder/Strauß 2014: 6).

Nieder and Strauß suggest that rather than focus on reducing distress caused by gender dysphoria, the German Standards concentrate on transsexuality as the problem requiring treatment (2014: 62). As the interim report on the development of the AWMF guidelines reveals, the guideline work group has decided to reconsider the former paradigm. Drawing upon terminological and conceptual developments in the DSM-5, the workgroup focuses on clinically significant distress caused by gender dysphoria as the issue relevant to diagnostics and treatment; depathologising individuals whose experienced and expressed gender does not coincide with the assigned gender, and avoiding the re-establishment of gender norms and acknowledging a diversity of non-binary genders and sexes, of whom the latter may also experience gender dysphoria (ibid: 61).

Contributors to the debate point out to several methodological deficiencies when creating the German Standards. Hamm and Sauer, and Nieder and Strauß criticise that the authors of the German Standards ignored trans organisations in the process of devising the German Standards (Hamm/Sauer 2014: 5). As a result, the then workgroup failed to capture trans individuals' needs (Nieder/Strauß 2014: 62) and developed a paternalistic attitude towards them instead (Hamm/Sauer 2014: 11). With regard to the AWMF guidelines, Hamm

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the authors of the German Standards produced »an anachronistic document featuring persistent helplessness« (Hirschauer 1997: 337; cf. Hamm/Sauer 2014: 27). Given their lack of respect for an individual's decision to live according to the other than the assigned gender, the German Standards rather resemble a milestone in the discrimination of trans individuals.

44 | Hamm and Sauer include trans individuals who e. g. wish to have surgery without hormone treatment (Hamm/Sauer 2014: 21).

45 | The authors emphasise that the right to self-determination applies to individuals facing mental and psychological challenges, too.

and Sauer demand equal participation and status of trans organisations from the beginning of the consultations in all relevant areas (ibid: 23).

While Nieder and Strauß agree that trans organisations should be involved in the process of creating new guidelines, they report that the initial attempt to recruit democratically legitimated trans representatives as permanent participants entitled to vote in the guideline committee[46] failed (Nieder/Strauß 2014: 65). Faced with these difficulties, the committee invited two ›non-representative‹ trans individuals to participate in the process of guideline creation, giving each of them a vote. In addition, the committee invited trans support group members based on a list of known trans support groups in German-speaking countries to present their experiences and recommendations for changes in trans health care in person and offered them the opportunity to submit statements within a two-month period following the hearings (ibid: 66).

Hamm and Sauer point out to a second major methodological flaw following the publication of the German Standards. They suggest that sexologists failed to revise the German Standards, even though they were heavily criticised right from the outset (Hamm/Sauer 2014: 5). The authors call for participatory research on trans health care needs (ibid: 23; 25). Nieder and Strauß agree with Hamm and Sauer's assessment. They state that – unlike the German Standards – AWMF guidelines are *per se* subject to revision every five years (Nieder/Strauß 2014: 66), and they suggest conducting a participatory research project to identify trans individuals' needs (ibid: 67).

As an additional methodological shortcoming in the process of compiling the German Standards, Nieder and Strauß identify a lacking systematic literature review and formal consensus strategy (ibid: 62). In order to achieve the goals of improving treatment in various settings (ibid), diagnostic quality and results of treatment (ibid: 63), Nieder and Strauß report that the committee is aiming at developing the guidelines on gender dysphoria to match the rules applying to the highest level of quality according to AWMF regulations. The rules for achieving recognition according to the highest standard of quality, the S3-level, includes basing knowledge on systematic evidence, a representative guideline committee and a structured procedure to arrive at a consensus (ibid: 64).

Finally, Hamm and Sauer address a number of functional shortcomings of the German Standards. As mentioned in the previous section of this chapter, the authors suggest that the German Standards facilitated psychologists' and psychiatrists' gatekeeping role. Rather than support trans individuals, professionals limited options to express gender identity to those that were compatible with the

46 | At the time, the guideline workgroup consisted of fourteen German, Swiss and Austrian psychiatric, psychosomatic, sexological and psychological associations and three professional associations (Nieder/Strauß 2014: 64 f.).

binary concept of gender (Hamm/Sauer 2014: 15). While Löwenberg and Ettmeier suggest to solve this particular problem by formulating as the main aim of the guidelines to reduce gender dysphoria and not to attempt to change an individual's gender identity (Löwenberg/Ettmeier 2014: 55), Hamm and Sauer call for quality standards for voluntarily sought psychotherapeutic support during a transition (Hamm/Sauer 2014: 25).[47] The provisional outline of the new guidelines of 19 Sept. 2012 indicates that the committee is contemplating measures to ensure the ongoing further qualification of professionals (Nieder/Strauß 2014: 67).

Referring to the inflexible standardisation of trans health care in the German Standards and the 2009 MDS instructions, Hamm and Sauer argue that the rigid standardisation of treatment left, and continues to leave, little choice of individual timing and individually needed measures (Hamm/Sauer 2014: 20). As such, they do not serve trans individuals, nor a health care system that relies on efficiency and actual requirements (ibid: 20). In order to remedy this drawback, the authors suggest replacing the German Standards with guidelines that can be used like a flexible »modular construction system«, rather than enforcing an »all-or-none law« (ibid). As Nieder and Strauß's interim report on the AWMF guideline development suggests, all committee members agree that treating gender dysphoria requires a »non-linear and multimodal therapy« (Nieder/Strauß 2014: 73).

Developments in advisory body of statutory health insurance company policies on issues related to transsexuality

Trans and sexological critiques of MDK rules and practices in the 1990s went unheard. To the contrary, rather than redress the problematic issues, MDKs and particularly the in the meantime newly created MDS aggravated the strain on trans individuals and the professionals that treat them. Based on the MDK Northrhine's perspective (Pichlo 2008) and the MDS instructions for the assessment and eligibility to statutory health insurance coverage of costs of somatic sex reassignment measures (MDS 2009),[48] this section briefly outlines the purpose and aims of the instructions, formal requirements for applications for statutory health insurance assumption of costs of sex reassignment

47 | Hamm and Sauer also demand standards to ensure the quality of sex reassignment surgery, which would allow for redressing botched surgery (Hamm/Sauer 2014: 23). However, the provisional outline of the AWMF guidelines (cf. Nieder/Strauß 2014: 67) suggests that the committee has decided not to include any statement on standards for sex reassignment surgery.

48 | The MDS instructions for the assessment and eligibility to statutory health insurance coverage of costs of somatic sex reassignment measures will be referred to as the MDS instructions for the rest of the chapter.

measures and, using examples, criteria for assessment before turning to the renewed critique of the instructions in the AWMF guideline debate.[49]

The purpose and aims of the MDS instructions can be divided into general ones and those that specifically apply in a case of transsexuality. The MDS defines as the purpose of its instructions to examine whether the preconditions exist for eligibility to medical services and to advise statutory health insurance companies accordingly (MDS 2009: 6). General aims are to realise the principle of solidarity by securing the equal treatment of the community of the insured, ensuring consistent assessment procedures, securing the quality of assessments and improving the collaboration of statutory health insurance companies and the MDS (ibid).

With regard to transsexuality, the MDS purports to carry out an additional assessment procedure to ›protect‹ the health-insured individual applying for statutory health insurance assumption of costs of sex reassignment surgery (ibid). Arguing that, »[t]he rarity and the complexity of the disorders, the diversity of individual developments and arrangements and the special implications of expert assessments and recommendations in individual medical advisory services require consultation and an assessment by experienced experts« (ibid), the MDS defines as a goal of a socio-medical assessment to avoid ›false positive‹ diagnoses of transsexualism in cases where trans identification has emerged as an effect of psychiatric and/or endocrine disorders (ibid).

A comparison between the formal requirements for applications for statutory health insurance coverage of sex reassignment measures reveals an increase in demands on trans individuals. The MDK Northrhine and the MDS require the applicant to submit a substantial set of documents. Pichlo lists as mandatory documents a report on somatic, hormonal and, if applicable, genetic exclusion diagnoses; a report on endocrine findings or the course of hormone replacement therapy; both expert reports for a change of first names and the court decision, provided that they are available at the time of application;[50] a

49 | The general framework, which allows for applying for statutory health insurance company assumption of costs of sex reassignment measures, has remained unchanged since Banaski published his article on the criteria and proceedings for assessing transsexual individuals by medical advisory bodies of statutory health insurance companies in 1996. These can be summarised as clinically relevant distress in individual cases caused by the tension between an individual's gender identity and sex characteristics that persist after having been treated with psychiatric and/or psychological means (Banaski 1996: 64 f.; Pichlo 2008: 120; MDS 2009: 12).

50 | The demand for expert reports for a change of first names and the court decision is however problematic. First, the MDK Northrhine and the MDS instructions generate extra-legal psycho-medical and legal entanglements. Second, a privacy issue is involved, since the above mentioned reports frequently contain intimate and confidential information on

detailed psychiatric report or progress report, including an indication for sex reassignment measures and, finally, a specialist's report or treatment schedule that corresponds with the interventions the applicant intends to undergo (Pichlo 2008: 128). While Pichlo considers a biographical report on the applicant's transsexual background optional (ibid), the MDS decided to render such a report mandatory a year later. The MDS instructions specify that the biographical report should, among other details, include information on the transsexual background, the treatment undergone at the time of application and the ›real life test‹ (MDS 2009: 17).[51]

While the MDK Northrhine guidelines and the MDS instructions are informed by the diagnostic criteria outlined in the German Standards,[52] the MDS instructions establish more rigid criteria than the MDK Northrhine.[53] This becomes evident, e. g. in the demands on the duration of psychotherapeutic or

an individual and possibly on the individual's social environment. Since some applicants have not applied for a change of first names prior to approaching the statutory health insurance company for the assumption of costs of sex reassignment measures whereas others have, the question arises why reports written for a different purpose would be required in the first place.

51 | With regard to the biographical report, the MDS instructions demand of the applicant to provide additional information on issues that are not necessarily transition-related, that might or might not be affected by a transition and ones that are definitely not indicative of an individual's gender identity. The MDS instructions, e. g., require details relating to the applicant's current life situation, family and partnership, education, occupation and employment, friends and acquaintances as well as leisure time activities and hobbies (ibid). The instructions do not specify how to deal with this information, leaving ample space for an MDK expert's subjective interpretations and arbitrary decisions.

52 | Like the German Standards, Pichlo and the authors of the MDS instructions assume that neither a self-diagnosis nor the intensity of the desire to undergo sex reassignment surgery are reliable indicators of transsexuality. Rather, they claim that a diagnosis and the ability to live according to the conventions of the ›new‹ gender role as preconditions for indicating sex reassignment surgery can only be established in the course of an extensive diagnostic and psychotherapeutic process (Pichlo 2008: 121 f.; MDS 2009: 10) and a ›real life test‹ (Pichlo 2008: 124 f.; MDS 2009: 10).

53 | Neither Pichlo nor the authors of the MDS instructions take into consideration developments on trans(sexuality) in sexology, let alone developments in the trans movement. However, Pichlo's perspective is also informed by the version of the HBIGDA Standards of Care (Pichlo 2008: 121), whereas the MDS instructions rely on the German Standards and the international classification systems ICD-10 and the DSM-IV only (MDS 2009: 6). This in part explains why the MDS instructions are more rigid than the perspective of the MDK Northrhine.

psychiatric treatment and the so-called real life test and in the MDS decision-making algorithms.

While Pichlo points out that the German Standards demand at least twelve months of psychiatric/psychotherapeutic treatment prior to allowing hormone replacement therapy, he recommends six to twelve months before granting access to trans-specific somatic health care provision instead. In doing so, Pichlo takes into consideration the then latest version of the HBIGDA Standards of Care and the actual medical care situation (Pichlo 2008: 126). In contrast, the MDS instructions demand that the respective formal time requirements for psychiatric/psychotherapeutic treatment need to be fulfilled according to the period the German Standards allocated to the particular somatic measure (MDS 2009: 16). This means as a rule no less than twelve months of psychiatric/psychotherapeutic treatment prior to e. g. hormone replacement therapy (ibid: 18) and no less than eighteen months prior to a bilateral mastectomy (ibid: 24) or genital surgery (ibid: 26).

Pichlo's recommendations and the MDS instructions also differ on the timeframe considered appropriate for a ›real life test‹.[54] Acknowledging that the German Standards require a ›real life test‹ of at least twelve months prior to hormone therapy, he nevertheless suggests that a period of three to six months suffice (Pichlo 2008: 126). According to the MDS instructions, however, a ›real life test‹ should generally have been carried out for at least twelve months before cost coverage will be granted for hormone treatment (MDS 2009: 18) and epilation (ibid: 20) and, as a rule, no less than eighteen months for a bilateral mastectomy (ibid: 24)[55] or any genital surgery (ibid: 26).

The specifications of the MDS finally culminate in rigid decision-making algorithms for every somatic intervention. With regard to hormone treatment,

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54 | However, Pichlo and the authors of the MDS instructions agree on several other issues pertaining to the ›real life test‹. They e. g. consider this requirement an essential component of the treatment schedule (Pichlo 2008: 122 and 124; MDS 2009: 10). While Pichlo accrues specific importance to performing the ›real life test‹ at the workplace (Pichlo 2008: 124), they concur on the issue that the ›real life test‹ should be practiced continuously in all social contexts (ibid). The authors of both instructions emphasise that the measure should be laid out in a socially acceptable manner (ibid). However, they do not explain how social acceptance and a 24/7 ›real life test‹ fit together in potentially highly conflictual, if not dangerous settings.

55 | In »special exceptional cases« (MDS 2009: 24), the MDS will allow an applicant to fall short of fulfilling the time requirement for a bilateral mastectomy in order to facilitate the ›real life test‹ for transmen (ibid). The instructions do not however provide for such an option for transwomen requiring epilation, despite the fact that the MDS suggests that, »male beard growth is incompatible with the outer appearance of a woman in the light of male-to-female transsexuality« (ibid: 20).

the responsible MDK expert is e. g. asked to check every step in the following order: Has the diagnosis been secured sufficiently? Are comorbidities, in particular mental health problems, sufficiently stabilised or have they been ruled out, respectively? Has the psychiatric/psychotherapeutic treatment been carried out correctly with regard to the nature, extent and duration? Does the applicant suffer from clinically relevant distress? Are the preconditions and the prognosis for the planned hormone replacement therapy positive? An answer in the negative to any one of these questions will inadvertently lead to a recommendation for the statutory health insurance company not to cover the costs of hormone replacement therapy (ibid: 19).

The critique of trans health care management in the AWMF guideline debate and recommendations for change

The critique of trans health care management in the AWMF guideline debate focuses on three issues. These include the use of the German Standards by the advisory bodies of statutory health insurance companies, the role of psychiatrists and psychologists in a complex framework of assessment, diagnostics and treatment, and general conditions for medical services offered by statutory health insurance companies.

All contributors to the debate object to the use advisory bodies of the statutory health insurance companies, above all the MDS, have made of the German Standards. Löwenberg and Ettmeier as well as Hamm and Sauer note that the abovementioned advisory bodies have gradually converted the outdated German Standards to a requirements specification that needs to be completed in order to secure insurance coverage of sex reassignment treatment (Löwenberg/Ettmeier 2014: 46; Hamm/Sauer 2014: 15). While the MDS formally provides exceptions to the standard procedure, Löwenberg and Ettmeier argue that these can barely be implemented in practice (Löwenberg/Ettmeier 2014: 46).[56]

As a result, the inflexible adoption of the German Standards by advisory bodies has led to inappropriate health care services for trans individuals. As Nieder and Strauß, Löwenberg and Ettmeier, and Hamm and Sauer point out, MDK practices and MDS instructions e. g. define the goals of treatment, no matter whether they match those of the respective trans individual.[57] Moreover,

56 | Löwenberg and Ettmeier give as an example of unrealistic treatment scenarios the option of psychiatric monitoring as an alternative to compulsory psychotherapy (Löwenberg/Ettmeier 2014: 46).

57 | One of these controversial goals is e. g. to achieve the inner coherence and consistency of the individual's gender identity (Nieder/Strauß 2014: 60), regardless of the fact that some individuals refuse to temporarily or permanently identify as one of the two legitimised genders or with any gender at all. See also de Silva 2014, Eisfeld/Radix 2014 and Hamm/Sauer 2014.

they demand of trans individuals to complete a fixed sequence of measures, regardless of whether these measures are needed,[58] have proven to be harmful (Hamm/Sauer 2014: 19)[59] or disproportionate.[60]

Several contributors also problematise the roles psychologists and psychiatrists play in assessment, diagnostic and treatment procedures. Löwenberg and Ettmeier remark that psychotherapists currently cater for the rules and standards of health insurance companies while they at the same time try to find individual solutions for their clients. They suggest that the conflict resulting from these different requirements occasionally cannot be solved (Löwenberg/Ettmeier 2014: 47). Similarly, Güldenring holds that medical and psychiatric professionals can barely do justice to the different contents, roles, relationships and tasks in any responsible way (Güldenring 2013: 160).

The rules and regulations that define the terms for obtaining health insurance coverage for sex reassignment surgery constitute another area of contention. Hamm and Sauer e. g. address the parameters provided by social law that inform statutory health insurance company policy. The authors particularly focus on the Federal Social Court decision on 06 Aug. 1987, which provides that statutory health insurance companies are only obliged to assume the costs of sex reassignment surgery when an applicant displays distress. Hamm and Sauer believe that many trans individuals do not experience significant distress, nor constraint in everyday life, simply because they are aware of the option to transition, pursue this goal with determination and are frequently accepted and supported by their respective social environments. The authors argue that frequently distress only arises when trans individuals seeking cost coverage of sex reassignment surgery are turned down on the grounds that they do not experience sufficient distress (Hamm/Sauer 2014: 13). Rather than prevent distress, which should according to Hamm and Sauer be the main goal of trans health care (ibid: 20 f.), the organisation of trans health care contributes to the destabilisation of trans individuals.

Furthermore and as Hamm and Sauer suggest, the MDS instructions ensure that statutory health insurance companies do not cover the costs of individually indicated measures for those who wish to pass inconspicuously as one of the two legally accepted genders. Facial feminisation, body contouring,

58 | This applies e. g. to compulsory psychotherapy which, as Löwenberg and Ettmeier argue, impedes a working relationship between psychotherapists and clients (Löwenberg/Ettmeier 2014: 46).

59 | Hamm and Sauer quote findings by Fuchs et al. (2012) and Franzen and Sauer (2010) that suggest that the ›real life test‹ is a harmful requirement (Hamm/Sauer 2014: 19).

60 | Becker notes that the advisory bodies of the statutory health insurance companies make as high demands for covering the costs of epilation as for genital surgery (Becker 2013: 157).

speech therapy and penis-testicle-epitheses are examples Hamm and Sauer list to prove their point (Hamm/Sauer 2014: 14). The authors argue that the exclusion of the aforementioned services from the service catalogue of statutory health insurance companies contravenes the right to pass and, as such, infringes the right to privacy (ibid: 14).[61] They suggest as a remedy to include the right to pass in the social security statute book, hence rendering health insurance coverage to this effect obligatory (ibid: 22).

In addition, the contributors to the debate take issue with the procedure regulating cost coverage of transition-related health care. Nieder and Strauß, and Güldenring e. g. point out to the statutory insurance company policy of deciding on an application for sex reassignment surgery only after having obtained a socio-medical assessment by the MDS. This additional screening has become mandatory, despite the fact that psychotherapists and psychologists have previously confirmed the indication for surgery (Nieder/Strauß 2014: 60; Güldenring 2013: 165).

Finally, Löwenberg and Ettmeier (2014: 46) and Güldenring address the effects the mesh of in part contradictory requirements have on trans individuals. Güldenring e. g. suggests that in contrast to the requirements for revising first names and gender status, social law regulations demand »maximum comorbidity« for access to sex reassignment surgery (Güldenring 2013: 165). Taking into consideration the extensive procedures and assessments trans individuals need to »pass like examination situations« (ibid) and the requirements and expectations they have to meet in order to be granted the assumption of costs (ibid), she poses the rhetorical question, »Can trans health ever be organised more pathologically?« (Ibid)

In summary, while contributors to the debate identify several deficiencies in current trans health care management, they offer different solutions with different implications for trans individuals. Löwenberg and Ettmeier e. g. suggest psychologists and psychiatrists withdraw from the task of being an »obligatory component of the set of rules of the health insurers« and focus on diagnostics and integrative treatment instead. They demand that psychotherapy should not be part of a »mandatory element« in the treatment schedule or even a prerequisite for inducing somatic measures (Löwenberg/Ettmeier 2014: 57). By contrast, Hamm and Sauer demand to reduce diagnostics in general, curb health insurance companies and advisory body arbitrary decision-making and simplify procedures by establishing in social legislation the right to pass as a health insurance company obligation to be met (Hamm/Sauer 2014: 22). While the former are primarily concerned about improving the conditions for

61 | Hamm and Sauer also suggest that statutory health insurance companies should assume the costs of cosmetic sex reassignment measures such as e. g. epilation provided by non-medical professionals (Hamm/Sauer 2014: 25).

diagnostics and treatment, the latter strive to increase trans individuals' independence from psycho-medical professionals as well as from health insurance companies and their advisory bodies without endangering health insurance assumption of costs of sex reassignment measures.

4.3.4 Rethinking psycho-medical involvement under the Transsexual Act

While the sexological debate on psychologists' and psychiatrists' participation in proceedings under the Transsexual Act was influenced by the same broader social and discursive developments that shaped the debate on the AWMF guidelines, the debate on the Transsexual Act was also inspired by the Federal Constitutional Court decision of 11 Jan. 2011. All contributors to the debate agree that the Transsexual Act requires revisions, and some criticise the federal government for failing to introduce legislation to this effect.[62] However, they disagree on the issue of psycho-medical involvement under the Transsexual Act and, as a result, make different suggestions for change. The suggestions mirror different assumptions on trans self-knowledge, have different implications for trans self-determination and for the relationship between medicine and law in this particular area.

Critique of the Transsexual Act

The psycho-medical critique of the Transsexual Act focuses on three broad areas. Sexologists object to the amalgamation of the legal and the medical realm. Moreover, they argue that the Act is outdated in the light of social, legal and

62 | Güldenring, for example, argues that to this very day, the federal government has decided to ignore calls by sexologists and trans organisations for revisions of the Transsexual Act (Güldenring 2013: 161). As a result of government inactivity, she suggests that the legislator has tacitly tolerated inconsistencies of the Act, which allow for the psychiatrisation of trans individuals and arbitrary modes of assessment (ibid: 163).
Becker aptly identifies government lack of responsiveness on the Transsexual Act as part of a larger policy of non-policy. She provides a bitter critique of government inactivity with regard to issues related to gender and sexual orientation in general: »Since the red-green government (1998-2005) did not deliver on its promise to reform the Transsexual Act, one federal government after the other has refused this overdue reform. De facto a fundamental reform of the Transsexual Act has however taken place through the decisions of the Federal Constitutional Court (BVerfG) that has little by little declared relevant, widely criticised sections of the Transsexual Act incompatible with the Basic Law and, in doing so, annulled them. [...] Politics has obviously for a long time ceded its tasks with regard to dealing with gender and sexual orientation to the Federal Constitutional Court. (Becker 2013: 148)

discursive change. Finally, they suggest that the concept of transsexuality that informed this piece of legislation no longer applies.

While several authors consider the entanglement of the legal and medical spheres in the Act a drawback, their critique points to different effects. Becker e. g. argues that in contrast to the legislator's intentions, statutory health insurance companies and their medical advisory service bodies regularly misuse the Act by demanding that the applicants produce expert reports as a precondition for health insurance assumption of costs of somatic measures (Becker 2013: 146). While this use of provisions of the Act for ulterior purposes is indeed unfortunate and her critique welltaken, Becker does not address the more profound and lawful amalgamation of the legal and the medical realm established by the assessment procedure and stipulated in ss. 4(3) and 6(2) TSG.

Güldenring and Schmidt offer an ethical and methodological critique of the assessment procedure. Both contributors to the debate argue against psychomedical involvement in the legal proceedings under the Act. Güldenring offers two reasons. First, she holds that the Act delegates issues relating to the determination of a person's gender to experts' subjective perspectives (Güldenring 2013: 163). Second, she raises objections against the psychiatrisation of trans individuals within the framework of the Act, claiming that it forces individuals to conform to the rules of the gender binary instead of making society and the legislator responsible for dealing with trans and gender nonconforming individuals in general as means to create a pluralist and tolerant society (ibid: 171).

Based on his experience as an expert in court proceedings for a revision of first names and gender status, Schmidt provides two methodological reasons against demanding psycho-medical assessments under the Act. He argues that considering that psycho-medical experts only reject few applications, the assessment requirement barely contributes to improving predictions on the lasting stability of an applicant's gender experience (Schmidt 2013: 176). Moreover, he notes that applications for reversals of the decision to change first names and revise gender status rarely occur. He concludes that, »[s]ince expert reports almost always approve of the applications [...], the small number of individuals seeking a reconversion impressively states the applicants' subjective expertise« (ibid).

Two authors address the issue of discursive, social and legal change since the enactment of the statute that as an effect render the Transsexual Act outdated. Becker observes that the poststructuralist critique of heteronormativity and the gender binary allowed recognising homophobic notions that informed the Act, mirrored in particular in the provisions that prevent apparent and *de facto* same-sex marriages and the legislator's intention to maintain the »traditional, essentialist gender dichotomy« (Becker 2013: 146). She also points out to a number of social developments that require a reform of the Transsexual Act. Arguing that the previously rigid gender role characteristics have become

socially more flexible, it has become increasingly questionable to determine a person's gender based exclusively on physical characteristics. Moreover, she observes growing tolerance with regard to ›ambiguous‹ sex characteristics and less social acceptance of homophobic attitudes (ibid: 147). Finally, she notes that the trans movement has diversified, allowing for the representation of individuals formerly marginalised within the social movement and society in general (ibid). Referring to the Federal Constitutional Court decisions on the Transsexual Act, Vogel suggests that social processes affecting gender and gender regime are also mirrored in jurisdiction (Vogel 2013: 179).

Several authors suggest that the Transsexual Act is based on outdated medical assumptions on transsexuality. These assumptions feature in the concept and terminology used in the Act. Becker and Vogel point out that in contrast to the understanding of transsexuality as a homogeneous entity, medical science nowadays agrees that transsexual developments vary (Becker 2013: 147; Vogel 2013: 181). As such, a »diagnosis of transsexuality« does not necessarily lead to an indication for surgery (Becker 2013: 147; Vogel 2013: 182 f.). Güldenring and Becker also point out to terminological flaws. They suggest that neither the phrase »transsexual imprinting«, nor the phrase »compelled to live according to their ideas« (ss. 1[1]1 and 8[1] TSG) coincide with current notions on transsexuality (Güldenring 2013: 162; Becker 2013: 151).

Suggestions for a reform of trans law

Minor differences between individual suggestions for a reform of trans law notwithstanding, sexologists' designs for future regulations of trans can be divided into two sets. The first set of suggestions advocates continuing psycho-medical involvement under a reformed act and is represented by Becker and Vogel, while the second opts for psycho-medical withdrawal from future legal proceedings and is advocated by Güldenring, Schmidt and Sigusch. The former necessarily implies a limitation of trans self-determination, whereas the latter cedes expertise to trans individuals and endorses a separation of medical procedures from future provisions for a revision of first names and gender status.

Before offering her suggestion, Becker discusses two further options, one of which would be to abolish gender as a feature of the civil status altogether. The second option would allow for a change of first names and a revision of gender status via application to the register office without a diagnosis and assessment, as practiced in Argentina and suggested by the BAK TSG-Reform in 2012. Becker rejects the first suggestion, assuming that a great number of trans and presumably quite a few cis individuals would be dissatisfied with such a solution on the short and medium term (Becker 2013: 149). She also objects to the second suggestion as long as this particular solution affirms the gender binary. However, she suggests this problem could be solved by creating an additional

gender category (ibid: 150). She reckons though that it is politically unrealistic that the legislator will abolish the Transsexual Act.

As proponents of the first set of suggestions, Becker and Vogel propose a reform of the Transsexual Act, rather than entirely abolishing it, albeit for different reasons. They address the title of the proposed act, terminology and various aspects relating to the issue of experts and expert reports.

Both contributors to the debate on the Transsexual Act agree that the Act requires renaming to account for the heterogeneity of trans individuals or gender-nonconforming individuals in general. Drawing upon the solution proposed by the DGfS in 2001 (Becker et al. 2001), Becker suggests calling the reformed statute »Transgender Act« (*Transgendergesetz*) (Becker 2013: 150), whereas Vogel suggests reducing the title of the act to »An Act to change first names and establish gender status in special cases« (Vogel 2013: 183). While both suggestions would offer a larger range of individuals access to gender recognition, Vogel's formulation can be interpreted more broadly, allowing e. g. intersex individuals and individuals who do not identify as transgender to make use of the act. However, he limits options significantly when making suggestions for terminological revisions.

Becker and Vogel take issue with the terminology in s. 1(1) TSG and suggest rephrasing the section. While Becker proposes to replace the term »imprinting« with »development« and the phrase »have felt compelled« with e. g. »experienced a persistent inner necessity« (Becker 2013: 151), Vogel suggests to replace the former expression with »due to his or her transsexual (or gender dysphoric, respectively) experience« (Vogel 2013: 183). Whereas Becker's proposed terminology is non-pathologising, Vogel's reference to gender dysphoria in a potentially revised act re-establishes a psycho-medical diagnosis in a piece of legislation. In addition, Becker suggests to either abolish or at least reduce the requirement of having to have experienced oneself as another than the assigned gender for a period of three years prior to applying for a change of first names and a revision of gender status (Becker 2013: 151).

Becker and Vogel argue in favour of maintaining an assessment procedure under a reformed act. Becker insists on involving experts other than trans individuals themselves, despite being aware of the fact that such a procedure can also be considered a violation of the right to self-determination (ibid: 154) and that such an option risks exerting applicants to abuse. Becker e. g. acknowledges that no act can guarantee that experts deal respectfully with the applicants, reflect upon their own notions of gender and are open to various transsexual developments (ibid: 151). In her opinion, however, applicants require assistance (ibid: 155), and this conviction seems to outweigh the abovementioned concerns.

Vogel advocates for continuing assessment procedures on the grounds that transsexuality or gender dysphoria, respectively, require extensive diagnostics,

differential diagnostic and counselling procedures (Vogel 2013: 183). Moreover, Vogel suggests that the legislator make provisions for granting experts interventionist functions (ibid: 183 f.) which could however have the effect of increasing expert control. Hence, while Becker's perspective is based on the paternalistic assumption that trans individuals are unable to make informed decisions on behalf of their gender, Vogel's perspective is in addition informed by pathologising assumptions.[63]

However, the authors suggest reducing the number of expert reports. While Vogel generally suggests limiting the number of expert reports to one only (ibid), Becker distinguishes between procedures for a change of first names and a revision of gender status in case the legislator decides to stick to a two-part act. With regard to the former procedure, Becker argues in favour of either dispensing with an expert report or reducing the prognostic demands on these documents, respectively. She suggests requiring one instead of two expert reports for a revision of gender status with higher prognostic demands, while securing the option for a reversal of a decision (Becker 2013: 150).

Both authors expand on the qualifications required to perform as an expert. Becker takes a stand against authorising medical experts only to compile expert reports, arguing that neither physicians nor psychologists are *per se* trained on issues related to transsexuality and gender identity. Rather professionals of either group need to acquire these particular qualifications in addition to their regular training (ibid: 151). Her statement however raises the question why physicians or psychologists should be considered more suitable as experts than members of other professions, such as e. g. social workers or peer counsellors. Rather than specify the professions responsible for producing export reports, Vogel in essence suggests maintaining the broad description of experts as outlined in s. 4(3) TSG (Vogel 2013: 183).

Finally, Becker argues in favour of reducing the duration of the legal proceedings under the Act. She suggests as one means to this effect to dispense with the representative of the public interest as a participant in the court proceedings for a change of first names and a revision of gender status (Becker 2013: 150).

When contemplating a reform of trans law, Güldenring, Schmidt and Sigusch's guiding principle is to achieve maximum self-determination with regard to issues related to gender identity (Güldenring 2013: 172; Schmidt 2013: 175; Sigusch 2013: 185). Sigusch's contribution is in addition motivated by the socio-political goal of achieving gender liquidity (Sigusch 2013: 187). The sex-

63 | This notion is also mirrored in the terminology he uses for the subjects. When referring to the heterogeneity of individuals whose experienced gender does not match the assigned gender, he speaks of a »heterogeneity of gender identity disorders« (Vogel 2013: 183).

ologists address the effects of abolishing any external assessments, demands on a new regulation and expand on the issue of an improper use of such a regulation.

Güldenring, Schmidt and Sigusch point out to a number of effects, if the determination of gender identity was left to the individual. Güldenring argues that such a solution would untangle the administrative mesh trans individuals are caught up in. Moreover, she argues that psychological and psychiatric resources that are currently tied down in assessment procedures could be used to improve trans health care instead (Güldenring 2013: 172). Finally, Güldenring and Schmidt suggest that medicine and law would be severed from each other (ibid; Schmidt 2013: 176).

While concrete proposals for a new regulation differ, the proponents of profound changes to trans law make a number of suggestions to avoid the shortcomings of the Transsexual Act as they have been voiced in the trans movement. Güldenring, Schmidt and Sigusch advocate access to a change of first names and a revision of gender status with as few obstacles as possible (Güldenring 2013: 172; Schmidt 2013: 176; Sigusch 2013: 185). As such, they demand a solution that guarantees a swift, financially less costly and unbureaucratic processing of an individual's desire for assignment to another than the natal gender (ibid) that observes, as Güldenring emphasises, human rights, in particular the right to self-determination, and does not impede individual developments (Güldenring 2013: 172).

Güldenring proposes a new act that is free of discrimination and pathologisation. In addition to the abovementioned requirement, she demands that the act should consider recent findings and insights from disciplines and areas other than medicine and psychiatry, too, in order to produce a legislative text without scientifically untenable contents and phrases, such as e. g., »transsexual imprinting« and »compelled to live according to their ideas« (ibid). She expects of such a regulation to save expenses of court proceedings, costs of expert reports and psychotherapeutic and psychiatric resources and a limitation of psycho-social stress and its detrimental effects on trans individuals (ibid).

In contrast, Schmidt and Sigusch argue against passing a new act. The former suggests that a declaration of one's chosen name and gender in a register office and paying for the fees to this effect suffice (Schmidt 2013: 175). While Schmidt sympathises with the legislator's concern to have to change an individual's first names and gender status once only, if possible (ibid: 176), Sigusch opts for a solution without any approval procedures for all individuals who have reached the age of majority (Sigusch 2013: 185).

Finally, Güldenring and Schmidt discuss the issue of the risk of an improper or frivolous use of either the act or the declaration, respectively. Arguing that there are sufficient social stressors when a person decides to live according to another than the assigned gender, Güldenring anticipates that this scenario is

rather unlikely to happen (Güldenring 2013: 172). Schmidt suggests establishing a waiting period of three or six months between the time of application and the decision, i. e. if the applicant confirms his or her intention to change first names and gender status after the waiting period, the decision becomes operative (Schmidt 2013: 176).

4.3.5 Summary: Sexological constructions of gender, trans(sexuality) and gender regime from 2011 to 2014

Despite a number of unresolved controversies, the course of the current debates on trans in sexology give reason to believe that the margin towards the recognition of gender diversity and the depathologisation of individuals who defy conventional notions of gender, if not gendering as such, is shifting. This development is e. g. mirrored in the conceptual distinction between non-pathologically defined gender identities, such as trans, and the clinical term ›gender dysphoria‹, which focuses on the distress a gender-nonconforming individual possibly experiences. Moreover, several contributors to the debate call into question the formerly assumed essentialist basis of the two socially sanctioned categories ›man‹ and ›woman‹. Altogether, these developments call into question the gender binary. At the same time, a diagnosis of gender dysphoria, or any diagnosis for that matter, conceals social factors contributing to gender-related distress, such as social expectations to embody and ›do‹ gender.

Issues related to diagnostics are clearly more contested for several reasons, and the different perspectives indicate different statuses of trans individuals in relation to cis individuals. Means of diagnostics the dominant faction in sexology formerly considered central to diagnostics, such as the ›real life test‹, mandatory psychotherapy and physical examinations in an assessment setting, no longer seem to be considered state of the art. In addition, sexologists agree that psycho-medical interventions should provide ›patient-centred‹, individualised health care rather than assume a gatekeeping function. However, they are divided over the issue of diagnosing gender dysphoria in the first place. Perspectives range from the conviction that trans individuals unlike cis individuals indiscriminately require psycho-medical guidance to those that question any heteronomous diagnostics and opt for informed consent instead. In between there are perspectives that for pragmatic reasons and to varying degrees suggest psycho-medical guidance. While the former delegitimises trans self-knowledge most significantly, the second set of perspectives reveals the limitations of the overall social law framework within which trans health care takes place in Germany. The latter requires a diagnosis in order to ensure that health care insurances assume the costs of medical and surgical sex reassignment measures.

Reconceptualising trans and rethinking diagnostics is part of a larger project of devising new guidelines that will replace the conceptually outdated and methodologically flawed German Standards and delegitimise the widely criticised instructions and procedures condoned and practiced by the advisory bodies of statutory health insurance companies. At the time of writing, it is premature to anticipate the outcome of the debate on the AWMF guidelines, in particular with regard to issues relating to the organisation of diagnostics and an overdue implementation of quality standards for psycho-medical professionals dealing with gender-nonconforming individuals. However, there are indications that a terminological and conceptual shift from ›transsexuality‹ to ›gender dysphoria‹ will take place in the guidelines, including the abovementioned implications for trans, gender and the gender regime, and it is to be expected that the process will include some trans and social scientific expertise.

While calls for trans self-determination have overall become more prominent, the current sexological debate on the Transsexual Act reveals a controversy similar to the one on the AWMF guidelines with regard to acknowledging trans self-knowledge and observing trans self-determination on the one hand and ensuring the subjects' dependency on psycho-medical professionals on the other hand.

While sexologists disagree on the issue of future expert involvement under a reformed act to regulate transitions, calls for a retreat from assessment procedures under the law have gained ground for a number of reasons. Sexologists increasingly recognise trans self-knowledge and non-pathological gendered embodiments. They critically assess their own participation in a heteronormative hegemonic project. Moreover, sexologists note that the increasing entanglements of medicine, law and statutory health insurance management of transsexuality with contradictory and unintended effects put a strain on psycho-medical professionals and trans individuals. Finally, sexologists observe that the Transsexual Act lags behind rapid social developments in the area of gender and, more specifically, trans.