



Depathologisation of Transgenderism and International Human Rights Law

Jens T. Theilen*

Bucerius Law School, Hamburg, Germany

*Corresponding author. E-mail: jens.theilen@law-school.de

ABSTRACT

This article approaches the depathologisation of transsexuality and transgenderism from the perspective of international human rights law. Building on the jurisprudence of the Committee on Economic, Social and Cultural Rights, it develops a right to trans depathologisation based in the right to health and the right to non-discrimination and engages with potential objections to such a right – in particular, the argument that depathologisation will adversely affect health-care access of trans persons. Having argued for the existence of a right to depathologisation, the contents of that right are then delineated and its relationship to the World Health Organisation is considered.

KEYWORDS: transsexuality – transgender – gender identity – right to health – non-discrimination – World Health Organisation

1. INTRODUCTION

Transsexuality is not a subject that has traditionally been accorded much attention in international law, but it is not a new one. The European Court of Human Rights (ECtHR) dealt with the issue substantively for the first time in 1986,¹ having already declared a similar case inadmissible for failure to exhaust domestic remedies in 1980.² Unreported cases before the European Commission of Human Rights date even further back.³ The European Court of Justice (ECJ) issued its first judgment relating to the discrimination of transsexual persons in 1996.⁴

In recent years, the number of cases has increased and more cases have been decided in favour of the transsexual applicants – most famously, the ECtHR's

1 *Rees v United Kingdom* A 106 (1986); 9 EHRR 56.

2 *Van Oosterwijk v Belgium* A 40 (1980); 3 EHRR 557.

3 For example, *X v Germany* Application No 6699/74, friendly settlement, 1979; cf. Mengel, 'Friendly settlements in den Fällen Peyer und Geerk gegen die Schweiz und X gegen die Bundesrepublik Deutschland' (1981) 8 *Europäische Grundrechte-Zeitschrift* 126 at 127.

4 C-13/94, *P v S and Cornwall County Council* [1996] ECR I-2143.

landmark decision in the case of *Christine Goodwin*,⁵ which finally recognised a right to gender identity. Gender identity has also begun to appear in official United Nations (UN) statements.⁶ Finally, the Yogyakarta Principles on the Application of Human Rights Law in relation to Sexual Orientation and Gender Identity⁷ contain several principles pertaining to transsexuality and have, on the whole, been well received by the international community.⁸

Yet there is one aspect of transsexuality that has still not been widely discussed against the backdrop of international law: its pathologisation, that is, the question of whether transsexuality should be considered an illness. This lacuna is perhaps unsurprising, since international law does not seem, at first glance, to have anything to say on the matter. This essay argues the opposite: international law has a great deal to say.

2. TAKING STOCK: THE TWO POSITIONS

Before turning to the position in international law, however, it is necessary to briefly introduce the empirical background. Pathologisation of transsexuality is widespread and has been since before transsexuality as a concept had even emerged in academic discourse.⁹ Most authoritatively, the International Classification of Diseases (ICD-10),¹⁰ a standard diagnostic tool published by the World Health Organisation (WHO), lists 'transsexualism' and 'other gender identity disorders' in its Chapter V, 'mental and behavioural disorders'. Its American counterpart, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),¹¹ speaks of 'gender dysphoria' rather than 'gender identity disorder' since its last revision in May 2013. Despite the name change, however, it is clear that transsexuality is still considered a mental illness since it is included in the list at all.¹² Similarly, pathologisation may occur implicitly by virtue of transsexuality *not* being named in certain recommendations; thus some documents that place great stock in the fact that homosexuality must not be considered an illness do not mention transsexuality in this context, even though it is otherwise discussed in the same section as homosexuality.¹³

Transsexual persons themselves are divided on the issue.¹⁴ Many have developed what one might call a stance of grudging acceptance towards the *status quo*: they

5 *Christine Goodwin v United Kingdom* 2002-VI; 35 EHRR 18.

6 O'Flaherty and Fisher, 'Sexual Orientation, Gender Identity and International Human Rights Law: Contextualising the Yogyakarta Principles' (2008) 8 *Human Rights Law Review* 207 at 230.

7 Available at: www.yogyakartaprinciples.org/ [last accessed 28 February 2014].

8 A helpful overview is given at: www.ypinaction.org/ [last accessed 28 February 2014].

9 More on the historical aspect below at Section 3A.

10 World Health Organisation, 'International Classification of Diseases, 10th Revision', last updated 9 November 2012, available at: www.who.int/classifications/icd/en/ [last accessed 28 February 2014].

11 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn (Washington, DC: American Psychiatric Publications, 2013).

12 Teich, *Transgender 101* (New York: Columbia University Press, 2012) at 80; and Human Rights Watch, 'Controlling Bodies, Denying Identities. Human Rights Violations against Trans People in the Netherlands', 13 September 2011, at iv, available at: www.hrw.org [last accessed 28 February 2014].

13 For example, Recommendation of the Committee of Ministers of the Council of Europe on measures to combat discrimination on grounds of sexual orientation or gender identity, 31 March 2010, CM/Rec(2010)5, at VII.34.

14 Teich, *supra* n 12 at 79.

dislike it, but they do not dispute it (mainly due to worries that depathologisation will have an adverse effect on their health care access).¹⁵ Yet a growing number of trans activists and organisations have begun to actively reject being pathologised. More than 360 of them have lent their support to a campaign entitled 'Stop Trans Pathologization' which seeks, among other things, to have both gender identity disorder and gender dysphoria removed from their respective diagnosis manuals.¹⁶ While human rights organisations that are not focussed solely on trans issues have been somewhat more hesitant about broaching the subject, many of them (for example, Human Rights Watch and Amnesty International) have recently spoken out in support of this demand.¹⁷ France rather famously became the first State to remove transsexuality from its list of mental disorders in 2009;¹⁸ while other States have not yet followed suit, a fair amount of public authorities have advocated trans depathologisation¹⁹ or at least commissioned reports which do so.²⁰

These two positions are mirrored by courts and tribunals, with most of them – more or less consciously – coming down in favour of pathologisation. Thus the ECtHR noted approvingly, even as it recognised a right to gender identity, that 'transsexualism has wide international recognition as a medical condition'.²¹ Likewise, the German Constitutional Court (*Bundesverfassungsgericht*, BVerfG), despite having decided a long string of judgments in favour of transsexual persons,²² still speaks of a 'diagnosis'²³ of transsexuality; and most recently, the Hong Kong Court of Final Appeal, despite also ruling in favour of the transsexual applicant, remained firmly rooted in the language of pathologisation over the course of several paragraphs.²⁴

The Committee on Economic, Social and Cultural Rights (CESCR) takes the opposing view. In its concluding observations on a report by Germany, it stated with charming brevity and precision:

The Committee notes with concern that transsexual and inter-sexed persons are often considered to be persons with mental illness and that the State party's policies, legislative or otherwise, have led to discrimination against these

15 On which, see below at Section 3B.

16 See: www.stp2012.info/old/en [last accessed 28 February 2014].

17 Amnesty International, 'Europe Still Has a Long Way to Go to Combat Violence against Transgender People', 20 November 2012, available at: www.amnesty.org [last accessed 28 February 2014]; and Human Rights Watch, *supra* n 12 at 12.

18 Teich, *supra* n 12 at 93.

19 For example, the European Parliament (EP), Resolution of 28 September 2011 on human rights, sexual orientation and gender identity at the United Nations, P7_TA(2011)0427, at para 13, available at: www.europarl.europa.eu [last accessed 28 February 2014].

20 For example, some of the reports cited below, n 39.

21 *Christine Goodwin*, *supra* n 5 at para 81; confirmed in ECtHR, *Van Kück v Germany* 2003-VII; 37 EHRR 51, at para 54.

22 For a summary, see Theilen, 'Der Schutz Transsexueller in der Rechtsprechung des Europäischen Gerichtshofs für Menschenrechte und des Bundesverfassungsgerichts – Ein Vergleich' (2012) 15 *Zeitschrift für Europarechtliche Studien* 363.

23 BVerfGE 128, 109 at 116.

24 Court of Final Appeal of the Hong Kong Special Administrative Region, *W v Registrar of Marriages*, Judgment of 13 May 2013, FAVC No 4 of 2012, particularly at paras 5–14.

persons as well as to violations of their sexual and reproductive health rights. (art. 12, 2.2)²⁵

3. A HUMAN RIGHT TO DEPATHOLOGISATION?

Since the CESCR is the only international body to engage with trans depathologisation as a substantive human rights issue, its stance deserves further examination. Indeed, its approach derives support from many other demands for depathologisation which are also framed in the language of human rights. Perhaps most prominently, the Yogyakarta Principles – which purport to describe human rights law as it stands²⁶ and are generally regarded as having mostly succeeded in this task²⁷ – claim that gender identity may not be treated as a medical condition.²⁸ Thomas Hammarberg, then Council of Europe Commissioner for Human Rights, commented that pathologisation ‘may become an obstacle to the full enjoyment of human rights by transgender people’.²⁹

A. Constructing the Right to Depathologisation

How, then, does the depathologisation of transsexuality relate to international human rights law? The CESCR, in the passage quoted above, refers to Articles 12 and 2(2) of the International Covenant on Economic, Social and Cultural Rights (ICESCR),³⁰ that is, the right to health and the right to non-discrimination. As a correlate to these rights, States have certain obligations, that is, not to discriminate, not to interfere with the right to health without due justification (the obligation to respect), and certain positive obligations (to protect and to fulfil). As shorthand for all those obligations that arise in the context of trans pathologisation, one might speak of a ‘human right to depathologisation of transsexuality’ – just as the ‘right to gender identity’³¹ is used as shorthand for those obligations arising for States under the right to private life in the context of gender recognition.³² The exact obligations that the right to trans depathologisation encompasses will be discussed further below;³³ this section aims to give a general overview of why they should be considered part of the right to health and the right to non-discrimination at all.

25 CESCR, Concluding Observations on the fifth report of Germany on the implementation of the International Covenant on Economic, Social and Cultural Rights, 20 May 2011, E/C.12/DEU/CO/5, at para 26.

26 Preamble to the Yogyakarta Principles, *supra* n 7.

27 O’Flaherty and Fisher, *supra* n 6 at 235; more cautiously, Brown, ‘Making Room for Sexual Orientation and Gender Identity in International Human Rights Law: An Introduction to the Yogyakarta Principles’ (2010) 31 *Michigan Journal of International Law* 811 at 862.

28 Principle 18 Yogyakarta Principles.

29 Hammarberg, Human Rights and Gender Identity, 29 July 2009, CommDH/IssuePaper (2009)2, at III.3.3.

30 International Covenant on Economic, Social and Cultural Rights 1966, 993 UNTS 3.

31 Van Kück, *supra* n 21 at para 75.

32 Theilen, *supra* n 22 at 372.

33 See Section 4A.

Discrimination has been identified as a major issue in the context of the right to health,³⁴ and gender identity is, in turn, accepted as an 'other status' on the basis of which discrimination often takes place (Article 2(2) ICESCR).³⁵ The main reason that trans pathologisation affects both the right to health and the right to non-discrimination lies in the stigma that it entails.³⁶

As Paul Hunt, the former Special Rapporteur on the Right to Health appointed by the Commission on Human Rights, noted: 'the links between stigma, discrimination and denial of the right to enjoy the highest attainable standard of health are complex and multifaceted'.³⁷ What seems clear, however, is that the stigma attached to mental illnesses³⁸ does have an impact on the health of trans persons. They face a myriad of problems in everyday life³⁹ which stem precisely from the fact that transsexuality is not accepted as normal but rather regarded as something unusual, a deviation, a cause for concern – in short, an illness. Some of these problems result from a complex interplay of legal norms and societal behaviour,⁴⁰ others are rather more straightforward: for example, there is an obvious connection between trans pathologisation and the highly problematic requirement of medical assessments before being able to obtain a change in name or legal gender:⁴¹ if transsexuality were not considered an illness, there would be no reason to have recourse to a medical

34 Hunt, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13 February 2003, E/CN.4/2003/58, at para 59; and CESCR, General Comment No 14: Right to Health (art. 12), 11 August 2000, E/C.12/2000/4; 8 IHRR 1 (2001), at para 18.

35 CESCR, General Comment No 20: Non-discrimination in economic, social and cultural rights, 10 June 2009, E/C.12/GC/20; 16 IHRR 925 (2009), at 32; and *P.V. v Espagne* Application No 35159/09, Merits and Just Satisfaction, 30 November 2010, at para 30.

36 Butler, 'Undiagnosing Gender' in Currah, Juang and Minter (eds), *Transgender Rights* (Minneapolis: University of Minnesota Press, 2006) 274 at 275; Teich, supra n 12 at XV; STP, 'Reflections on the ICD Revision Process from a Depathologization and Human Rights Perspective', July 2012, at 4, available at: www.stp2012.info [last accessed 28 February 2014]; and LGBT Denmark, 'Stop pathologizing gender variation!', 25 May 2011, at 2, available at: www.kvinfo.dk [last accessed 28 February 2014].

37 Hunt, supra n 34 at 62; see also Tobin, *The Right to Health in International Law* (Oxford: Oxford University Press, 2012) at 129.

38 Ibid. at 93; Gable and Gostin, 'Mental Health as a Human Right', in Clapham, Robinson, Mahon and Jerbi (eds), *Realizing the Right to Health* (Zürich: Rüffer & Rub, 2009) 249; and Callard, Sartorius and Arboleda-Flórez, *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (Somerset, NJ: Wiley-Blackwell, 2012) at 20.

39 A growing number of empirical reports document these problems, see, for example, European Union Agency for Fundamental Rights, 'European Union lesbian, gay, bisexual and transgender survey', 2013, available at: fra.europa.eu/en; ILGA-Europe, 'Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe', 2013, available at www.ilga-europe.org; Fuchs, Ghattas, Reinert and Widmann, 'Studie zur Lebenssituation von Transsexuellen in Nordrhein-Westfalen', 2012, available at: www.lsvd.de; Grant, Mottet, Tanis, Harrison, Herman and Keisling, 'Injustice at Every Turn: A Report of the National Transgender Discrimination Survey', 2011, available at: www.thetaskforce.org; Agius and Tobler, 'Trans and intersex people. Discrimination on the grounds of sex, gender identity and gender expression', 2011, at 19-21, available at: ec.europa.eu/justice/; and Franzen and Sauer, 'Benachteiligung von Trans Personen, insbesondere im Arbeitsleben', 2010, available at: www.antidiskriminierungsstelle.de [each website last accessed 28 February 2014].

40 See CESCR, General Comment No 20, supra n 35 at 12 ('systemic discrimination').

41 See Spade, *Normal Life. Administrative Violence, Critical Trans Politics, and the Limits of Law* (New York: South End Press, 2011) at 123; and STP, supra n 36 at 4. See further on gender recognition below at Section 4A.

assessment. All these problems, taken together, often lead to depression, anxiety and, at worst, suicidal tendencies of trans people.⁴²

Due to these detrimental effects of pathologisation on trans persons' well-being, the right to health is implicated and may be violated in any number of scenarios, for example, by failing the obligation to respect when a State pathologises transsexuality itself (for example by requiring medical assessments) or by failing its positive obligations when others do so. Furthermore, the fact that only transsexual and transgender persons are pathologised, but not the large majority of cisgender persons, constitutes unequal treatment. If no justification for such treatment can be found – as indeed it cannot⁴³ – then the right to non-discrimination is likewise violated.⁴⁴

If one takes the right to gender identity seriously, then the same reasoning holds true for similar rights in other treaties,⁴⁵ most importantly the right to private life as contained in Article 8 of the European Convention on Human Rights⁴⁶ and in Article 17 of the International Covenant on Civil and Political Rights:⁴⁷ changing a person's birth certificate does not constitute true 'gender recognition' if the person is considered mentally ill and their legal gender is changed just to humour them. The ECtHR itself cites 'human dignity', 'human freedom' and 'personal autonomy' as the basis of the right to gender identity⁴⁸ (as do most courts and scholars):⁴⁹ such values cannot be reconciled with trans pathologisation.⁵⁰

Empirical support for the unspoken premise of this section – that depathologisation would at least be a step in the right direction and help combat the stigma still attached to transsexuality – can be derived from the history of homosexuality. Both homosexuality and transsexuality, initially conflated for lack of proper terminology,⁵¹ were originally pathologised in an attempt to protect those concerned from being criminalised.⁵² The negative effects, however, soon outweighed the good: first, the stigma that came with the pathologisation precluded a general acceptance of homosexuality,⁵³ all the more so since pathologisation implies the possibility of a cure;⁵⁴

42 Fuchs, Ghattas, Reinert and Widmann, *supra* n 39 at 45–9; see also Teich, *supra* n 12 at 92.

43 The only substantial argument to be made for a justification is discussed below at Section 3B.

44 See, most famously, *Case relating to certain aspects of the laws on the use of languages in education in Belgium* A 6 (1968); 1 EHRR 252, at para 10 of the Interpretation Adopted by the Court.

45 See LGBT Denmark et al., *supra* n 36 at 3.

46 Convention for the Protection of Human Rights and Fundamental Freedoms 1950, 213 UNTS 222; ETS 005.

47 International Covenant on Civil and Political Rights 1966, 999 UNTS 171.

48 *Christine Goodwin*, *supra* n 5 at para 90; see also *Van Kück*, *supra* n 21 at para 73.

49 Theilen, *supra* n 22 at 381, with further references.

50 See Butler, *supra* n 36, on the different concepts of autonomy present in the trans debate.

51 Whittle, *Respect and Equality: Transsexual and Transgender Rights* (London: Cavendish, 2002) at 35–38; and Teich, *supra* n 12 at 62.

52 Whittle, *supra* n 51 at 35; Richter, 'Die Wiederentdeckung des "Dritten Geschlechts" – Homosexualität im Völker- und Europarecht', in Zimmermann, Giegerich and Heinz (eds), *Gender und Internationales Recht* (Berlin: Duncker & Humblot, 2007) 49 at 60; cf. Bronski, *A Queer History of the United States* (Boston: Beacon Press, 2011) at 166; Mildenerberger, 'Der Diskurs über männliche Homosexualität in der deutschen Medizin von 1880 bis heute', in Groß, Müller and Steinmetz (eds), *Normal – anders – krank?* (Berlin: MWV, 2008) 81 at 84.

53 See Hekma, 'The Gay World: 1980 to the Present', in Aldrich (ed.), *Gay Life and Culture: A World History* (London: Thames & Hudson, 2006) 333 at 347.

54 Bronski, *supra* n 52 at 186; and Mildenerberger, *supra* n 52 at 83.

and secondly, those intent on criminalising it were not – and still have not been – deterred from doing so, despite having themselves adopted the language of pathologisation.⁵⁵ When this became clear, much effort was put into the depathologisation of homosexuality, and much emphasis is still placed on the fact that it does not constitute a mental illness.⁵⁶ Given the common origins, it is painfully ironic that the removal of homosexuality from the DSM was followed in the very next edition by the inclusion of transsexuality.⁵⁷

B. The Infamous Counterargument: Access to Health Care

In light of the above, it seems perfectly plausible to view Articles 12 and 2(2) of the ICESCR as containing a right to trans depathologisation. There is, however, one major argument that inevitably rears its head when discussing trans depathologisation, and it must be dealt with before affirming such a right. Many transsexual persons wish to have access to trans-specific health care such as hormone treatment or operations. Such treatment is, in most States, dependent on an ICD-based diagnosis.⁵⁸ It is therefore, so the argument goes, in their best interests to be considered ill. Indeed, it is because of this that the situations of transsexual and homosexual persons are said to differ radically as regards their interest in depathologisation.⁵⁹

There can be no doubt that the argument is to be taken seriously: it would not do to advocate trans depathologisation, only to bring about new and possibly even more serious problems for trans people. At worst, it would serve to promote multiple discrimination, for example, making life a great deal worse for trans people living in poverty.⁶⁰ Therefore, the ‘health care argument’ causes many people to hold back from actively endorsing trans depathologisation⁶¹ and it somewhat dampens the enthusiasm even of those who do.⁶²

(i) *Translating the health-care argument into human rights language*

Having just accepted – at least in principle – a human right to depathologisation, the ‘health care argument’ must also be framed in human rights terms in order to be a valid counterargument at all. One might think, at first glance, that it is simply a matter of common sense; if something has far-reaching negative consequences, then it is not a right at all, but rather something else entirely, something to be avoided. Yet even if one accepts this logic (which is not at all evident from a self-determination perspective), there is a simple reason why it does not apply to the case at hand: the alleged negative effects of trans depathologisation do not extend to all those persons

55 Rizzo, ‘Public Spheres and Gay Politics since the Second World War’, in Aldrich, supra n 53 at 197, 205; cf. Richter, supra n 52 at 61.

56 See the explicit statement in the ICD-10, supra n 10 at n 66.

57 Whittle, supra n 51 at 21.

58 Teich, supra n 12 at 86.

59 Ibid. at 91.

60 Butler, supra n 36 at 287.

61 For example, Sacksofsky, ‘Grundrechtlicher Schutz für Transsexuelle in Deutschland und Europa’, in Hohmann-Dennhardt, Masuch and Villiger (eds), *Grundrechte und Solidarität. Festschrift für Renate Jaeger* (Kehl: Engel, 2011) 675 at 699; and Butler, supra n 36 at 288; cf. LGBT Denmark et al., supra n 36 at 1.

62 For example, Hammarberg, supra n 29 at III.3.3; and Rauchfleisch, ‘Diskriminierung Transsexueller’, in Steger (ed.), *Was ist krank?* (Gießen: Psychosozial Verlag, 2007) 189 at 190.

affected by its positive effects.⁶³ This distinction seems to be often overlooked, most likely because courts and legislators alike focus only on transsexuality and widely ignore the existence of transgenderism as a broader category.

This restricted view is reflected in a somewhat careless use of the terms 'transsexuality' and 'transgender'.⁶⁴ This article has, until now, used the term 'transsexuality' without comment, given that it is the most common term in legal discourse. However, the terminology in matters of gender identity is varied and colourful,⁶⁵ reflecting the manifold different ways of perceiving one's gender. Many connect transsexuality in some (often vague) way with the desire to change one's physical appearance by way of operation⁶⁶ – hence the apparently innate connection to trans-specific health care. But it has also become increasingly common to refer only to a person's gender identity, whether or not an operation is desired: transsexual people, by this definition, are those who feel they belong to a different gender than that they were assigned at birth.⁶⁷ And this broader definition still does not come even remotely close to capturing the different gender identities that exist – Laura Adamietz speaks of the 'refusal to obey definitions'.⁶⁸ The term 'transgender' in its current usage, commonly referred to as an 'umbrella term',⁶⁹ reflects this fact and aims to include all those who, in any way, defy stereotypical gender norms,⁷⁰ for example, genderqueers, transvestites, two-spirited people, and – with some important caveats⁷¹ – intersex people.

Pathologisation is not restricted to transsexuality, but extends to all transgender persons;⁷² the arguments developed above hold true for all of them and it is therefore more precise to speak of a 'right to depathologisation of transgenderism', rather than just depathologisation of transsexuality. However, most transgender persons have no interest in hormone treatment or operations – indeed, intersex persons put a lot of effort into combating operations performed on them without their consent.⁷³

63 See Butler, *supra* n 36 at 276.

64 See BVerfGE 115, 1 at 13 (conflating the two terms).

65 Theilen, *supra* n 22 at 364.

66 Rees, *supra* n 1 at para 38 ('often'); ICD-10, *supra* n 10 at n 64.0 ('usually'); Whittle, *supra* n 45 at xxiii; Castagnoli, *Transgender Persons' Rights in the EU Member States*, 2010, PE 425.621, at 3; and Stryker, *Transgender History* (Berkeley: Seal Press, 2008) at 18.

67 BVerfGE 128, 109 at 115; and Teich, *supra* n 12 at 3.

68 Adamietz, "Transgender ante portas?" (2006) 39 *Kritische Justiz* 368 at 371 ('Definitionsgehorsamsverweigerung').

69 Currah, 'Gender Pluralisms under the Transgender Umbrella', in Currah, Juang and Minter (eds), *Transgender Rights* (Minneapolis: University of Minnesota Press, 2006) 3 at 4, with many further references.

70 Teich, *supra* n 12 at 3, 114; Adamietz, *supra* n 68 at 371; Shults, 'Sharply Drawn Lines: An Examination of Title IX, Intersex, and Transgender' (2005–2006) 12 *Cardozo Journal of Law and Gender* 337 at 338, 340; and Stryker, *supra* n 66 at 19, 123.

71 Since intersex persons face issues which can be very different from those of other transgender persons, their inclusion may, in some situations, cause more harm and confusion than good; but see also Spade, *supra* n 38 at 166; Currah, Juang and Minter, 'Introduction', in Currah, Juang and Minter, *supra* n 69 at xiii, xv.

72 For example, ICD-10, *supra* n 10 at n 64.1 and n 65.1 (transvestism); on intersexuality, see for example, Bird, 'Outside the Law: Intersex, Medicine and the Discourse of Rights' (2005–2006) 12 *Cardozo Journal of Law and Gender* 65; and Benson, 'Hacking the Gender Binary Myth: Recognising Fundamental Rights for the Intersexed' (2005–2006) 12 *Cardozo Journal of Law and Gender* 31 at 37.

73 See the demands of many intersex-focused non-governmental organisations such as Organisation Intersex International (OII) or the Intersex Society of North America (ISNA).

If one adopts the broad definition of transsexuality, even the majority of transsexual persons do not wish to have an operation.⁷⁴ The group of people affected by trans-specific health care is therefore a great deal smaller than the group affected by trans pathologisation.

This does not, of course, mean that their interests are not vitally important. They are. Trans persons to whom health-care access is denied often suffer from precisely those conditions described above in the context of pathologisation – depression, anxiety and suicidality.⁷⁵ Yet because transsexuality and the desire for an operation are not as closely linked as is commonly believed and the concept of transgenderism is wider still, the ‘health care argument’ should not be taken as an argument to deny that the right to depathologisation exists. Instead, the right to trans-specific health care should itself be considered a human right,⁷⁶ and has indeed been recognised as such by the ECtHR.⁷⁷ There has even been some movement towards the recognition of a positive obligation to provide funding for such health care,⁷⁸ though the ECtHR has so far restricted itself to deciding individual cases on very narrow terms.⁷⁹

(ii) Countering the counterargument

In light of the above, the ‘health care argument’ may be stated in human rights terms as follows: Depathologisation would hinder a State from adequately fulfilling the positive obligations which follow from the right to access trans-specific health care. At the same time, the right to access trans-specific health care serves as a justification for infringing the right to depathologisation. The latter is interfered with, but the interference is proportionate: when balancing the two rights, the right to access trans-specific health care comes out on top.

Thus rephrased, it becomes easier to see why the argument is not convincing. It is simply because depathologisation does not necessarily interfere with the access to trans-specific health care at all: it is not the health care as such, but merely the current, pathologising *method* of granting it that comes under attack.

One might argue, first, that there is no empirical proof for the claim that depathologisation would adversely affect health-care access. As distressing as it may be, the fact is that even now, gaining access to trans-specific health care is anything but easy.⁸⁰ Indeed, gender-related treatment such as hormone prescription is frequently granted to non-trans people and denied only and specifically to those seeking it on a

74 BVerfGE 128, 109 at 115; numbers differ greatly according to surveys and the definitions they use: see, for example, Spade, *supra* n 41 at 145; and Grant et al., *supra* n 39 at 78.

75 Spade, *supra* n 41 at 149.

76 STP, *supra* n 36 at 7.

77 *L v Lithuania* 2007-IV; 46 EHRR 22, at paras 57–60 (in the context of gender recognition).

78 Mahon, ‘Sexual Orientation, Gender Identity and the Right to Health’, in Clapham, Robinson, Mahon and Jerbi (eds), *Realizing the Right to Health* (Zürich: Rüffer & Rub, 2009) 235 at 242.

79 *Van Kück*, *supra* n 21; and *Schlumpf c. Suisse* Application No 29002/06, Merits and Just Satisfaction, 8 January 2009.

80 Teich, *supra* n 12 at 52, 86; Fuchs et al., *supra* n 39 at 87–89; Mahon, *supra* n 78 at 239; and STP, *supra* n 36 at 3.

gender identity disorder diagnosis.⁸¹ It can safely be assumed that this is due to the outdated gender conceptions of many physicians serving as ‘gatekeepers’⁸² for access to health care: they are caught up in a rigid, binary gender model (as is the diagnosis of gender identity disorder itself)⁸³ and fail to truly understand the concept of transsexuality or transgenderism.⁸⁴ Numerous reports of trans persons having to act out gender stereotypes in order to obtain positive reports confirm this fact.⁸⁵ How to change it? By working towards more genuine acceptance of transgenderism⁸⁶ – a task which is bound to be difficult, but made near impossible if transgenderism is perceived as a mental illness. From this perspective, trans depathologisation may even improve access to health care, at least in the long run.

Such long-term reasoning, of course, matters little to those who wish to assert their right to trans-specific health care in the here and now. One must therefore back it up with more individualistic and tangible proposals.⁸⁷

Richard Posner, discussing *The Merchant of Venice*, notes that ‘legalism is the pariah’s protection’.⁸⁸ It may not have worked out for Shylock, but then, trans people are not after other people’s flesh; they just want control over their own bodies. So, why not be legalistic? Having a disease is not a necessary condition of being afforded health care⁸⁹ – that various issues relating to pregnancy are covered by health insurance companies in most countries offers proof. In this respect, trans activism has been likened to the reproductive freedom movement: both wish to ‘secure access to competent, legal, respectfully provided medical services for a nonpathological need’.⁹⁰ Such medical services can be ensured simply by enacting a law which provides an entitlement specifically for trans people, while simultaneously indicating (implicitly or expressly)⁹¹ that transgenderism is not an illness.

When executed in such a way, depathologisation does not conflict with the right to trans-specific health care in the least. This also means that the right to access health care cannot serve as a justification for infringing upon the right to depathologisation: there is a less restrictive alternative (non-discriminatory access) available to achieve the same aim, so that the interference is not necessary⁹² and therefore disproportionate.

81 Spade, supra n 41 at 148; and Butler, supra n 36 at 283.

82 Teich, supra n 12 at 95; see also STP, *Reflections on the SOC-7* (2012) at 5, available at: www.stp2012.info [last accessed 28 February 2014].

83 Butler, supra n 36 at 292.

84 See Stryker, supra n 66 at 73, 94.

85 Fuchs et al., supra n 39 at 74, 84 (interviews for the change of legal gender), and 90 (interviews for health care access).

86 Rauchfleisch, supra n 62 at 196; and Teich, supra n 12 at 113.

87 Butler, supra n 36 at 280.

88 Posner, *Law and Literature*, 3rd edn (Cambridge, Mass: Harvard University Press, 2009) at 148.

89 STP, supra n 36 at 9, 11; Hammarberg, supra n 29 at III.3.3; LGBT Denmark et al., supra n 36 at 4, more sceptically (for the US); and Butler, supra n 36 at 287.

90 Stryker, supra n 66 at 98.

91 The latter would not be a novelty: see ICD-10, supra n 10 at n 66 (*chapeau*); for proposals, see STP, supra n 36 at 6.

92 On which, see generally Brems, ‘Human Rights: Minimum and Maximum Perspectives’ (2009) 9 *Human Rights Law Review* 349 at 359.

C. Interim Conclusion

To sum up the findings thus far: a human right to trans depathologisation, as advocated by the CESCR, does indeed exist. It need not necessarily come into conflict with the right to trans-specific health care, since such health care can be provided even if transgenderism is not considered an illness. That the two rights can coexist peacefully is reflected in the demands of various organisations and institutions advocating trans depathologisation: they call for both depathologisation and access to health care without seeing any contradiction between the two.⁹³

Two caveats are in order on what accepting a right to trans depathologisation does *not* mean. First, it does not imply acceptance of the stigmatisation of illnesses in general. Transgenderism is a special (though not necessarily unique) case in that there is no justification for considering it an illness in the first place; one can therefore tackle the problem at the meta-level, as it were. Where an actual illness is concerned (for example, HIV/AIDS), the general destigmatisation of illnesses remains important.⁹⁴ And secondly, advocating depathologisation of transgenderism does not preclude (though nor does it entail) seeing transgenderism as a disability, in the critical disability studies sense that disabilities are caused by the social environment:⁹⁵ in fact, the stigma that follows in part from trans pathologisation is the main reason why some scholars consider transgenderism to be a disability in that sense.

4. DELINEATING THE RIGHT'S CONTENTS

Having accepted a human right to trans depathologisation, it is now time to examine in more detail what that right entails.

A. States' Obligations

The right to health – and thereby the right to depathologisation – correlates with States' obligations to respect, protect and fulfil. The first and foremost obligation incumbent on every State is to *respect* the right to depathologisation,⁹⁶ that is, to refrain from any action which interferes with it. An obvious way of violating the right to depathologisation would be, for example, the publication or support by public authorities of pamphlets describing transsexuality or transgenderism as a mental illness; in this vein, the CESCR has spoken of the obligation to refrain from 'misrepresenting health-related information'.⁹⁷

As mentioned above,⁹⁸ such interference may also be implicit: one example is the requirement of some sort of medical or psychological report in order to have one's legally assigned gender changed. The connection between such reports and trans

93 STP, *supra* n 36 at 1 at 7; Amnesty International, *supra* n 17; LGBT Denmark, *supra* n 36 at 5; and EP, *supra* n 19 at 13; see also Stryker, *supra* n 66 at 14; Franzen and Sauer, *supra* n 39 at 84; see also Articles 6 and 7 of the International Bill of Gender Rights, reprinted in Currah, Juang and Minter, *supra* n 71 at 328, 329.

94 See Hunt, *supra* n 34 at 68.

95 Levi and Klein, 'Pursuing Protection for Transgender People through Disability Laws', in Currah, Juang and Minter, *supra* n 71 at 74, 81.

96 See generally CESCR, General Comment No 14, *supra* n 34 at 34.

97 *Ibid.*

98 See Section 3A (specifically, n 41).

pathologisation is made explicit by the United Kingdom's Gender Recognition Act (GRA):⁹⁹ it demands two reports by specialised medical practitioners or psychologists which must, among other things, contain 'details of the diagnosis of the applicant's gender dysphoria' (Section 2(3) GRA). Other statutes are less explicit, for example, the German Transsexuality Act (TSG)¹⁰⁰ which likewise demands two reports by independent specialists (paragraph 4(3) TSG). Similar provisions are included in most statutes dealing with transsexuality¹⁰¹ and they have been seen as constitutional even by those otherwise critical of preconditions for gender recognition, such as the BVerfG.¹⁰² Nonetheless, by deferring to medical experts rather than the applicants and thereby refusing to acknowledge their autonomy,¹⁰³ these statutes all implicitly pathologise the applicant's transsexuality and thereby violate the right to health and the right to non-discrimination.¹⁰⁴

Aside from the obligation to respect, it is well established that human rights, and the right to health in particular, also include obligations to protect and to fulfil,¹⁰⁵ that is, positive obligations.¹⁰⁶ Upon taking a closer look at the relevant provisions of the Yogyakarta Principles, it emerges that they actually refer to the obligation to *protect*: 'States shall ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed';¹⁰⁷ it is the medical practitioners, not the State, who are pathologising transgenderism in this scenario.

Protecting trans persons from pathologisation through others is a necessary part of the right to depathologisation if it is to be practical and effective, as human rights should be.¹⁰⁸ The Yogyakarta Principles' wording indicates that this is particularly the case with regard to medical practitioners; for as Susan Stryker notes, they hold the primary 'social power to determine what is considered sick or healthy, normal or pathological, sane or insane – and thus, often, to transform potentially neutral forms of human difference into unjust and oppressive social hierarchies'.¹⁰⁹ So, for example, one might consider an obligation of the United States to take action against the

99 Chapter 7 Gender Recognition Act 2004 (GRA).

100 Gesetz über die Änderung der Vornamen und die Feststellung der Geschlechtszugehörigkeit in besonderen Fällen, BGBl, 1980 I, at 1654 (*Transsexuellengesetz*, TSG).

101 For a very helpful (though slightly outdated) overview, see Basedow and Scherpe (eds), *Transsexualität, Staatsangehörigkeit und Internationales Privatrecht* (Tübingen: Mohr Siebeck, 2004).

102 BVerfGE 128, 109 at 130 (*obiter dictum*).

103 See Rauchfleisch, supra n 62 at 190.

104 As well as the right to gender identity, see Theilen, supra n 22 at 381; and specifically for transgender in the broader sense, see Theilen, 'Intersexualität, Personenstandsrecht und Grundrechte' (2014) 67 *Das Standesamt* 1 at 5.

105 CESCR, General Comment No 14, supra n 34 at 35.

106 Mahon, supra n 78 at 242.

107 Principle 18(F) Yogyakarta Principles.

108 Thus the settled case-law of the ECtHR, for example, *Airey v Ireland* A 32 (1979); 2 EHRR 305, at para 24; *Loizidou v Turkey (preliminary objections)* A 310; 20 EHRR 99, at para 72; *Hirsi Jamaa and Others v Italy* ECHR Reports 2012; 55 EHRR 21, at para 175; and *El-Masri v The Former Yugoslav Republic of Macedonia* ECHR Reports 2012; 57 EHRR 25, at para 134.

109 Stryker, supra n 66 at 36.

American Psychiatric Association, the publisher of the DSM (taking into account their own, competing human rights).¹¹⁰

But while the medical profession should, by its nature, be the primary target of such action, it should not be the only one. Society at large also continues to pathologise transgenderism, mainly due to widespread ignorance – or even misrepresentations¹¹¹ – on the topic. Susan Stryker again: ‘ignorance or misinformation about a less common way of being in the world can perpetuate harmful stereotypes and mischaracterizations’.¹¹² The CESCER has suggested that the promotion of health education is one aspect of the obligation to *fulfil*,¹¹³ where transgenderism is concerned, such education and awareness training is particularly important.

Given that the right to health is rooted in the ICESCR, one might argue that the above obligations are qualified by the so-called ‘progressive realisation’ clause (Article 2(1) ICESCR), which has been said to severely curtail the ICESCR’s effectiveness. But Article 2(1) of the ICESCR contains the unqualified obligation ‘to take steps...to the maximum of [a State’s] available resources’.¹¹⁴ At the very least, then, the obligation to respect the right to depathologisation is not hindered by Article 2(1) of the ICESCR: no resources at all are needed to refrain from pathologisation. The positive obligations, on the other hand, are in principle dependent on the available resources (and therefore subject to progressive realisation)¹¹⁵ – this is no particularity of Article 2(1) of the ICESCR, it is also widely accepted for positive obligations under other human rights treaties.¹¹⁶ Two points should be born in mind, however. First, even accepting such restrictions, they do not carry much weight given that the actions required by these particular positive obligations, that is, mainly the dissemination of information, ‘can be pursued with minimum resource implications’.¹¹⁷ And secondly, given the discriminatory aspect of trans pathologisation, it is doubtful whether the restrictions even apply – the right to non-discrimination in Article 2(2) of the ICESCR is not qualified by Article 2(1).¹¹⁸

B. The Right to Depathologisation and the WHO

So much for States’ obligations in the context of their own legal systems. The right to depathologisation reaches further than that: it influences their actions on the international level as well. Their conduct within the WHO is of particular relevance here, given that the ICD-10 was identified above as one of the main bastions of trans

110 The US has not ratified the ICESCR, as noted above, though the same result may be reached under Articles 2(1) and 17 ICCPR.

111 Juang, ‘Transgendering the Politics of Recognition’, in Currah, Juang and Minter *supra* n 71 at 242, 253.

112 Stryker, *supra* n 66 at 5.

113 CESCER, General Comment No 14, *supra* n 34 at 36.

114 See CESCER, General Comment No 3: Nature of States parties’ obligations (art. 2, para. 1), 14 December 1990, E/1991/23; 1-1 IHRR 6 (1994) at 2.

115 Alston and Quinn, ‘The Nature and Scope of States Parties’ Obligations under the International Covenant on Economic, Social and Cultural Rights’ (1987) 9 *Human Rights Quarterly* 156 at 173.

116 *Ibid.* at 172; Xenos, *The Positive Obligations of the State under the European Convention of Human Rights* (London: Routledge, 2012) at 208; and Dröge, *Positive Verpflichtungen der Staaten in der Europäischen Menschenrechtskonvention* (Berlin: Springer, 2003) at 151.

117 CESCER, General Comment No 14, *supra* n 34 at 18.

118 *Ibid.* at 40; CESCER, General Comment No 20, *supra* n 35 at 7; and Senyonjo, *Economic, Social and Cultural Rights in International Law* (Oxford: Hart, 2009) at 3.23.

pathologisation. The following section gives an overview of the relationship between the right to trans depathologisation and the WHO as well as its Member States.

The WHO is an international organisation and a specialised agency of the UN,¹¹⁹ in existence since the entry into force of its Constitution¹²⁰ in 1948. As does every international organisation, it takes action through its organs, notably the World Health Assembly (WHA), the Executive Board and the Secretariat. The WHA is comprised of up to three delegates representing each Member State; each State has one vote.¹²¹ It is these delegates who, by majority vote, endorse the revised versions of the ICD pursuant to Article 21 lit. (b) of the WHO Constitution.¹²² The next such revision, ICD-11, is scheduled for 2015.¹²³

The result of such endorsement by the WHA may be attributable to the WHO rather than the individual Member States: at the moment of voting, the Member States, through their delegates, will nonetheless act in violation of the right to depathologisation if various forms of transgenderism should still be considered illnesses in ICD-11 – this is both in accordance with general principles¹²⁴ and confirmed in the context of the right to health by the ‘internationalisation’ of States’ obligations in Article 2(1) of the ICESCR.¹²⁵ However, given that the ICD revisions are prepared in decades’ worth of work before being put before the WHA and that transgenderism constitutes just one controversial issue among many, it is unrealistic to expect delegates to refrain from voting in favour of ICD-11 because of this. While States might enter reservations pursuant to Article 22 of the WHO Constitution, a negative effect would still emanate from the inclusion of transgenderism in the document at all. The focus must therefore be on the WHO itself.

There is broad agreement that international organisations, due to their independent legal personality, are not bound by the obligations of their Member States,¹²⁶ that is, the fact that its members are States Parties to the ICESCR has no implications for the WHO. Where the obligations of international organisations stem from is a subject wrought with controversy.¹²⁷ What is uncontroversial, however, is that

119 Beigbeder, ‘World Health Organization’, in Wolfrum (ed.), *Max Planck Encyclopedia of Public International Law* (Oxford: Oxford University Press, 2012) at para 1.

120 Constitution of the World Health Organization 1946, 14 UNTS 185.

121 Articles 10, 11 and 59 WHO Constitution in conjunction with Rule 69 of the Rules of Procedure of the World Health Assembly.

122 Beigbeder, *supra* n 119 at para 26; historically, see Vierheilig, *Die rechtliche Einordnung der von der Weltgesundheitsorganisation beschlossenen regulations* (Heidelberg: Decker’s Verlag, 1984) at 73.

123 See www.who.int/classifications/icd/revision/en/ [last accessed 28 February 2014].

124 Feinäugle, *Hoheitsgewalt im Völkerrecht. Das 1267-Sanktionsregime der UN und seine rechtliche Fassung* (Heidelberg: Springer, 2011) at 93.

125 See Tobin, *supra* n 37 at 325.

126 *Ibid.* at 93–6; and Verdirame, *The UN and Human Rights. Who Guards the Guardians?* (Cambridge: Cambridge University Press, 2011) at 86–8.

127 One might, for example, consider the right to health as binding upon the WHO as customary law; or one might point to Article 25 of the Universal Declaration of Human Rights, a General Assembly (GA) resolution that might be binding on the WHO as a specialised agency. One might also, with good reasons, rebut both claims.

international organisations are, by their nature, bound to their constituent instruments: the treaties which give them life.¹²⁸ And the very first article of the WHO Constitution, its flagship as it were, states: ‘The objective of the World Health Organisation... shall be the attainment by all peoples of the highest possible level of health’ (Article 1 WHO Constitution).

Every act by the WHO’s organs must be in accordance with this objective. The question remains, though, which understanding of ‘the highest possible level of health’ should be adopted – the WHA surely has a certain margin of appreciation in ascertaining the meaning of such a general objective,¹²⁹ one might argue, and the ICD might be covered by that margin. In refuting such an argument, one might propose interpreting the reference to ‘health’ in the WHO Constitution in line with the right to health; of the many different codifications,¹³⁰ Article 12 of the ICESCR would seem to constitute the most likely candidate given that it is the ‘most comprehensive’¹³¹ codification, the ‘cornerstone protection’¹³² of the right to health – but the ICESCR was not adopted until 1966, 18 years after the WHO Constitution. Given that the WHO has more Member States than the ICESCR has parties, Article 31(2) lit. (b) of the Vienna Convention on the Law of Treaties¹³³ is not (directly) applicable either.¹³⁴

There is, however, no need to directly link the WHO to the ICESCR. The WHO Constitution itself contains a definition of health in its preamble: ‘health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. This definition is notoriously broad, even utopian;¹³⁵ therefore, the thoughts developed above for the ICESCR must apply, *a minore ad maius*, to the WHO Constitution.¹³⁶ Confirmation can be found not only in the preamble’s condemnation of discrimination, but also in Article 2 lit. (m) WHO Constitution which instructs the WHO to take action in the field of mental health with special regard to ‘the harmony of human relations’: the problem with trans pathologisation, as shown above,¹³⁷ is precisely that it has such a negative effect on the human relations of trans persons.

128 *Reparation for injuries suffered in the service of the United Nations*, Advisory Opinion, ICJ Reports 1949, 174 at 180; *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, Advisory Opinion, ICJ Reports 1996, 66 at 78; Schmalenbach, ‘International Organizations or Institutions, General Aspects’, in Wolfrum, *supra* n 119 at para 42; and Verdirame, *supra* n 126 at 73.

129 See generally Osieke, ‘The Legal Validity of Ultra Vires Decisions of International Organizations’ (1983) 77 *American Journal of International Law* 239 at 249.

130 For an overview, see Tobin, *supra* n 37 at 376.

131 CESCR, General Comment No 14, *supra* n 34 at 2.

132 Hunt, *supra* n 34 at 11.

133 Vienna Convention on the Law of Treaties 1969, 1155 UNTS 331.

134 See Villiger, *Commentary on the 1969 Vienna Convention on the Law of Treaties* (Leiden: Martinus Nijhoff, 2009) at 433.

135 Tobin, *supra* n 37 at 122, 125; Meier, ‘The World Health Organization, the evolution of human rights, and the failure to achieve Health for All’, in Harrington and Stuttford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Florence, KY: Routledge, 2010) 163 at 166; and Riedel, ‘Health, Right to, International Protection’, in Wolfrum, *supra* n 119 at para 29.

136 See Meier, *supra* n 135 at 174.

137 See Section 3A.

By endorsing the ICD when it contains the category of 'gender identity order', the WHA is thus in conflict with the purpose of the WHO Constitution, and consequently acting *ultra vires*.¹³⁸ Although the right to depathologisation as contained in the ICESCR is binding only on States and only States can be the target of scrutiny by the CESCR (for example, under the ICESCR's Optional Protocol which recently entered into force),¹³⁹ the WHO itself is constrained by its Constitution to a similar effect. Recent statements by members of the relevant Working Group indicate that they may be coming to realise this.¹⁴⁰

5. CONCLUSION

Due to the interrelation with the WHO and the origins of the right to trans depathologisation in the jurisprudence of the CESCR, this article has treated the right to depathologisation as based primarily on the right to health (in combination with the right to non-discrimination). It bears repeating, however, that it is likewise a part of the right to gender identity, properly understood.

The right to depathologisation of transgenderism may be both less accepted and less tangible than what is commonly understood to be part of the right to gender identity, that is, the right to have one's gender legally recognised; but the two issues are interrelated. They also resemble one another in that the problems which human rights law may solve were only ever created by the law itself – in the case of gender recognition, by attaching legal importance to gender in the first place,¹⁴¹ and in the case of trans depathologisation, by enacting pathologising laws and regulations. Pathologisation of transgenderism, by way of the stigma that comes with it, has a closer connection to society at large, however.¹⁴² Such stigmatisation is a peculiarly human phenomenon:¹⁴³ while there are many instances of what one might term transgenderism in the animal kingdom,¹⁴⁴ the problems described in this article do not arise there. If animals are wiser than humans in this respect, it is all the more important that the law of *human* rights recognises the humanity, rather than the alleged illness, of trans persons.

ACKNOWLEDGEMENT

Special thanks are due to Sarah Schadendorf for her insightful comments and support and to Julian Udich for being a charming *advocatus diaboli*.

138 See *Nuclear Weapons*, supra n 128 at 82; and Schmalenbach, supra n 128 at 51.

139 Optional Protocol to the International Covenant on Economic, Social and Cultural Rights 2008 (entered into force 5 May 2013), GA Res A/RES/63/117.

140 See STP, *Recent Developments related to the DSM and ICD Revision Processes*, January 2013, at 4, with further references, available at: www.stp2012.info [last accessed 28 February 2014].

141 Theilen, supra n 22 at 385.

142 Rauchfleisch, supra n 62 at 191.

143 Teich, supra n 12 at XVI.

144 Roughgarden, *Evolution's Rainbow: Diversity, Gender, and Sexuality in Nature and People* (Berkeley: University of California Press, 2004).