PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

RESPONDING TO CONCERNS ABOUT COMORBIDITIES

August 2015

Context: During the 2015-2016 repeal process, Pentagon opponents of inclusive policy marshaled every possible argument to derail the lifting of the ban. In August 2015, they amplified concerns about the high rate of mental health problems (comorbidities) among transgender civilians and suggested that the high rates justified leaving the military ban in place. In this policy memo, which we circulated to Pentagon officials, we emphasized research that showed that transgender troops were as medically fit as their cisgender peers, and that the military already screened for disqualifying conditions on an individual basis. Hence, there was no reason to assign risk to groups rather than individuals. Consistent with that point, we showed that other subpopulations (such as children of military parents) had high rates of comorbidities but that those high rates were not invoked as rationales to ban entire classes of applicants from military service, as medical fitness was determined on a case-by-case basis. Our arguments prevailed, and opponents pivoted to other rationalizations to derail the repeal process.

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

RESPONDING TO CONCERNS ABOUT COMORBIDITIES

August 2015

The science about comorbidities can be critiqued, in particular due to wide variance in the literature. According to a 2015 meta-review, "Since the first [1953] report on transgender suicidality, 97 other reports (53 studies) and 77, sometimes very disparate, estimates of transgender suicidality have followed. In fact, over the last 55 years, suicide attempts have ranged from a low of 3% to a high of 63%, while ideation has ranged from 4% to 89%."[1]

Despite wide reported variance and other flaws in the literature, the prevalence rate of comorbidities in the transgender community is high. According to the 2015 meta-review mentioned above, the average reported prevalence rate of suicide attempts among transgender individuals, across all studies published in North America since 1998, is 27%.[2]

The high prevalence rate of comorbidities, however, is not an argument against inclusive policy.

- The American Medical Association, endorsed by four former Surgeons General, passed a resolution stating that there is no medically valid reason for discharging transgender service members.[3] Peer-reviewed research by a former Surgeon General and retired Flag and General Officers found that the vast majority of transgender service members are fit for duty, and all should be presumed fit for duty absent specific disqualifying factors.[4]

- Accession standards already filter out disqualifying conditions, and are sufficient for assessing risk on an individual basis. For example, a 2015 study found that children of service members were 62% more likely to have attempted suicide in the previous year than non-military-connected children.[5] The former need not be banned *as a class*, however, because accession standards disqualify suicidality on an individual basis.

- Gender dysphoria should not be conflated with unfitness. The American Psychiatric Association concluded that "gender nonconformity is not itself a mental disorder."[6] APA retained the diagnostic option of gender dysphoria in *DSM-5* to ensure transgender individuals could obtain insurance coverage, not to judge fitness. In our medical system, without a diagnosis, there is no access to care.[7] All of the hundreds of *DSM-5* diagnoses are based on a generic diagnostic criterion, often worded as a condition that "causes clinically significant distress or impairment." The military permits enlistment and retention of individuals with a variety of *DSM-5* diagnoses—without waivers or medical retention boards—and so a *DSM-5* diagnosis of "distress or impairment" is not an indication of unfitness. Only the most serious conditions, or those resistant to treatment, are disqualifying. Treatments for gender dysphoria are safe, effective, and reliable.[8]

- The lifting of the ban and provision of transition-related health care will decrease suicidality, as research has found that non-discrimination policy and health care access reduce suicide risk among transgender individuals.[9] And, inclusive policy will mitigate stressors such as negative command climate and peer ostracism that are strongly associated with suicidality among service members, regardless of gender identity, especially if the policy change is accompanied by strong, supportive leadership.[10]

The British military provision on mental health and transgender service may warrant consideration: "Although transsexual people generally may have an increased risk of suicide, depression and self-harm, transsexual applicants should not automatically be referred to a Service Psychiatrist. Transsexual applicants with no history of mental health problems or deliberate self-harm who meet other fitness standards should be passed as being fit to join the Armed Forces."[11]

---

[1] Noah Adams (2015), Finding Order in Chaos: Account for Variation in Estimates of Suicidality Among Transgender Adults, Unpublished MSW thesis, Dalhousie University: 69.
[2] Adams (2015), Finding Order in Chaos: 130.
[3] American Medical Association House of Delegates Resolution 011, Military Medical Policies Affecting Transgender Individuals, Received April 29, 2015, Passed June 9, 2015, available at http://www.palmcenter.org/files/A-15%20Resoultion%20011.pdf (accessed August 9, 2015).
[4] M. Joycelyn Elders, George R. Brown, Eli Coleman, Thomas A. Kolditz, and Alan M. Steinman (2015). Medical Aspects of Transgender Military Service, *Armed Forces & Society*, 41(2): 199-220.
[5] Tamika Gilreath, Stephani Wrabel, Kathrine Sullivan, Gordon Capp, Ilan Roziner, Rami Benbenishty, and Ron Astor (2015), Suicidality Among Military-Connected Adolescents in California Schools, *European Child & Adolescent Psychiatry*, DOI 10.1007/s00787-015-0696-2, published online March 20, 2015. The authors found that in the previous year, 7.3% of non-military connected youth had attempted suicide, compared to 11.8% of military-connected youth.
[6] American Psychiatric Association, Gender Dysphoria Fact Sheet (2013), http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf.
[7] "Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won't be used against them in social, occupational, or legal areas. … To get insurance coverage for the medical treatments, individuals need a diagnosis. The Sexual and Gender Identity Disorders Work Group was concerned that removing the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care." Gender Dysphoria Fact Sheet.
[8] Department of Health and Human Services, Departmental Appeals Board, Appellate Division, NCD 104.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014.
[9] Greta Bauer, Ayden Scheim, Jake Pyne, Robb Travers, and Rebecca Hammond (2015), Intervenable Factors Associated with Suicide Risk in Transgender Persons: A Respondent Driven Sampling Study in Ontario, Canada, *BMC Public Health* , 15, DOI 10.1186/s12889-015-1867-2, published online June 2, 2015. Also see Bill Jesdale and Sally Zierler (2002), Enactment of Gay Rights Laws in U.S. States and Trends in Adolescent Suicide: An Investigation of Non-Hispanic White Boys, *Journal of the Gay an d Lesbian Medical Association*, 6(2): 61-9.
[10] Matthew K. Nock, Charlene A. Deming, Carol S. Fullerton, Stephen E. Gilman, Matthew Goldenberg, Ronald C. Kessler, James E. McCarroll, Katie A. McLaughlin, Christopher Peterson, Michael Schoenbaum, Barbara Stanley, and Robert J. Ursano, Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors (2013), *Psychiatry*, 76(2): 97-125.
[11] Ministry of Defence. Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces. January, 2009, London: UK.