or imprisonment could be the establishment of institutions aimed at housing, treating, and monitoring people with mental health disorders. In addition to the Mental Health Ordinance 2001, and the Sindh Mental Health Act 2013, Pakistan must look into revising its laws for dealing with wrongdoers diagnosed with a mental illness.

We declare no competing interests.

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How social norms affect psychiatric approaches to gender incongruence

The social nature of human beings influences the behaviour of not only patients and research participants but also clinicians and researchers. Uncritical applications of gender norms and binaries are sadly rife in both the clinic and empirical research.[1] Institutional psychiatry must promote not only the health and wellbeing but also the dignity and equality of the lives it touches.

The role of social norms in psychiatry is often striking in the field of gender incongruence. For example, recommendations for ICD-11 contain a criterion concerning gendered behaviours such as toy or peer preference.[2] In a cisgender child, such gendered behaviours do not, under the currently proposed ICD-11 criteria, constitute the presence of gender incongruence. However, this criterion implies that the presence of behaviours congruent with assigned gender in a child professing an incongruent gender identity casts doubt on the declared gender identity of the child in question. This criterion therefore seems to suggest that the authenticity of the declared gender identities of transgender children is dependent on whether these children conform to outdated gender norms that are expressly not applied to cisgender children.

Similarly, Ramachandran's work on phantom genitals shows that the somatosensory system of transgender individuals often concurs with their self-perception.[3] However, a minority of the transgender people in Ramachandran's study experienced phantom genitals after, and not before, genital surgery. This could be explained by proposing that social pressures have compelled these patients to undergo treatments they do not truly desire, in addition to the treatments they do require for a safe and comfortable gender identity. Social pressure on transgender patients to undergo a binary transition is already a source of clinically significant harm,[4] and staff at gender identity clinics should make an effort to remove or minimise these pressures to enable patients to make authentic and informed decisions. Patient-centred care is as important for transgender individuals as for anyone else, and the psychiatric training of many gender identity specialists could be particularly useful in overcoming these challenges.

Although the compound stigma conferred by pathologisation of transgender identities is one way in which this form of pathologisation is unethical,[2] ICD-11 recommendations fail to clarify that pathologisation of identities—corresponding to sexual orientation or gender identity—that do not deviate from any empirical ideal of health but merely deviate from social norms is also empirically flawed. The only reason why a distinction is required is to facilitate the diagnosis and treatment of mood disorders arising from socially mediated distress, which are partly caused by undermining of one's identity by others.[5] Diagnosis of gender incongruence should not, therefore, imply pathology. Furthermore, treatments aimed at suppressing transgender identities are unethical, harmful (especially to children), and—despite many attempts to find one—do not have a basis in evidence.[1] Alternative treatments, such as social care support, gender-literacy coaching, and social and medical transition are ethical and effective, unlike treatments that attempt to suppress transgender identities.

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