APORIA · ISSUE SIX

06

The Gate and the Name.

A young person asks you to certify who they are. The clinical standard says their identity is not a diagnosis and not yours to validate. A new law says recognition now runs through a medical board, and a national protocol says transition runs through your signature. One patient, two opposite duties.

CLINICAL DILEMMAS IN PSYCHIATRY

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01 / APORIA

The patient asks you to certify the self

A 22-year-old, assigned male at birth, comes to your outpatient clinic with a printout from a government portal and a question. Since early childhood they have known themselves to be a woman; the family has known for years; the neighbourhood, for the most part, has made its peace. There is no confusion in the room about who this person is. What they want is paperwork: the certificate that will let them change their name on a degree, the route to begin hormones, eventually surgery. They have heard the rules changed last month. They ask you, the psychiatrist, to sign the thing that makes them real to the state. You believe, as your training tells you, that their womanhood is not a disease, not a delusion, and not a finding you are competent to confer or withhold. And yet the form in front of you has a line for your opinion, the new law routes recognition through a medical board you may sit on, and the national protocol will not release a single dose of oestradiol until a psychiatrist has certified gender incongruence. You are asked, in one appointment, to be the clinician who affirms and the gatekeeper who decides. These are not the same job.

This is the aporia of the sixth issue. The clinical world has spent two decades moving gender out of the catalogue of mental disorders. ICD-11 took gender incongruence out of the mental and behavioural disorders chapter entirely; DSM-5-TR kept a diagnosis but states plainly that gender nonconformity is not in itself a disorder; the international standard of care treats the clinician as a member of the patient's team, not the guardian of a gate. The Indian legal world, in 2026, moved the other way. The Transgender Persons (Protection of Rights) Amendment Act, brought into force on 25 May 2026, replaced the self-identification standard the Supreme Court had affirmed in 2014 with a requirement that a district medical board recommend before the state recognises a person's gender. A national clinical protocol from 2024 already routes every step of medical transition through psychiatric certificates. The depathologising clinician and the certifying gatekeeper are now asked to be the same person, in the same chair, holding a pen. This issue is about how to hold that contradiction without harming the patient in front of you.

It is written to be read from the beginning. It teaches the vocabulary first, then the full spectrum of identities a clinician in India will meet, then the Indian epidemiological and community picture, then what to diagnose and what never to diagnose, then the affirmative management model and the certification machinery in detail, then a dedicated treatment of adolescents, and finally the traps and the resolution of the case above. The legal sections carry a dated status box, because the central statute is days old and under active constitutional challenge; treat every legal claim here as current as of late May 2026 and verify it against the live position before you rely on it in a certificate or a court.

WHAT THIS ISSUE COVERS

The whole field, not the narrow diagnosis. Foundations and vocabulary first; then the spectrum of gender-diverse identities including India's own; then the Indian epidemiology, community structure, and psychiatric morbidity; then diagnosis, and the longer list of things that are not the diagnosis; then the affirmative model of care and the full certification pathway under the Transgender Persons (Protection of Rights) Act as amended in 2026 and the Ministry of Health 2024 standard operating procedure; then a dedicated section on adolescents; then the traps and the teaching point. The register throughout is clinical and measured: the piece states the law as it now stands, names where it conflicts with the clinical standard and with the 2014 self-identification ruling, and leaves the reader to form a view. Identity is treated as identity, never as pathology.

Why this matters in Indian practice

Three facts make this an Indian problem and not an imported one. First, India has one of the oldest and largest publicly visible gender-diverse populations in the world, organised in living social structures (the hijra, kinner, aravani, jogappa, and other communities) that predate every diagnostic manual and do not map onto a Western binary or a Western clinic. Second, the access gap is lethal in a specific, documented way: in Indian clinic series, patients reach a qualified doctor on average around the age of twenty-five despite knowing their gender from around the age of nine, and a sizeable minority arrive only after undergoing crude castration or mastectomy at the hands of non-medical operators, because the legitimate route was too slow, too expensive, or too humiliating to use.[16] Third, the law a psychiatrist must work inside changed in 2026 in a direction that pulls the profession back toward gatekeeping, at the same moment the clinical evidence pulls the other way. The resident who understands only the international standard, or only the new statute, will mishandle the patient. This issue holds both.

02 / FOUNDATIONS

The vocabulary, and why each word matters

The single most common clinical error in this area is a vocabulary error: collapsing identity, expression, anatomy, distress, and sexual orientation into one undifferentiated thing and then attaching a diagnosis to the whole blur. Each of the following is a separate axis. A person can vary on any one without varying on the others. Getting the words right is the first act of competent and respectful care.

SEX ASSIGNED AT BIRTH

The label (male, female, or in some cases indeterminate) recorded at birth on the basis of visible anatomy. It is an administrative and biological starting point, not a verdict on identity. The preferred phrasing is **assigned male at birth** or **assigned female at birth** rather than the older "biological sex," which conflates chromosomes, gonads, hormones, genitalia, and identity that do not always agree.

GENDER IDENTITY

A person's internal, durable sense of their own gender as a man, a woman, both, neither, or another gender. It is not observable from the outside, is not inferred from anatomy, and in most people is stable from mid-childhood. The patient's report is the primary datum; there is no laboratory test and no collateral that overrides it.

GENDER EXPRESSION

The outward presentation of gender through dress, hair, voice, mannerism, and name. Expression is a social act and may or may not match identity; a person may conceal their identity for safety. Expression is never, on its own, grounds for a diagnosis or for a conclusion about identity.

GENDER INCONGRUENCE

A marked and persistent mismatch between experienced gender and assigned sex. In ICD-11 this is the named *condition* (gender incongruence), placed in the chapter on conditions related to sexual health, not among mental disorders. Incongruence is the entry point to gender-affirming care; it is not, in itself, a mental illness.

GENDER DYSPHORIA

The clinically significant distress that can arise from incongruence, especially when compounded by stigma, family rejection, and blocked access to affirmation. Dysphoria is what the patient may suffer; it is not the identity, and it frequently eases with social, legal, and medical affirmation. DSM-5-TR retains "gender dysphoria" as a diagnosis built around this distress.

SEXUAL ORIENTATION

Who a person is drawn to romantically and sexually. It is a wholly separate axis from gender identity. A trans woman may be attracted to men, to women, to both, or to none; conflating her identity with her orientation is the commonest family-level and clinic-level error in India, and it drives both misdiagnosis and conversion pressure.

THE THREE-LAYER SPINE OF THIS ISSUE

Hold these three apart and most of the clinical confusion dissolves. **Identity** is who the person is; it is not pathology and not yours to certify. **Incongruence** is the ICD-11 condition, the recognised mismatch that opens the door to care. **Dysphoria** is the distress, which is real, sometimes severe, often treatable, and frequently a product of how the world treats the person rather than of the person themselves. The clinician treats dysphoria and comorbidity, supports affirmation, and certifies process where the law demands it. The clinician does not adjudicate identity.

One further distinction governs everything that follows. **Gender variance is not gender incongruence.** A boy who plays with dolls, a girl who refuses dresses, an adult who crosses conventional gender lines in dress or manner, are expressing diversity, not declaring a condition. ICD-11 and DSM-5-TR are explicit that variant behaviour and preferences alone are never a basis for diagnosis. The diagnosis rests on a marked, persistent incongruence of identity, reported by the person, not on a failure to conform.

03 / THE SPECTRUM

Everything between, including India's own

"Transgender" is an umbrella, not a single destination. The clinician who expects every gender-diverse patient to want the same binary endpoint (full social, hormonal, and surgical transition from one pole to the other) will misread most of the people they meet. The field runs across a wide range, and India adds living indigenous categories that no imported manual contains.

The umbrella in brief

- **Trans woman / trans-feminine:** assigned male at birth, identity female or feminine. **Trans man / trans-masculine:** assigned female at birth, identity male or masculine. These binary trajectories are the best studied but are not the majority of the umbrella.
- **Nonbinary, genderqueer, genderfluid, agender:** identities outside or between the binary, or shifting over time. Care needs are individual and frequently partial: some want no medical steps, some want a specific subset (chest surgery without hormones, low-dose hormones without surgery), some want only social and legal recognition. The clinical trap is insisting on a binary destination as the price of care.
- **Cross-dressing / dual-role (ICD-10 F64.1):** wearing the clothes of another gender for periods, without a different gender identity and without a wish for permanent change. This is a boundary case, not gender incongruence, and not a disorder when it causes no distress.

India's indigenous identities

India's gender-diverse communities are older than the vocabulary above and carry their own social architecture. They must be met on their own terms, with cultural formulation, not pressed into a Western template.

IDENTITY	REGION / LANGUAGE	CLINICALLY RELEVANT NOTES
Hijra	Pan-Indian, esp. north and west; Hindi/Urdu	The most widely recognised trans-feminine community. Organised around a guru-chela (teacher-disciple) lineage and household (gharana); livelihood historically through badhai (blessings at births and weddings), begging, and sex work. Many undergo nirvaan (ritual castration), sometimes outside medical settings.
Kinner	North India; Hindi	Often used interchangeably with hijra; some communities prefer it as a less stigmatised term.
Aravani / Thirunangai	Tamil Nadu; Tamil	Thirunangai is the dignified self-chosen term; aravani the older usage. Tamil Nadu's welfare board and health programmes are built around this community.
Jogappa / Jogta	Karnataka, Maharashtra, Telangana; Kannada/Marathi	Trans-feminine devotees dedicated to the goddess Yellamma; identity is bound to a religious role, which shapes how distress and care are understood.
Mangalamukhi, Shiv-Shakti, others	Regional	Further community-specific trans-feminine identities, each with its own ritual and social meaning.

Two clinical points follow. First, membership of one of these communities is a **social and often spiritual identity**, not a diagnosis; the clinician's job is to understand the person's goals within their world, not to translate them into a manual. Second, the guru-chela household is frequently the patient's actual family, support system, and source of housing and income after a family of origin has rejected them; treating it as pathology or as an obstacle, rather than as the support structure it usually is, will lose the patient.

Eunuch identity

The 2026 Amendment explicitly lists "eunuch" among recognised categories. Clinically, some people in the hijra tradition identify specifically as eunuchs and seek orchidectomy framed around that identity rather than around becoming female. The care pathway is gender-affirming but the destination is the person's own; the danger,

documented repeatedly in Indian endocrine series, is that the legitimate surgical route is so inaccessible that castration is performed by non-medical operators, with the predictable surgical and endocrine harms. [16,17]

Intersex and differences of sex development

Intersex people, born with variations in chromosomes, gonads, or genitalia that do not fit typical binary definitions, are a **distinct population** whose frame intersects with but is not the same as gender incongruence. Most intersex people are not gender-incongruent; some are. The defining ethical issue is the history of non-consensual surgery on intersex infants, which the gender-affirming ethic (consent, the person's own goals, no irreversible steps without capacity) directly opposes. The 2026 Amendment also lists persons with intersex variations among recognised categories.

> THE CLINICIAN'S STANCE
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> Across the whole spectrum, the posture is the same: the patient is the authority on their identity; the clinician is the authority on safety, comorbidity, capacity, and the evidence for each intervention. Cultural formulation, in the DSM-5-TR sense, is mandatory in India, because the meaning of a gender-diverse identity, its community structure, and its relationship to family and faith differ sharply from the settings in which the international guidelines were written.

04 / INDIA

The numbers, and the cost of the delay

India's gender-diverse population is large, ancient, and badly counted. The 2011 Census recorded roughly 490,000 people in the "other" gender category, a figure community organisations and researchers regard as a profound undercount that captures only a fraction of the trans-feminine population and almost none of trans-masculine, nonbinary, and rural people. [27] Self-identification is suppressed wherever disclosure is unsafe, which is most places. The honest position for a clinician is that prevalence is unknown, that international self-identification surveys (0.3 to 0.5 per cent transgender, higher in younger cohorts) are the best available anchor, and that the Indian denominator is larger than any official count. [28]

The clinically decisive Indian datum is not prevalence but **delay**. In a referral series of 73 patients from an eastern Indian endocrine clinic, the median age at which gender incongruence was first felt was about nine years, yet the mean age at first qualified medical contact was close to twenty-six. [16] Seventeen years pass, for the average patient, between knowing and being helped. Only about one in nine had family support. The consequence is not abstract: roughly one in six trans-feminine patients arrived having already undergone castration, and about two-thirds of those castrations had been performed by people with no medical qualification; a similar fraction of trans-masculine patients arrived after mastectomy. [16] Estimates of the eunuch population run to several million, many presenting to endocrinologists only after crude orchidectomy or penectomy. [17]

THE HARM THE DELAY PRODUCES

When the legitimate route to care is slow, costly, humiliating, or simply unavailable, patients do not stop transitioning; they transition dangerously. Unsupervised castration, injectable hormones bought without monitoring, and silicone injected by non-professionals are the predictable results of a closed front door. Every barrier a clinician or a system erects (a needless gate, a dismissive interview, an unaffordable referral) has a foreseeable downstream cost in surgical and endocrine harm. This is the strongest clinical argument for making the affirmative, legitimate pathway genuinely reachable.

05 / INDIA

The morbidity, and where it comes from

Psychiatric morbidity is high in gender-diverse populations, and the reason matters as much as the rate. In clinic-referral cohorts, lifetime depression runs from roughly a quarter to two-thirds, anxiety disorders from a fifth to a half, lifetime suicidal ideation around 40 to 50 per cent, and lifetime suicide attempts from a quarter to 40 per cent.[1,15] Post-traumatic stress and substance use are elevated, tracking histories of violence, family rejection, and structural exclusion.

The explanatory model is **minority stress**, not intrinsic pathology. Hendricks and Testa's framework holds that the excess morbidity is generated by external stressors (discrimination, violence, rejection) and internalised ones (concealment, expectation of rejection, internalised stigma), layered on the ordinary stresses everyone carries.[15] The prediction the model makes is testable and confirmed: morbidity falls when affirmation rises. Chosen-name use in more contexts is associated with large reductions in depressive symptoms and suicidality in trans youth, and prospective cohorts of youth receiving gender-affirming care show improved mental-health outcomes.[21,22] Distress, in other words, is substantially a function of how the person is treated, not of who they are.

Indian field data fit this exactly. A study of transgender women and Hijra in Vadodara traced a direct path from social strain to psychological distress and dysphoria.[18] A scoping review of Indian transgender mental-health research from 2014 to 2024, covering 124 studies, found substantial need against a narrow and uneven evidence base, with several studies revealing researcher misconceptions that themselves caused epistemic harm; trans-masculine, nonbinary, and rural populations were largely invisible, and the literature was skewed toward Hijra communities studied mainly through the lens of HIV and sex work.[19] The clinical reading: the Indian evidence base is thin, what exists confirms the minority-stress account, and the trans-masculine and nonbinary patient in your clinic is under-represented in everything you have read.

CLINICAL CONSEQUENCE

Assess and treat comorbidity to the same standard you would for any patient, at every visit, because the rates are genuinely high and suicide risk is real. But do not attribute the distress to the gender identity, and do not make treatment of the identity conditional on the distress resolving first. The order of operations is: treat what is treatable, reduce the stressors you can reach (affirmation, family work, safety), and support the person's own goals. Comorbidity is a reason to treat, not a reason to gatekeep.

06 / INDIA

Stigma, conversion practice, and professional conduct

The Indian clinical encounter is shaped by stigma that often begins inside the family and is sometimes reinforced by clinicians. A recurring pattern, documented in Indian case reports, is the family that brings a gender-diverse or same-sex-attracted young person to a psychiatrist explicitly to be "changed," conflating gender identity with sexual orientation and both with illness.[20] The psychiatrist who accepts that brief, even tacitly, does harm.

Two legal facts bound clinician conduct. First, in *Navtej Singh Johar v. Union of India* (2018) the Supreme Court read down Section 377 to decriminalise consensual same-sex relations between adults, removing the criminal shadow that had long distorted these consultations.[11] Second, and directly governing practice, the Madras High Court in *S. Sushma v. Commissioner of Police* (2021) directed a prohibition on attempts to medically "cure" or change the sexual orientation or gender identity of LGBTIQA+ persons, and the regulator subsequently moved to treat such conversion efforts as professional misconduct.[10] Conversion practice is not a grey area: it is contraindicated by the clinical standard and prohibited by direction. The clinician's task when a family demands it is to decline the brief, name the harm, and redirect toward support of the person, while managing the family relationship that the patient often still depends on.

> *The standard is unambiguous. There is no legitimate clinical procedure that aims to change a person's gender identity. The only question the clinician faces is how to support the person and, where possible, bring the family along.*
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> THE CONVERSION-PRACTICE LINE, IN ONE SENTENCE

07 / DIAGNOSIS

Three manuals, one patient

A clinician in India must hold three classification systems at once, because they say structurally different things and are used for different purposes. The depathologisation story is the key to reading them.

AXIS	DSM-5-TR (2022)	ICD-11 (IN FORCE 2022)	ICD-10 (STILL USED IN INDIA)
NAME	Gender Dysphoria	Gender Incongruence	Gender Identity Disorders (F64)
WHERE IT SITS	Its own chapter; nonconformity stated not to be a disorder	Conditions related to sexual health, outside mental disorders	Inside mental and behavioural disorders
DISTRESS REQUIRED	Yes, clinically significant distress or impairment is part of the criteria	No, distress is not required; incongruence alone is the condition	Implied by "disorder" framing; dated
CODES	302.85 (F64.0 adol/adult; F64.2 children)	HA60 adol/adult; HA61 childhood; HA6Z unspecified	F64.0 transsexualism; F64.1 dual-role; F64.2 childhood
DURATION	At least 6 months	Marked and persistent; HA61 about 2 years	F64.0 usually at least 2 years
Use in India	Clinical formulation, research	The direction of travel; the affirmative frame	Still the working code for certification and insurance forms pending transition

The structural points worth memorising: **ICD-11 moved gender incongruence out of the mental-disorders chapter entirely**, an explicit act of de-psychopathologisation while preserving a code so that care can be accessed and funded.[2,5] DSM-5-TR kept a diagnosis but built it around distress and stated plainly that nonconformity is not a disorder.[1] ICD-10's F64 language ("transsexualism," "disorder") is dated and stigmatising, yet it remains the code most Indian certification and insurance workflows still require; the practical instruction is to document the F64 code where a form demands it while formulating the patient in the affirmative ICD-11 / DSM-5-TR frame.[3] The criteria themselves, in both current manuals, insist that variant behaviour or preference alone is never sufficient: the diagnosis rests on a marked, persistent, self-reported incongruence of identity.

08 / DIAGNOSIS

What to diagnose, and what never to

The hardest discipline in this area is negative: knowing what is *not* the diagnosis. The identity is never the pathology. The clinical work is to recognise genuine incongruence, treat genuine comorbidity, and rule out the short list of conditions that can mimic or accompany a gender-identity presentation without being one.

NOT THE DIAGNOSIS	HOW IT CAN LOOK SIMILAR	WHAT SEPARATES IT
Transient adolescent gender questioning	Exploration of gender during normative identity development	Watchful, longitudinal stance; intensity and persistence of incongruence into puberty mark genuine cases; avoid premature closure either way
Body dysmorphic disorder	Distress focused on a sex characteristic	BDD targets multiple body parts, often unrelated to sex; no coherent cross-gender identity report; no wish to live as another gender
Autism spectrum (overlap, not exclusion)	Over-represented in gender-diverse people; literal, intense self-description	Co-occurs; never a reason to deny care. Assess with accommodations; both are real together
Psychosis with body or gender delusion	A delusional belief about the body or sex	Acute or bizarre content, instability over time, other psychotic features; a stable identity since childhood is not psychotic. Can co-occur and need parallel treatment
Trauma-driven identity instability	Identity questioning after childhood sexual abuse	Trauma does not invalidate identity; many trans people have trauma. Stabilise trauma, hold an open stance, sequence irreversible steps after stabilisation
Intersex / DSD	Atypical sex characteristics	A distinct population; some are gender-incongruent, most are not. Do not conflate the two frames
Dual-role cross-dressing (F64.1)	Cross-gender dress	No different gender identity, no wish for permanent change, no distress about anatomy

What to diagnose, and treat, routinely

Assess at every visit and treat to standard, while never gating affirmation against them: major depression, anxiety disorders, PTSD and complex PTSD, substance use disorders, and disordered eating. Two cautions. First, chronic minority stress can produce a presentation that mimics a borderline pattern; assess carefully and do not over-diagnose a personality disorder onto the effects of sustained invalidation. Second, comorbidity is a reason to treat alongside, never a reason to withhold gender-affirming care; the international standard is explicit on this point.[4]

09 / DIAGNOSIS

Capacity, not diagnosis, is the threshold

For every medical step in gender care, the gate that actually matters clinically is **capacity to consent**, not a psychiatric diagnosis. The international standard sets out the test: the person understands the nature of the intervention, its reasonable expectations, its reversible and irreversible elements, and the alternatives; can apply that understanding to their own decision; and decides voluntarily, free of coercion from family, community, or system.[4]

Comorbid mental illness does not, in itself, remove capacity. The question is decision-specific: a person with treated depression or a stable psychotic illness may have full capacity to consent to hormones. The clinician's role is to ensure capacity is present and the decision is informed and voluntary, to stabilise anything that genuinely clouds judgement, and then to support the decision the person makes. This is the precise point at which the clinical model and the new legal model diverge, and the next Part takes up that divergence in full.

10 / CARE

The affirmative model, in full

The international standard of care, the WPATH Standards of Care version 8, frames gender-affirming care as patient-led, individualised, and harm-reduction-informed, delivered by an interdisciplinary team in which the mental-health clinician is a member, not a sentry.[4] The menu of interventions is wide, and most patients want a subset of it, not all of it.

Mental-health support

Assessment and formulation; treatment of comorbid depression, anxiety, PTSD, and substance use; family work; school and workplace navigation; safety planning; and supportive psychotherapy through transition. The psychotherapies that earn their place are the affirmative model first, then supportive and cognitive-behavioural work for comorbidity, dialectical skills for emotion regulation and self-harm, schema work for the chronic invalidation patterns minority stress lays down, narrative therapy for re-authoring identity, and family and group formats. None of these aims to alter identity; any practice that does is contraindicated by the standard and prohibited by the conversion-practice direction.[4,10,25]

Social transition

Name, pronouns, dress, hair, and disclosure decisions. Reversible, and for prepubertal children the only indicated intervention. Chosen-name use is not cosmetic: it is associated with measurable falls in depression and suicidality.[21]

The medical menu

- **Pubertal suppression** in adolescents at Tanner stage 2 or beyond, using GnRH analogues to pause endogenous puberty and buy assessment time. Reversible, with bone-density and fertility considerations to discuss. Detailed in Part VI.
- **Gender-affirming hormone therapy.** Oestradiol with an anti-androgen for the trans-feminine spectrum; testosterone for the trans-masculine spectrum. Partially reversible. Agents, starting doses, and monitoring intervals should be set against a current endocrinology reference and the locally available formulary rather than a fixed recipe; fertility-preservation counselling precedes initiation.[4,24]
- **Gender-affirming surgery.** Chest or top surgery, genital or bottom surgery, facial procedures, and body contouring. Largely irreversible; eligibility follows the standard and the patient's goals.
- **Voice and communication therapy** and other allied input, often underused and high-value.

> THE CLINICAL DEFAULT
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> Treat comorbidity alongside, never as a precondition. Support the goals the person actually has, including partial or no medical transition. Counsel fertility before hormones. Keep the irreversible steps behind a genuine capacity-and-information threshold, not behind an arbitrary gate. This is the model the evidence supports; the next sections describe the legal machinery the clinician must operate, which does not always match it.

11 / CERTIFICATION

The certificate of identity, after May 2026

Two separate certifications exist in India and are routinely confused: the legal **certificate of identity** (which changes a person's recognised gender for official purposes) and the clinical **certificates that gate medical transition** (hormones and surgery). This section is the first; the next is the second.

Under the Transgender Persons (Protection of Rights) Act 2019, a transgender person could apply to the District Magistrate for a certificate of identity, and the Rules of 2020 framed this around the self-perceived identity that the Supreme Court had affirmed in *NALSA v. Union of India* (2014).[6,7] The **2026 Amendment, brought into force on 25 May 2026, changed this materially.** The District Magistrate now issues the certificate only after examining the recommendation of a designated medical board, headed by a Chief Medical Officer or Deputy Chief Medical Officer and able to include other medical experts; a person who undergoes gender-change surgery is now required to obtain a revised certificate, and the medical institution must report the surgery to the District Magistrate.[8] The Amendment also rewrote the list of recognised categories, retaining socio-cultural identities (kinner, hijra, aravani, jogta) and intersex variations, adding eunuch and persons forced into a transgender identity, and removing the previously explicit categories of trans man or trans woman irrespective of surgery, and genderqueer.[8]

The route in practice runs through the National Portal for Transgender Persons, where the application and the medical-board step are processed.[26] The honest clinical and legal reading, stated plainly: the 2026 Amendment **reintroduces a medical-board gate over identity recognition that the Supreme Court expressly rejected in 2014**, when it grounded recognition in self-identification. That is not a marginal critique; it is the basis of the constitutional challenge now before the Court.

LIVE STATUS, AND WHAT IT MEANS FOR YOU

The Amendment is in force, but its central provision is under challenge. In 2026 the Supreme Court issued notice to the Union and **declined to grant an interim stay**, referring the matter to a three-judge bench; petitioners argue the medical-board requirement violates the rights to equality, non-discrimination, expression, and dignity under Articles 14, 15, 19, and 21, and dismantles the self-identification NALSA secured.[9] For the clinician this means the rules may change again with little notice. Tell patients the current requirement honestly, do not promise that today's process will hold, and verify the live position before advising on or contributing to any certificate.

Where a psychiatrist is asked to sit on such a board or to give an opinion toward a certificate of identity, the role should be understood for what it is: an administrative gate the law has created, not a clinical judgement about whether the person's identity is genuine. The clinician can attest to the absence of a disqualifying factor and to capacity; the clinician cannot, and should not pretend to, adjudicate the truth of a person's gender.

12 / CERTIFICATION

The medical-transition pathway you actually sign

Separate from identity recognition, the Ministry of Health and Family Welfare issued a Standard Operating Procedure in August 2024 governing the clinical pathway to hormones and surgery. It is the document that puts a pen in the psychiatrist's hand, and it prescribes a **linear sequence**.[13,14]

01 **Certificate of gender incongruence, for hormones.** One psychiatrist provides a certificate of gender incongruence; on that basis gender-affirming hormone therapy may begin.

`This is the single most common certificate a psychiatrist will write in this field.`

02 **Hormones for a minimum of one year.** The SOP requires at least a year of hormonal treatment before surgical intervention is accessed.

`A fixed minimum, not an individualised judgement.`

03 **Certificates for surgery.** Two certificates from psychiatrists and one from an endocrinologist are required before gender-affirming surgery.

`The surgical gate is heavier than the hormonal one.`

What the psychiatrist actually assesses

The certificate of gender incongruence is not a verdict on whether the person is "really" their gender. What you are competent to assess and should document is narrower and defensible:

- That a marked and persistent gender incongruence is present on the person's own consistent account, with its history.
- That the person has **capacity** to consent to the intervention contemplated, on the decision-specific test.
- That any comorbidity has been assessed and is not, at this time, clouding the capacity to make this decision (treated alongside, not used as a bar).
- That expectations of the intervention are realistic and the decision is voluntary, free of family or community coercion.

What to write

A clean certificate states the assessment performed, the presence of gender incongruence on the person's account, the presence of capacity, that comorbidity has been addressed, and the specific intervention supported. It does not editorialise about the legitimacy of the identity, does not import ICD-10's stigmatising language into the patient's hands, and does not over-claim a certainty the clinician does not have.

> WHERE THE SOP AND THE CLINICAL STANDARD DIVERGE, STATED PLAINLY
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> The SOP's fixed, linear pathway (psychiatric certificate, then a mandatory year of hormones, then multiple certificates for surgery) sits awkwardly against the international standard, which favours an informed-consent model, individualises timing, and does not require this layered gatekeeping. Indian clinicians who have studied the SOP note that it can contradict global standards and structurally exclude nonbinary people who do not want a linear binary pathway.[14] The resident should know the SOP because it is the operating rule in Indian practice, and should also know that it is not the clinical state of the art. Hold both, and advocate within the system for the patient in front of you.

13 / CERTIFICATION

A defensible certificate, and what never to certify

01	**Certify process and capacity, not identity.** Your signature attests that you assessed the person, that incongruence is present on their account, that capacity is intact, and that the decision is informed and voluntary. It does not certify that their gender is real; that is not a medical question.
02	**Never certify a "cure" or a change of identity.** There is no such procedure; offering or attesting to one is contraindicated and prohibited.
03	**Do not weaponise comorbidity.** A treated mood or psychotic illness is not, by itself, a reason to withhold a certificate. Capacity is decision-specific.
04	**Keep diagnostic language out of the patient's hands.** Where a form demands an ICD-10 F64 code, record it for the form; do not narrate a disorder to the patient. Identity is not a disease.
05	**Document, date, and qualify.** Note the assessment, the basis, the specific intervention supported, and the date. Given the shifting legal frame, a certificate is a point-in-time clinical opinion, not a permanent warrant.
06	**Do not let the gate cause the harm.** Remember the downstream cost of refusal: an unreachable legitimate pathway pushes patients toward unsupervised hormones and crude surgery. Reasonable, timely certification is itself harm reduction.

14 / ACCESS

The machinery, and where it leaks

Knowing the law is not enough; the clinician must know the access routes, because the gap between entitlement and reality is where patients fall. The central machinery exists on paper.

- **National Portal for Transgender Persons** and the **National Council for Transgender Persons**: the online route to the identity certificate and identity card, and the statutory advisory body created under the 2019 Act. [26]
- **SMILE** (Support for Marginalized Individuals for Livelihood and Enterprise), the central umbrella scheme that includes transgender welfare, scholarships, and rehabilitation, and the **Garima Greh** shelter homes providing housing, food, medical care, and skill-building. [26]

State variation, which is large

What a patient can actually get depends heavily on the state. Tamil Nadu, the historical pioneer with a dedicated welfare board, integrated gender-affirming surgery and hormone therapy into its state health-insurance scheme, with several thousand enrolled and hundreds treated across empanelled hospitals by late 2025. Kerala reimburses surgical costs and provides a monthly post-operative support payment and a lump-sum grant through its social-justice department. Some government hospitals in Delhi offer gender-affirming surgery without charge. Most other states have far less, and the patient in a district town faces a very different reality from the patient in Chennai or Thiruvananthapuram.

> THE NATIONAL INSURANCE GAP
>
> The central promise of gender-affirming surgery coverage under the national health-assurance scheme, announced in 2022 as a dedicated transgender provision, had still not been meaningfully operational by 2025, and private insurers in India generally exclude gender-affirming surgery from coverage. The practical effect is that, outside a handful of states, the cost falls on the patient, which is precisely the pressure that drives the unsupervised, dangerous route described in Part III. Map the local resources for each patient; do not assume a national entitlement that does not yet function.

15 / LAW

The status box, dated

The legal frame around this clinical field is unusually fluid in 2026. The box below is the snapshot a clinician needs; every item is tagged as settled or in flux, and the whole is dated, because the central statute is weeks old and under challenge. **Verify before you rely on any of this in a certificate or a court.**

LEGAL STATUS AS OF 29 MAY 2026

NALSA v. Union of India (2014). [Settled, but partly undercut] Recognised transgender persons as a third gender with the right to self-identification and full constitutional protection. Remains the foundational judgment; its self-identification principle is the very thing the 2026 Amendment narrows and the current challenge seeks to restore. [6]

Transgender Persons (Protection of Rights) Act 2019 and Rules 2020. [In force] Established the certificate of identity, anti-discrimination protections, and the National Council. [7]

Transgender Persons (Protection of Rights) Amendment Act 2026. [In force from 25 May 2026, under constitutional challenge] Makes a district medical board recommendation mandatory before the certificate of identity, mandates a revised certificate and hospital reporting after gender-change surgery, and rewrites recognised categories. The Supreme Court has issued notice, declined an interim stay, and referred the matter to a three-judge bench on Articles 14, 15, 19, and 21. [8,9]

MoHFW Standard Operating Procedure 2024. [In force] The linear medical-transition pathway: a psychiatric certificate of gender incongruence for hormones, a minimum year of hormones, then two psychiatrist certificates and one endocrinologist certificate for surgery. [13]

S. Sushma v. Commissioner of Police (Madras HC 2021). [Settled, governing conduct] Prohibition on conversion practices; clinician participation is professional misconduct. [10]

Navtej Singh Johar v. Union of India (2018). [Settled] Section 377 read down; consensual same-sex relations between adults decriminalised. [11]

Mental Healthcare Act 2017. [In force] Governs capacity, consent, and admission; relevant wherever a gender-diverse patient also has a mental illness requiring its protections. [12]

ICD-11 adoption. [In transition] India still runs most certification and insurance on ICD-10 F64; document both for forward-compatibility. [2,3]

16 / ADOLESCENTS

The most contested ground, held honestly

Adolescent gender care is the zone where the clinical, the evidential, and the political collide hardest, and where a resident is most likely to be pushed toward a confident position the evidence does not support in either direction. The honest stance holds two things at once: the affirmative standard is the international baseline, and the adolescent medical-intervention evidence base is genuinely thinner and more contested than the adult one.

What the standard says, by age

- **Prepubertal children** (the standard's Chapter 7): the only indicated intervention is social and supportive. No medical steps. The work is with the child, the family, and the school, holding space for fluidity without forcing closure in either direction.
- **Adolescents** (Chapter 6): pubertal suppression with GnRH analogues from Tanner stage 2, which pauses endogenous puberty and is reversible, with bone-density and fertility matters to discuss; then, for carefully assessed cases, gender-affirming hormones. Eligibility turns on persistent and well-documented incongruence, capacity to consent, guardian involvement as feasible, and adequate mental-health support. [4]

Persistence, desistance, and the evidence problem

Childhood gender-variant feelings do not always persist; the literature on desistance is contested and methodologically weak, and the cleanest signal is that severe, persistent dysphoria intensifying into puberty predicts persistence.[5] The honest reading is that clinicians cannot reliably predict the individual trajectory of a young child, which is exactly why the standard reserves irreversible steps and uses the reversible pause of pubertal suppression to buy assessment time.

> THE CASS REVIEW AND THE POLICY SHIFT, STATED WITHOUT SPIN
>
> England's Cass Review (2024) and more cautious policy moves in Sweden, Finland, and the Netherlands re-framed adolescent gender care toward greater caution about medical intervention in minors, citing a weak evidence base. The WPATH Standards of Care version 8 remains the international clinical baseline. These are not reconciled, and a resident should not pretend they are. The defensible clinical posture is neither reflexive denial of care nor reflexive medicalisation: it is careful, individualised assessment; the reversible step first; irreversible steps behind a genuine capacity threshold and guardian involvement; and honesty with the young person and the family about what is known and what is not.[4,23]

The Indian adolescent reality

India has very few adolescent gender services, concentrated in a small number of tertiary academic centres; most districts have no pathway at all, and the default for a family is a general psychiatrist with limited specific training. In this setting two things matter most. First, family work is central, not optional: in the Indian family structure the adolescent's safety, housing, and access to any care usually depend on bringing the family along, and the same family is often the source of conversion pressure. Second, the 2026 identity-certificate process and the 2024 medical-transition protocol interact with minors in ways still being worked out; for anyone under eighteen, proceed with particular caution, involve guardians, document capacity carefully, and seek specialist consultation rather than acting alone.

17 / TRAPS

The errors that follow from the confusion

01 **Pathologising the identity.** Treating the person's gender as the disorder to be fixed. The identity is never the pathology; the distress and the comorbidity are what you treat.

02 **Confusing the two gates.** The identity certificate is an administrative gate the 2026 law created; the medical-transition certificate is a clinical one. They are different roles with different thresholds. Do not import the law's gatekeeping into the consulting room as if it were clinical judgement.

03 **Over-attributing to gender.** Reading every symptom as caused by the gender identity, and so missing a treatable depression, or the reverse, dismissing a stable identity as a symptom of a mood or psychotic illness.

04 **Misreading a lifelong identity as delusion.** A stable, childhood-onset, internally consistent identity is not a psychotic symptom. Acute, bizarre, unstable body or gender content in the presence of other psychotic features is a different matter.

05 **Conflating identity with sexual orientation.** The commonest Indian family-level and clinic-level error, and the one that drives conversion demands. They are separate axes.

06 **Participating in conversion practice.** Including the soft version dressed as "just making sure it is not a phase" when the aim is to talk the person out of their identity. Contraindicated and prohibited.

07 **Certifying without assessing capacity, or refusing to certify at all.** Both fail the patient. The first is negligent; the second, when the route is otherwise reachable, pushes the patient toward unsupervised hormones and crude surgery.

08 **Speaking the manual to the patient.** Narrating an ICD-10 "disorder" to a person whose identity is not a disease. Use the code for the form; use affirmative language with the person.

09 **Imposing a binary, Western destination.** Assuming every patient wants full binary transition, and missing the nonbinary patient who wants a partial path or the hijra or jogappa patient whose identity is bound to a community and a faith.

18 / TEACHING POINT

The case, resolved

Return to the 22-year-old at the start, the woman with the printout asking you to make her real to the state. The resolution is not that you decide whether she is a woman; you never were competent to, and the clinical standard says you do not need to. What you do is this. You assess her capacity and find it intact. You ask about her goals, which are documents, then hormones, then in time surgery, and you support them. You screen for and treat any depression, anxiety, or trauma, none of which is a reason to make her wait. You write, honestly, a certificate of gender incongruence that attests to the assessment you performed and the capacity you found, not to the truth of her womanhood. You tell her plainly that the identity-certificate route now runs through a medical board, that this is new, that it is being challenged in the Supreme Court, and that the rules may shift. And you make the legitimate pathway reachable enough that she never has to take the dangerous one.

> *The gate is the law's. The name is hers. The clinician's task is to keep the gate from becoming a wall, and never to confuse signing a form with judging a soul.*
>
> APORIA 06, THE TEACHING POINT

That is the whole of it. Witness and clinician, not judge of the self. Hold the affirmative standard and the new law together, name the distance between them without pretending it is not there, treat what is treatable, certify process and capacity honestly, and remember that in this field the most common way to do harm is to make care hard to reach.

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Educational note. This clinical-reasoning essay is for clinicians and students. It is educational, not treatment advice for any individual. Care decisions belong with the treating clinician. At Weave, care is led by Dr. Niharika Reddy, Consultant Psychiatrist.

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Aporia 06 - The Gate and the Name. Built from the WPATH Standards of Care version 8, the WHO ICD-11 and DSM-5-TR diagnostic frames, the Endocrine Society guideline, and Indian sources including the Transgender Persons (Protection of Rights) Act 2019 and its 2026 Amendment, the Ministry of Health 2024 standard operating procedure, NALSA (2014), S. Sushma (2021), and Indian clinical and community studies. The legal frame is current as of 29 May 2026. This issue is an educational clinical-reasoning aid for qualified clinicians and is not legal advice. The central statute is weeks old and under active constitutional challenge; every legal claim here must be verified against the live position before it is relied upon in a certificate, an application, or a court. Identity is not a disorder. **Dr. Wilfred D'souza**, Weave - Centre for Integrative Psychiatry. Series: *Aporia - clinical dilemmas in psychiatry*.