JSNMA
Journal of the Student National Medical Association

Transgender Medicine: Depathologization, Organizing, and Practice

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Is being transgender a medical condition? While some researchers attempt to attribute transgender (trans) identities to neurobiological mechanisms, there has never been conclusive, significant research illustrating how these identities are biological.[i] Even then, there is always the issue of neuroplasticity, the concept of neurons changing due to environment or behavior, some hypothesize that simply identifying as transgender could lead to the observed differences in the nervous tissue from a cisgender (people who identify as their sex assigned at birth) control group.[ii] The essentializing of what some may consider being medical "causes" of transgender identities can also be harmful if a certain aspect of biology become the standard to test for to make sure a trans person is "actually" trans. Any form of pathologization (which is encoded with stigmatizing and societally negative attitudes of "mistake" and "abnormality") of transgender people has had an oppressive history in the community along with holding the potential to leave out many trans people who do not fit the diagnostic criteria.

Bearing all this in mind, though trans people are not "born this way" as a pathological condition would suggest, being trans should continue to not be treated as a choice or lifestyle. In my own organizing experiences, I have worked with some trans activists who have internalized the rhetoric of pathology and cling onto the notion of an inherent male or female identity that correlates with a trans person's gender identity as "proven" through the medicine. These conceptualizations of transness do not just leave out people who identify outside the gender binary, but can be dangerous to the community as a whole.

Both psychological and medical models for being transgender have limited the ability for trans people, particularly trans people of color, trans youth, and queer (non-heterosexual) trans people to access medical care. One classic example of this is Ray Blanchard's "typology of transsexualism", which limited queer trans women's access to medical transitioning by describing non-heterosexual trans women as "autogynephilic men." His theory of autogynephilia claimed that any trans woman who was attracted to cisgender women was also sexually attracted to the notion of having a vagina. Additionally,

to be considered a "woman trapped in a man's [sic] body" (as Blanchard would designate), a trans woman would have to almost exclusively be hyperfeminine and have consistently presented as feminine since a young age, contrary to the experiences of many trans women. [iii] Consequentially, psychological and medical professionals began refusing medical treatment to trans women who did not fulfill these narrow criteria (it should be noted that a psychologist's letter is generally necessary to receive medical treatment as a trans person). [iv] Even though this blatantly discriminatory model originated over 30 years ago, it remains prevalent in practices today.[v]

My childhood experiences did not fit the limited narrative of the inherent transgender identity: I exclusively identified as a boy until I was eight and never questioned my gender during that period. I also did not exhibit an "innate" affinity for feminine things, I enjoyed a mix of toys marketed to both girls and boys and only opted to play with "girl" toys due to my peers' interrogation of my gender identity. I am not and have never been heterosexual, but was only coerced into identifying as straight during a short period of my life because the people in my rural community could not comprehend a trans woman who was queer, incorrectly conflating the concepts of gender, sex assigned at birth, and sexual orientation (in reality, each is a district, separate spectrum).[vi] According to the 1980's pathological model of being transgender, I would be a heterosexual man from this description.

Unfortunately, when I came out as female in 2003, the predominant research available relied on a limited cognitive-behavioral training model of gender identities. My mother is a doctor and, like many others, was only willing to respect peer-reviewed medical and psychological publications despite a faulty understanding of the etiology of transgender identity. At the time, Kenneth Zucker and Susan Bradley were the leading researchers on gender in youth. Their publication, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*, concluded that if a gender nonconforming child's gender identity and expression were not affirmed, they would continue to identify as their sex assigned at birth.[vii] This, while incorrect and dangerous, was what my parents believed and they continued to not affirm my gender identity for five years. I was lucky that they realized how unhappy I was and allowed me to transition when I was 13. However, though my social transition had begun, my medical transition was ridden with pathologizing institutional barriers that prevented me (along with many other trans youth) from accessing the care I needed.

At the time, WPATH – The World Professional Association for Transgender Health – was still using its sixth version of the Standards of Care, which provided guidelines, often used as regulations, for transgender medicine. Because I was required to be 16 years old to obtain hormones by this model and was only 15, I had to drive for dozens of hours and visit two therapists, two doctors, and an endocrinologist to get the medical treatment I needed.[viii] These institutional barriers still exist in a lesser form: one must be 13 to have hormone treatment (long after many children begin puberty), 16 to receive some surgical treatments, and 18 to receive genital surgery (which can cause intense psychological distress due to the unnecessary waiting

period).[ix] These numbers are still somewhat strictly enforced despite extremely low rates of regret from trans people of any age: one thorough study of several hundred trans people found that 97% were satisfied with hormone therapy and 90% with surgery.[x] Another found significant increases in psychological functioning for a group of trans youth after puberty suppression, hormone treatment, and gender affirming surgeries.[xi]

You may be wondering why WPATH has such strict Standard of Care guidelines if it is so clear trans youth are satisfied with their medical transitions. The answer is as easy as looking at the writers and influencers of the criteria, among which are Kenneth Zucker and Ray Blanchard. Cisgender professionals, who have a limited understanding of transgender psychological and medical needs, and not transgender activists, wrote most of the Standards of Care.

I urge medical professionals and institutions to be aware of WPATH's publication, but not use their Standards of Care as a concrete model, particularly regarding the requirements for treatment. After years of organizing in the transgender community along with knowledge gained from personal experiences, I now understand that the most effective, affirming, and safe times to allow informed trans youth access to hormones or puberty suppressants is directly before puberty begins and access to surgery at age 16.

Additionally, practice on a larger scale needs to be critically interrogated. While some practices retain the very restrictive Standards of Care as a stringent protocol, more and more institutions such as the Howard Brown Health Center in Chicago and The Center of Excellence for Transgender Health at University of California – San Francisco are using an informed consent model, which educates the patients of the benefits and consequences of their medical choices and trusts them to make their own decisions.[xii, xiii]

Reforming the ways transness is medicalized to become more inclusive is not enough: depathologization is necessary for transgender medical justice.[xiv] It is not possible for all transgender people to be represented under any medical model and medicalization within itself confines the definition of being transgender to a limited essentialist framework. Depathologization would be a move from seeing our lives as a "mistake" of biology to understanding and celebrating trans identities as a central part of our concepts of gender.[xv] Along with this, informing medical and psychological institutions about the importance of the depathologization of transgender people is critical for our care. With a new standard of informed consent, institutions can profoundly expand access to the medical care transgender people need. No longer regarding transgender people as having a medical or psychiatric disorder is central to our wellbeing as a community and has the potential to expand knowledge and support for our lives.

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