

Pathologising trans people: Exploring the roles of patients and medical personnel

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Despite the 2013 decision to replace the diagnostic labelling of gender identity disorder with gender dysphoria, there remains wide consensus amongst scholars that transgender identities are pathologised. Yet the claim that trans identity has been pathologised has yet to be rigorously substantiated. Adapting a model for verifying the credibility of medicalisation claims, this inquiry confirms that the human phenomenon of gender-variance has undergone pathologisation to embed trans identity within a medical model by (1) historicising how trans identity became viewed as a medical condition; (2) highlighting that medical explanations for trans identity are adopted by trans people and the culture at large; and (3) showing that medical theory for trans identity gains traction over any other explanation. *[Article copies available for a fee from The Transformative Studies Institute. E-mail address: journal@transformativestudies.org Website: <http://www.transformativestudies.org> ©2018 by The Transformative Studies Institute. All rights reserved.]*

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INTRODUCTION

In contemporary Western nations most people identify and express their gender in ways that culturally match their birth sex. These people can be described as cisgender and are contentiously understood to represent the baseline of ‘healthy’ or ‘normal’ gender identity and expression, despite significant rejection of these labels from transgender health research and advocacy (Davis et al. 2016; Schilt & Westbrook 2009). On the other hand transgender and other gender-variant (trans) people experience a

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diverse range of life experiences, gender identities, and behaviours that are atypical of their birth-assigned sex, including cross-sex identification and/or the use of medical technologies to transform their bodies. In addition to their shared status as trans people, individuals within this group will find many of their unique life experiences listed as diagnostic criteria for the psychiatric condition currently listed as ‘gender dysphoria’ (GD) in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA 2013). This condition was listed as ‘gender identity disorder’ (GID) in previous editions of the DSM. The tenth edition of the *International Statistical Classification of Diseases* lists GID as a psychiatric diagnosis (WHO 1992), however this is anticipated to change with the release of the eleventh edition in 2018 (Inch 2016). Measured against cisgender (non-trans) identities, those whose gender does not adhere to biological sex are outliers according to this medical model. Reflecting what Foucault (1994) describes as medicine’s ‘healthy/morbid opposition’ (p. 35), cisgender gender identities are implicitly ‘healthy’ and ‘normal’, whereas trans gender identities are rendered as pathological deviations.

Embedding the human phenomena of gender-variance within a medical model is a relatively recent Western development of the mid-twentieth century. For this reason, literature from the theoretical domain of trans studies and empirical trans health research takes for granted that trans identities have undergone medicalisation and pathologisation (Conrad 1992; Davis et al. 2016; Johnson 2015; Lev 2013; Vipond 2015), and that processes of medicalisation and pathologisation are phenomena that have been *done to* trans people by clinicians and researchers (Butler 2001; Davis et al. 2016; Eckhart 2016). However, the explicit claim that trans identity has been pathologised has yet to be rigorously substantiated. Adapting Sadler and colleagues’ (2009) three-pronged model for verifying the credibility of medicalisation claims, this novel inquiry streamlines Sadler et al.’s (2009) approach by (1) historicizing how trans identity became viewed as a medical condition; highlighting that (2) medical explanations for trans identity are adopted by trans people and the culture at large; and showing that (3) medical theory for trans identity gains traction over any other explanation. Using this rubric, the goals of this inquiry are two-fold: First, this article seeks to confirm the credibility of claims that trans identity has undergone pathologisation. And as a tertiary goal, the relational ways that both trans people and medical providers leverage the medical model of trans identity are explored, taking a departure from understanding

pathologisation as an event that trans people have been exclusively passive recipients of.

This article begins with a brief refresher on the field of medicalisation and its sibling concept, pathologisation. Next, literature related to the pathologisation of trans identity is discussed to provide evidence of scholars' explicit discussions surrounding the phenomenon. The substantive section that follows centres Sadler and colleagues' (2009) model for the purpose of understanding the social and historical processes through which trans identity has come to be viewed as a mental health condition. Finally, limitations of this project are discussed and future directions are offered.

MEDICALISATION

Conceptualizing medicalisation

Medicalisation emerged as a theoretical concept from scholarship within the sociology of health and illness in the 1960s-1970s. Critiques of the medical institution began in the 1960s in concert with the social constructionist paradigm shift. Without being explicitly named medicalisation, Parsons' (1951) analysis of 'the sick role' may have been the first to advance the notion that medicine exists as a tool for social control (Conrad 1992). Conrad (1979) also established three ways in which the medical institution contributed to social control: medical ideology (imposing a dominant medical model); collaboration (doctors as gatekeepers and agents of the medical institution); and technology (the use of drugs, surgery, and genetics for social control). During this period Freidson (1970) untangled the social experiences of illness from biological realities, asking 'how signs or symptoms get to be labeled or diagnosed as an illness in the first place?' (p. 212). Largely based on structuralism, constructionist critiques of the medical institution formed the foundational knowledge to deploy the theory of medicalisation. Later, it was Conrad's seminal studies (1975; 1992) that explicitly developed medicalisation as a conceptual tool to understand the social control of deviancy. Medical sociologists (Conrad & Schneider 1992; Zola 1972) additionally studied how and why certain human behaviours are controlled by medical means. French historian and philosopher, Foucault (1970; 2003; 2006), for instance, was interested in power relations between macro-level medical structures and micro-level interactions between doctors and patients that gave rise to the expansion and authority of medical knowledge, and the subsequent creation of

disease categories. Foucault (2003) writes that ‘the hospital doctor going from bed to bed was one of the major agents of contagion... the role of the hospital space and the doctor’s knowledge was to produce the ‘critical’ truth of the disease’ (p. 337). The powerful role that patient-provider interactions within the medical institution play in the discovery and creation of disease categories is illustrated here.

Psychiatry was the first discipline to hold medical sociologists’ attention in terms of the connection between medicine, deviancy, social control, and the rise of pharmaceutical treatments and biomedical interventions (Conrad 1975; 1992). In the 1970s social scientists were critically attuned to the proliferation of psychiatry and processes that contributed to making deviancy and delinquency a medical issue (Conrad 1975; Friedson 1970; Zola 1972). For instance, medicalisation has been used by scholars to explore how homosexuality was added and then removed from the DSM (Conrad 2007), trans peoples’ interactions with the medical system (Conrad 1992; Davis et al. 2016; Johnson 2015; Reicherzer 2015) and how the medical model shapes trans people’s legal rights (Johnson 2015; Vipond 2015).

A conglomerate of Zola (1983) Conrad (1992), and Sadler et al’s (2009) theorizing on medicalisation is given primacy in this investigation. Zola (1983) explains that medicalisation is a ‘process whereby more and more of everyday life has come under medical domination, influence, and supervision’ (p. 295). Conrad (1992) describes medicalisation as ‘a process by which *nonmedical problems* become defined and treated as medical problems, usually in terms of illness or disorders’ (p. 209, italics added). In direct response to Conrad’s definition, bioethicists Sadler and colleagues (2009) instead strike ‘nonmedical problems’ from their interpretation of medicalisation because this wording connotes that some human problems may be unquestionably nonmedical. Rather than investigate what constitutes authentic and inauthentic medical conditions, Sadler et al (2009) instead launch a bioethical question of the value of medicalisation suggesting ‘medicalisation, as a social practice, may represent a broad range of interests and values, as well as serve one or more social purposes or functions’ (p. 414). Their three-step rubric for verifying when a human experience has indeed undergone medicalisation will be more extensively explored later.

Pathologisation: the connection between processes of normalisation and gatekeeping

Theoretical and empirical research projects in the areas of trans identity are heavily peppered by both of the terms medicalisation and pathologisation. Jacob and others (2014), however, caution researchers to distinguish between medicalisation and pathologisation, noting that a phenomenon must first be defined medically and then used in clinical practice to label individuals as abnormal. This is an important distinction given the prevalence of these terms within literature related to trans identities. Pathologisation calls upon normative standards in order to calculate deviations from a baseline, such as the case with cisgender versus trans experiences, with the latter group's characteristics taxonomized as mental disorder complete with biomedical treatments.

According to scholars within the field of medicalisation, 'normalisation' refers to actions surrounding the use of medical interventions that align the body into a cultural expectation of what is a more 'normal' or socially desirable aesthetic (Conrad 2007). Normalisation occurs, for instance, when parents of short children request human growth hormone in hopes the child will reach 'normal' height, or when women's small breasts are labelled as 'micromastia' and surgically enhanced (Jacobson 2000). Scholars have similarly argued that the medicalisation of gender-variance and corresponding hormone replacement therapies (HRT) and gender-confirming surgeries, also termed sex reassignment surgeries (SRS), contributes to the normalisation of non-normative expressions of sex and gender (Butler 2001; Vipond 2015). This argument has been applied to the case of trans adults and gender-independent children who medically transition sexes (Pyne 2014), and in circumstances in which parents and doctors make decisions on behalf of intersex babies (Davis et al. 2016; Holmes 2002; Repo 2013). Similarly, the argument has been made that SRS may exist to normalise gendered bodies that are misaligned with anatomical sex, and to render deviant bodies into a normative gender binary system (Repo 2013).

Gatekeeping of transition-related treatments such as HRT and SRS contributes to the pathologisation of trans identity. This is in part due to medical providers exclusively holding the power to define trans experiences as mental illness, while guarding and sometimes obstructing access to transition-related care. Conrad (2010) and Conrad and Bergey (2014) importantly draw attention to the role that clinicians play in the medical profession, calling medical professionals 'gatekeepers' in the

context of increased power of pharmaceuticals and biomedicine. Interestingly though, whereas in the context of the seminal medicalisation literature ‘gatekeeping’ refers to the shrinking power that health care providers carry, yet for trans health researchers ‘gatekeeping’ is decidedly used to underscore the power that physicians hold as the protectors of transition-related medical interventions (Bouman et al. 2014; Collazo 2013; Vipond 2015). Physicians (often psychiatrists) are typically solely responsible for conducting the mandatory psycho-social assessments that verify the authenticity of a trans patient’s diagnosis prior to being granted access to HRT and/or SRS. But on the other hand, Eckhert (2016) observes the fraught role that trans patients play in this interaction, rehearsing and recycling the narratives necessary to pass through this clinical gateway, espousing what Butler (2001) calls the ‘truth’ of transsexuality. In other words, trans people present medical providers with the imagined life stories that are necessary to gain access to HRT and SRS, which is what Cohen-Kettenis and Pfafflin (2010) refer to as a search for an authentic or truthful transsexual. Yet for trans people this may be a pragmatic approach to accessing services, as research indicates that some clinicians continue to conduct assessments based on a normative trans narrative and gender expression, rather than the dysphoria and distress that patients describe (Serano 2007; Moleiro & Pinto 2015). Conrad and Bergey (2014) similarly draw attention to the role that patient advocacy groups play in assisting others in being knowledgeable of diagnostic criteria in order to receive necessary treatments.

Pathologisation of trans identity and transnormative medical narratives

Due in part to processes related to pathologisation, it is well documented within academic and grey literature that the relationship between trans people and medical providers is strained (Cheng Thom 2015; Kosenko et al. 2013; Snelgrove et al. 2012). For instance, some health care professionals express barriers to delivering care to trans individuals, and some explain that treating trans people ought to remain within the domain of psychiatry (Snelgrove et al. 2012), which may contribute further to the pathologisation of trans identity (Inch 2016). From the perspectives of trans studies scholars, however, clinicians’ exclusive authority to verify, scrutinize, and diagnose the authenticity of trans identities ultimately protracts the pathologisation and stigmatization of gender-variance (Butler 2001; Davy 2015; Inch 2016; Johnson 2015; Reicherzer 2008; Vipond 2015).

Vipond (2015) reflects on the normalisation of some trans people through processes of medicalisation using a construct called ‘transnormativity’. Dominant narratives of transnormativity, such as being ‘born this way’, having an awareness of one’s trans identity from a young age, being ‘trapped in the wrong body’, and desiring to surgically and hormonally transform one’s body to the opposite sex, among others, do a number of important actions in relation to medicalisation and pathologisation (Eckhart 2016; Vipond 2015). These narratives 1) form the basis of diagnostic criteria to assess the authenticity of a patient’s gender dysphoria; 2) reinforce the notion that there are only two genders; and 4) affect how medical personnel interact with trans-identified clients. According to Dewey and colleagues (2016), these dominant transnormative narratives also position gender as biologically determined. In Vipond’s (2015) analysis, *gender conforming* trans persons (those who access transition-related medical interventions to physically transform their bodies. I.E. – transsexuals, trans men, trans women, people with a history of transitioning) are privileged and legitimized by medical discourses over those who are *gender non-conforming* (those who have not yet transitioned medically, or do not wish to. E.g. - genderqueer, non-binary) (italics added). Meanwhile in a clinical context, patients who disclose transnormative narratives are rendered intelligible to clinicians and are seen as ‘sick enough’ to access transition-related medicine, and post-medical transition may be seen as ‘no-longer-sick’ (Vipond 2015 p. 29). Inch (2016) extends a similar conversation about trans people who must say the ‘right’ things to clinicians in order to meet criteria for diagnosis and treatment, ‘perhaps overemphasizing their distress’ (p. 197). Conversely, gender non-conforming trans-identified individuals who do not adhere to medical narratives become unintelligible in the face of transnormative medical narratives and risk being seen as too deviant, or even incurable from the perspective of medical providers who are also influenced by these dominant transnormative medical narratives. This is not to suggest that trans people who present clinicians with transnormative medical narratives in order to access transition services are morally bankrupt or to be blamed for the discrepancies experienced by gender non-conforming trans people - regardless of whether those life stories are authentic or embellished. Parens (2013) and Purdy (2001) underscore that many people choose to use medical technologies to enhance their quality of life. Indeed for many trans people who want to transition, gaining access to medical technologies is associated with improved mental health outcomes (Mizock 2017). Yet these choices for trans people are often

limited based on the constraints of transnormative narratives and the ways in which clinicians act as the gatekeepers of mental health care services.

Toward depathologisation

Given the current debates within trans research surrounding shifting diagnostic terminology and advocacy in support of removing GID and GD from psychiatric manuals (see Davy 2015; Drescher 2010; Eckhert 2016; Inch 2016; Johnson 2015), it is also pertinent to consider the concept of ‘demedicalisation’. Demedicalisation references conditions that were once considered medical issues, and then cease to be defined according to medical terms - with medical treatments being no longer seen as appropriate treatments (Conrad 2007). Contemporary research related to the interactions between trans people and health care providers has delineated the over-pathologisation of expressions of gender-variance and called for the depathologisation of trans identity namely through the removal of GD from the DSM and GID from the ICD (Inch 2016; Kosenko 2013; MacKinnon et al. 2016; Snelgrove et al. 2012). While Dewey et al (2016) recognize that many medical personnel aim to depathologise trans identity through providing biological explanations for the emergence of gender-variance, trans people cannot be understood as healthy under a framework that views this phenomenon as a pathology. In fact Inch (2016) suggests that it may be unethical to withhold medical treatments that have been proven to improve trans people’s quality of life unless patients are willing to be diagnosed with a psychiatric illness. For this reason, the complete removal of GD from the DSM and GID from the ICD is argued to be the best path to depathologisation (Inch 2016).

Transitioning from labelling GID to GD is not unlike the rationale provided for the DSM’s 1980 shift from labelling homosexuality as a de facto illness to a focus on the ‘symptomatic’ distress experienced by gays and lesbians. Conrad (1992; 2007) spends considerable attention to studying the processes through which homosexuality first became pathologised and then later depathologised, drawing attention to the potential bi-directionality of the medicalisation of a human phenomenon. For instance, in the early to mid-twentieth century physicians and psychiatrists considered same-sex sexual behaviour and attraction to be pathological and thus much energy was focused on curative conversion therapies (Moleiro & Pinto 2015). In 1952, the first edition of the DSM labelled homosexuality as a ‘sociopathic personality disturbance’, but by

1968 the DSM-II reclassified the phenomenon as a ‘sexual deviation’ (Moleiro & Pinto 2015 p. 2). Conrad (1992) offers homosexuality as perhaps the sole instance of depathologisation through its removal from the DSM-II in 1973. However, scepticism remains concerning the persistent pathologisation of gender and sexuality because in 1980 the DSM-III launched a new category for sexuality disturbances called ‘ego-dystonic homosexuality’, which remained there until 1987. Rather than disordering homosexuality per se, ego-dystonic homosexuality pathologised the impairments and discomfort that individuals experienced as a result of homosexuality, while at the same time legitimizing conversion therapy practices for those who desired to change their sexual orientation (Moleiro & Pinto 2015). Yet there are opponents of the demedicalised homosexuality claim as same-sex sexualities may remain medicalised through HIV and other LGBTQ research and clinical services (Conrad, 1992; 2007; Eckhert, 2016), and pathologised through the current gender dysphoria diagnosis (Conrad 2007; Drescher 2010). Oddly similar to the homosexuality diagnosis, the change in nomenclature from GID to GD discussed extensively by Beek and colleagues (2016) and Lev (2013), limits psychiatric diagnosis to the period of a trans person’s life in which they are distressed about an incongruent gender identity (Drescher 2013).

To summarise, the scholarship surrounding medicalisation and its sibling concepts - normalisation, pathologisation, and depathologisation - laid the groundwork for theorists and empirical researchers to identify and critique practices related to the disordering of gender-variance and pathologising trans identities. Critical works within the domain of trans studies illustrates how access to transition-related medicine is predicated on certain medical transnormative narratives, extending the pathologisation of trans experiences. Meanwhile, this literature also provides ample evidence of the ubiquity of assumptions that trans identity has undergone pathologisation. In the next section, Sadler and colleagues’ (2009) model for verifying the credibility of medicalisation claims is applied using literature that straddles trans studies, medicalisation, and neuroscience research in order to substantiate the claim that trans identity has indeed underwent pathologisation. Before proclaiming that a condition has been medicalised, Sadler and colleagues (2009) caution that researchers should conduct a robust evaluation. As described briefly earlier, this process urges critical scholars to (1) situate the phenomenon in a recent historical context to ensure it is a recent medical development; (2) identify that medical rationales and theories are voiced by society at large or populations within that society; and

verify (3) medicalisation claims by establishing the dominance of medical explanations. While the wording of their approach has been amended slightly to enhance clarity, the integrity of the process is maintained.

CONFIRMING THE PATHOLOGISATION OF TRANS IDENTITY: A THREE-PRONGED APPROACH

1. Historicise how trans identity became viewed as a medical condition

The human phenomenon of gender-variance is not a recent occurrence. Indeed, gender-variance has been present across many cultures globally throughout history (Bartlett & Vasey 2006; Medicine 2002; Stryker 2008). However, viewing gender-variance as a medical condition in concert with specific medical treatments is a relatively recent twentieth century development. Medical work with gender-variant people originated in Western Europe in the 1920s-1930s, creating the contemporary psycho-medical categories of GID/GD. In London, England the first documented vaginoplasties were completed in the 1920s on two biological males who were referred to as ‘transvestite homosexuals’ (Abraham 1997). These surgeries were done out of fear the patients would otherwise self-castrate (Reicherzer 2008). During this time period in Berlin, Germany, SRS experimentation was conducted at the Magnus Hirschfeld Institute for Sexual Science where Dr. Magnus Hirschfeld studied gender-variance and individuals who desired to change their sex (Reicherzer 2008). Hirschfeld ostensibly studied these phenomena out of a personal interest, as he was described as a ‘transvestite and effeminate homosexual’ (Rector 1981 p. 25).

Following the Nazi’s destruction of Hirschfeld’s institute prior to the Second World War, American sexologist Dr. David Cauldwell was influenced to study and classify persons who were determined to live as the opposite sex as ‘psychopathic transsexual’. Cauldwell may have been the first American physician to use the term transsexual, and wrote that:

Transsexuality, although individuals do not thus define it, occurs in a far greater number of people than the surveys have revealed. It would seem that here is a fertile field for research which has been neglected because sexologists, taxonomists, statisticians and others have been looking for such departures from sex codes as those

diversions of the sex instinct known as homosexuality, bisexuality, etc. (Cauldwell 1950 29)

Being uncomfortable with making ethical judgments surrounding human sexual behaviours and desires, however, Cauldwell saw cross-dressing as nothing more than a ‘quirk’, and in complicating the notion that the medical institution was exclusively pathologizing toward gender-variant people, he argued that just like heterosexuals, transsexuals could be mentally healthy or unhealthy (Ekins & King 2001). Yet it may have been Dr. Harry Benjamin’s research, writing, and public speaking that popularized the term transsexual. Benjamin credits himself for using the medical description of ‘transsexualism’ for the first time in a public lecture in 1953, although he also references Cauldwell’s earlier research that described a girl who desired being male as ‘psychopathia transsexualis’ (Ekins & King 2001). And Hirschfeld similarly used the descriptor ‘psychic transsexualism’ (Ekins & King 2001). Ostensibly, the first taxonomising and medical labelling of gender-variant identities and behaviours can be historically traced to these primary pioneering physician-researchers in the 1920s-1950s.

The early period of the medicalisation of trans identity began not exclusively as a venture of cisgender medical authorities pathologizing gender-variance. Rather this process began with early SRS patient advocacy by and for gender-variant people, and a nuanced understanding that trans people’s behaviours and desires could, according to Cauldwell, fall along the continuum of mentally healthy or not (not unlike heterosexuals). Interestingly, it was not until later that trans identity was added to diagnostic manuals of mental disorders, due in part to the ‘trapped in the wrong body’ transnormative medical narratives publicized by trans people. In fact, it was an 1967 autobiography authored by American trans woman Christine Jorgensen who detailed her transition from male-to-female (MTF), describing many of the transnormative medical narratives that remain with us today (i.e. being ‘trapped’ in the wrong body; and having a trans awareness from an early age). This autobiography was endorsed by her physician, Dr. Harry Benjamin, and was highly influential in developing medical narratives for diagnostic criteria. With Benjamin writing a compelling forward to Jorgensen’s autobiography, he provided a medical authority which legitimized that she indeed was once sick, but following HRT and SRS she became a ‘normal’ and ‘healthy’ woman (Reicherzer 2008). Hence, both trans patients and medical providers played distinct roles in the medicalisation and pathologisation of trans identity in terms of

describing which life experiences went on to form the basis of the gender dysphoria diagnosis, and whose authority held the power to endorse these unique character traits as a pathological condition.

Beginning in the late 1970s and early 1980s, interventions to treat gender-variance underwent further pathologisation in terms of moving toward a focus on ‘curing’ gender-variant bodies with biomedical technologies such as SRS and HRT. On par with the discipline of psychiatry in the 1920s-1960s, sexologists’ studies of gender-variance were laced with psychoanalytic and health psychology theory, arguing that gender-variant expressions could be treated with behavioural rehabilitation, including conversion therapy. This is not surprising given that prior to the growth of the pharmaceutical industry approaches to broad mental health concerns were grounded in psychoanalysis and theories of the subconscious (Smith 2014). In the 1950s to 1980s, prescribed treatments for psychological suffering were typically talk-based rather than biomedical or pharmaceutical. In fact, a late 1960s study named the ‘Sissy Boy Syndrome’, funded by the National Institution of Mental Health in the United States, was heavily influenced by psychoanalytic development theories. Findings from this controversial study eventually informed the DSM-III’s first-ever inclusion of GID in 1980 (Reicherzer 2008). But in 1979 Benjamin made a pivotal move creating the Harry Benjamin International Gender Dysphoria Association, urging the medical community to discontinue the use of psychotherapy to cure transsexualism, while citing that biomedical transition technologies, such as SRS and HRT, were superior treatments (Reicherzer 2008). This transfer from psychoanalytic development theories and psychotherapy over to biomedical interventions and pharmaceutical treatments highlights the relatively recent shift in the culture of medical explanations and treatments in connection to the medicalisation and pathologisation of trans identity.

2. Medical explanations for trans identity are adopted by trans people and the culture at large

Today, trans people and their allies may be the loudest force in advocating for increased access to transition-related medical treatments and for adding mandatory trans-specific units to medical education programs (see Collazo et al. 2013; MacKinnon et al. 2016). Along with institutions like the Harry Benjamin International Gender Dysphoria Association, which later became known as the World Professional Association for Transgender Health, trans people and empirical trans

health researchers consistently argue that access to transition-related medicine is vital for the health and well-being of the population, citing that transitioning improves mental health and lowers risk of suicidality (Bailey et al. 2014; Dhejne et al. 2015). These trends within the broader population, and especially amongst trans human rights advocates, indicate that trans experiences are becoming further integrated within a medical model. Yet Johnson (2015) cautions that the DSM's heavy focus on medically transitioning sexes as a necessary action to relieve gender dysphoria tends to obscure some trans experiences, as HRT and/or SRS interventions are not the solution for many trans people, particularly non-binary individuals.

The ways in which trans people embody transnormative medical narratives provides evidence that trans people do voice medical theories. Relying heavily on Benjamin's 1966 book, *The Transsexual Phenomenon*, clinical assessment standards for the diagnosis and treatment of transsexualism [sic] focused on individuals' dissatisfaction and lack of sexual pleasure associated with their genitalia prior to SRS, same-sex sexual desire prior to transitioning, and a convincing performance of the 'opposite sex' (Eckert 2016). Given these constraining and heteronormative clinical assessment tools working alongside the 'born in the wrong body' transnormative devices, trans people quickly learned and performed these rituals. In this way both trans people and clinicians discursively shaped and perhaps even permanently altered the trans identity category (Eckert 2016).

Importantly, the recycling of transnormative medical narratives by trans people in clinical interactions is not explicitly an error on the part of those who desire to medically transition sexes. Rather it may be more of a reflection of the constraints of the psychiatric care system, and the limitations of a 'healthy/morbid' dichotomy (Foucault 1994). Trans people feel that in order to meet their goal of accessing treatment and/or being seen as a legitimate sick person, they ought to say the 'right' thing to clinicians (Inch 2016). Yet a body of critical theoretical literature delineates the underlying complexities of trans peoples' active participation in processes surrounding medicalisation and pathologisation (Butler 2001; Johnson 2015; Vipond 2015). This scholarship underscores the interactionist roles that both trans people and medical personnel play in leveraging transnormative narratives within the growing field of normative discourses of trans identity for the purpose of advancing authentic diagnostic criteria, assessment, and treatment protocol. When trans people locate their gender identity narrative in childhood, using for instance the discursive notion of being 'born this way', it may have the

unintended consequence of re-positioning gender as biologically determined (Davis et al. 2016). In fact, Butler (2004) refers to the courtship between trans patients and providers as an ‘instrument of pathologisation’, highlighting transnormative medical narratives within clinical procedures surrounding diagnoses of GID/GD. However, Butler (2004) also cautions that the inclusion of these diagnoses in medical manuals, and the diagnostic dances performed by patient and providers constructs trans people as ‘ill, sick, wrong, out of order, abnormal...’ and reifies the stigmatization of gender-variance (p. 76). With that said however, earlier research into the dynamics of the trans community from the 1990s (Gagne & Tewksbury 1998; Gagne et al. 1997; Schrock 1996) indicates that at the micro-level, trans people conducted ‘accountability practices that were deeply reliant on the medical model of transgender identity and experience’ (Johnson 2015 p. 807). Practices of community accountability created a culture in which the medical model of trans identity was strictly enforced by trans people through processes of intra-group surveillance, and those who did not subscribe to the medical transsexual narrative (transnormativity) were scrutinized and deemed ‘not trans enough’ (Mog & Swarr 2008). But on the other hand, Butler (2001) poignantly observes the role that trans patients play in coaching other trans people in rehearsing the narratives necessary to espouse the ‘truth’ of transsexuality to pass through this clinical gateway. This is not unlike Conrad and Bergey’s (2014) discussion on the role of patient advocacy groups in assisting others in being knowledgeable of diagnostic criteria in order to receive necessary diagnosis and treatments.

3. Medical theory for trans identity gains traction over any other explanation

The final stage of verifying the pathologisation of trans identity is relatively uncomplicated. Given that there are no explanations for the existence of trans people that lie outside of the psycho-medical domain that the author is aware of, it can be stated that medical theory provides us with the strongest explanation for the trans phenomenon. This has arisen in a few notable ways, but particularly through the medical community’s exclusive focus on treating or even ‘curing’ gender dysphoria with biomedical and pharmaceutical interventions such as HRT and SRS, and through the emergence of neuroscientific research studies that search for distinct trans brains.

The existence of neuropsychology research, including neuroimaging technologies such as magnetic resonance imaging (MRI), operates in

concert with the medicalisation and pathologisation of trans identity. Asking whether the brain phenotype of a trans person more closely resembles that of their natal sex or that of their gender identity group, neuropsychologists delve into brain imaging studies (see Kreukels & Guillamon, 2016). For instance Hahn and colleagues (2015) found that pre-HRT MTF and FTM trans subjects' have unique structural connectivity in comparison to female and male 'healthy' controls. In fact, a number of similar studies have found that trans subjects' brains more closely matched those of their same gender identity 'healthy' controls than to those of their same biological sex in terms of neurons and subcortical nuclei (Zhou et al. 1995; Garcia-Falgueras & Swaab 2008), and structural distinctions of gray (Simon et al. 2013) and white matter microstructure (Rametti et al. 2011a; Rametti et al. 2011b). For example, it has been shown that the size and number neurons found in the striata terminalis and the anterior hypothalamus of MTF trans people was typical to that of females (Zhou et al. 1995). In all of these studies, MRI, diffusion tensor imaging, or voxel based morphometry data is used to compare images of trans people's brains prior to, or following, HRT treatments in order to draw boundaries around the brain of people who experience gender dysphoria and identify as trans. Simon and colleagues (2013) summarise neuroscience research related to gender dysphoria. They explain:

A recent review about sexual differentiation of the human brain, transsexualism [sic] might be the result of the fact that the development of the sexual organs in the fetal life occurs well before the sexual differentiation in the brain... The disturbance of the testosterone surge that masculinize the fetal brain might be at the background of GID in certain cases (p. 1).

However interesting these findings are, this area of research contributes to the development of biomedical scientific knowledge that seeks to study, quantify, taxonomise, and provide medical explanations for abnormalities, underscoring Foucault's (1994) healthy/morbid dichotomy. As there continues to be skepticism toward research that searches for a 'gay gene' (see Servick, 2014), neuroscience researchers examining images of trans people's brains in order to discover differences in regional brain alterations and structural networks should proceed with much caution and hesitation. Echoing research that aims to discover a gay gene, brain scans attempting to map the brains of trans people is at best a feeble attempt to make sense of a complex schema of

human behaviours, and at worst, may hold the potential of creating a range of future ethical issues such as verifying whose brains are authentically trans and worthy of health insurance funded treatments, or perhaps even selective abortion practices.

Despite much controversy psychiatric researchers and clinicians working in the area of gender dysphoria continue to label trans identities as a mental health condition, as evidenced in the DSM-5 (APA, 2013). Opponents of psychiatric medical theory remind us, however, that trans identities are not expressions of ill health, but merely deviations of social norms, and ‘diagnosis of gender incongruence should not, therefore, imply pathology (Walsh 2017 p. 98). In fact Parens (2013) identifies psychiatric geneticists that state that variations in species is normal and conditions that are thought of as ‘mental illness’ are nothing more than the quantitative extreme of a normal distribution of traits. Even still, some researchers argue that the association of trans identity with mental illness is spuriously predicated on an anachronistic belief in binary gender roles and the power of Western psychiatry to define what is normal or deviant (Inch 2016; Walsh & Krabbendam 2017).

In sum, by using Sadler and colleague’s rubric, it has been shown that trans identity was pathologised through various clinical interactions between trans patients and medical personnel, advocacy on the part of trans individuals, and the creation of discipline-specific clinical knowledge by physicians and researchers. This confirms the ubiquitous claims within academic and grey literature that trans identity has been pathologised. The article now concludes with a discussion of the limitations of this research and future directions below.

Limitations of this work and future directions

While this article substantiated the claim that trans identity has undergone pathologisation, there are many limitations to discuss. First, a scan and summary of the relevant scholarly literature was conducted to illustrate the social processes that enabled the pathologisation of trans identity. However, a full scoping or systematic review is warranted in order to evaluate the rigor of included studies on the basis of application of theory, data analysis, and in some cases, statistical validity. Admittedly, this inquiry included only English-language articles that discuss the Western European, American, and Canadian context. To fill this gap, future work in the area of the medicalisation and pathologisation of trans identity could look at the applicability of this article’s argument in non-Western contexts, and perhaps even examine

the association between globalisation and the expansion of the GID/GD diagnosis in international contexts.

This conceptual project lacks the empirical validation that is necessary to generate a more robust analysis of how these processes culminate in pathologisation. In particular, future directions should prioritise harnessing the experiences of both trans patients and medical providers who provide health services to trans people. While the few empirical studies discussed in this article do include researchers' speculations on how pathologisation shapes the clinical relationships between trans patients and providers, the voices of those who directly contribute to the pathologisation of trans identity is largely absent. Hence, future studies may consider conducting qualitative interviews or focus groups with trans and non-binary folks on themes related to medicisation and pathologisation. Given that the vast majority of qualitative research in the area of trans health solely engages the experiences of trans people, it is crucial to balance these perspectives by hearing from medical professionals. For instance, empirically collecting the insights of medical professionals who are critical of the medical model of gender-variance and the pathologisation of trans identity, and for whom inclusion of GID/GD in diagnostic manuals ought not to be a precondition of transition-related health care. Capturing these counter-viewpoints and publishing these ideas in high-impact medical and other applied healthcare journals is likely to influence the belief systems of physicians and other professional health providers (MacKinnon et al. 2016). And given the positive correlations between trans-related stigma and poor mental health outcomes, quantitative researchers may instead take up an exploration of rates of stigma and mental health conditions in jurisdictions undergoing depathologisation - where assessments for SRS and HRT are transitioning from the domain of psychiatry to primary care.

Lastly, in recognizing the literature's consensus that the inclusion of GD in the DSM and GID in the ICD contributes to the pathologisation of trans identity and subsequent stigma faced by trans people, complementary research could investigate the impact that clinical texts have on trans patients and medical providers. For his unpublished master's thesis Rowe (2009) conducted an institutional ethnography into trans men's experiences accessing health care services in Ontario, Canada. However, there are no known published studies that analyze the ways in which these clinical texts shape, constrain, and rule the clinical relationships between trans service users and service providers.

CONCLUDING REMARKS

Through this conceptual exploration the ubiquitous claim that trans identity was pathologised has been rigorously verified. Yet the status quo assertions that pathologisation was something done to trans people by agents of the medical institution was jettisoned in favour of a critical inquiry into the interactionist and relational roles played by both trans patients and medical personnel that contributed to this phenomenon. Using a three-pronged conceptual model developed by Sadler and colleagues (2009), it was shown that trans identity was embedded within a medical model and underwent pathologisation through social and clinical processes beginning in the mid-twentieth century. The recommended next steps of this project include conducting an enhanced systematic or scoping review, empirically studying the associations between trans-related stigma, pathologisation/depathologisation, and mental health outcomes, and investigating the ways in which clinical texts such as the DSM and the ICD shape the provision of mental health services for trans people and clinicians.

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