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Stigma, Cisgenderism, and the Pathologization of Transness

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Abstract:

Cisgenderism is the culture and system, constituted by both ideology and practice, that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned sex at birth. Medicine and law are jointly deterministic of the wellbeing of transgender people. This analysis seeks to explore how stigma, operationalized by cisgenderism, manifests in legal and medical structures to negatively impact the wellbeing of transgender people. Thus, this analysis begins with the definition of key terms necessary to understanding concepts related to sex, gender, and gender variance. After delineating how stigma operates, the recent history of transness is outlined and is proceeded by a discussion on deviance and institutional repression. After examining the evolution of pathologizing codes for gender variance in the ICD and DSM, the essay concludes with a discussion of depathologization activism and liberatory legal models for trans self-determination.

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I. Introduction:

The interwoven mechanisms of medicine and law are jointly deterministic of the wellbeing of transgender people. This is problematic when considering the cis-normative structuring of both institutions.⁵ Thus, this analysis seeks to investigate how cisgenderism, operationalized via stigmatizing processes, manifests in legal and health-related domains to negatively impact transgender people. This essay focuses on the U.S. but these systems are interlinked globally albeit with different specific modalities. The aim of this analysis is to explicate specific instances of discrimination against transgender people in both spheres, to explore opportunities for systematic change to lessen the extensive destructive reach of cisgenderism and its resulting gender-based discrimination, and to point to the multiple embodied and violent consequences on the wellbeing and longevity of transgender people.

Road Map: How Does This Essay Proceed?

This essay begins with the definition of with key words relevant to the operation of ideas in concepts relating to sex, gender, and gender variance. These terms will be defined with consideration to stigma as a tool of cisgenderism, and in particular its operation in law and medicine with attention to the concept of embodiment, as this is a register in which rights injuries can be seen and made visible. The essay proceeds by tracing the history of how recent understandings of transness came to be constructed in the context of deviance and institutional repression. This essay then outlines the evolution of pathologizing codes for gender variance in the ICD and DSM, followed by discussion of depathologization activism and liberatory legal models for trans self-determination.

II. Key Terms and Concepts:

Due to the potential discordant understandings of sex, gender, and related terms, along with variation in definitions across various academic and activist domains, this discussion on anti-transgender stigma and discrimination will provide definitions of relevant terms which will appear in this analysis. Defining terms offers a more precise delineation of relevant concepts and therefore produces more effective, accessible, and productive commentary on the various forms of stigma faced by transgender people, interpersonally and structurally, in legal and medical domains. Thus, for the purposes of this work on anti-transgender stigma and the relevance to the affected groups, terms related to sex, gender, and expressions of each will be defined from public health and legal works.

Sex is a term referencing a particular taxonomic construct premised upon biological characteristics enabling sexual reproduction, which people categorize variously in relation to secondary sex-characteristics, such as sex chromosomes and genitalia.¹ Secondary sex characteristics are the socially agreed upon biological criteria which are used to categorize, or assign, people at birth as male, female, or intersex.¹ Although often conflated with gender identity, sexed bodies are not the basis for gender, but are the referent that is used to produce the male and female binary conception of gender, which produces such sexed bodies.¹⁴ In other words, sex is not determinative of gender but is the reference from which gender and ideas of what it means to be gendered (i.e. norms) are conceived.

What is often perceived to be a “naturally gendered body” is in fact a socially mediated product.¹⁷ **Gender**, which is the conducting of one’s self in accordance to activities and attitudes deemed normatively acceptable for an individual’s sex category, was introduced to describe the sociocultural constructs that assign roles, behaviors, forms of expression, activities and attributes according to the meaning given to biological sex characteristics.^{2,6} Gender as a term first

appeared in feminist writings in the 1970s to challenge the then-dominant position of biological determinism, by which membership to dominant and subordinate groups is ascribed by supposed connection to or causation by biological processes and traits.^{2,3} Among scientific and medical professionals at the time, gender emerged amid similar debates about “transsexuality” and the explanatory powers of biology and psychology, the merits of sex-change operations, and the resulting increased advocacy and acceptance of “transsexuality” vis-à-vis sex assignment surgeries, leading to the medical gatekeeping of transness by medical professionals before seeking both gender-affirming treatment and amendments to sex on legal documentations.^{4,5}

Variants of the term **transgender** first appeared in the 1960s among self-organized communities of self-described “transgenderists” to counter medical and scientific labeling as transvestites, a term with erotic connotations, and transsexual, a term related to medicalized body transformations for the purposes of legal sex change and accomplishment of gender norms.¹¹ Transgender emerged to “convey a nonpathological sense that one could live in social gender not...associated with one’s biological sex or that a single individual should be able to combine elements of different gender styles and presentations.”¹¹ Thus, transgender represented a resistance to medicalization, pathologization, and efforts of the administrative state to limit the disruptive potential of sex and gender variance.^{11,31}

The term transgender burgeoned in the early 1990s amid shifts in attitudes toward the meaning and purpose of gender and gathered together multiple historical shifts in how sex, sexuality, gender, identity, and embodiment are conjoined.¹¹ The term, with broad intellectual reach, also represented how constructs related to gender might be reconfigured.¹¹ Although the term transgender was initially deployed in legal and public health works with great liberatory potential, the label evolved into one that reduces, and potentially extinguishes, the diverse

expressions and differences of various gender variant groups into a singular category.¹¹ Thus, with attention to the diverse expressions the term encompasses, transgender is defined as persons whose gender identity does not correspond with their sex assigned at birth.² Transgender can also be understood as persons whose gender identity and/or gender expression are at odds with gender norms in a particular context at a particular point in time.² For the purposes of this work, transgender can be considered an umbrella-term that encompasses gender-variant, gender non-conforming, and gender-diverse persons, all of whom depart from societal expectations and norms around gender.^{2,8} **Cisgender** refers to persons whose experience of gender aligns with their sex assigned at birth.²

In the context of international human rights law, gender is treated as a construct pertaining to persons in gendered societies, and gender analysis is used to elucidate preconceptions and power hierarchies that create the context for the development of each individual's personal identities and social interactions.² Gender can manifest as experiences of both privilege and discrimination, such as having identification documents that align with experienced gender, which can either contribute to full participation in society or experiences of discrimination.^{2,46} Thus, gender theory can be conceptualized as a tool to assess and transform inequitable systems based on gendered power hierarchies.² Given these considerations, this essay uses cisgenderism as the entry point onto the following discussion of anti-transgender stigma and discrimination.

In sum, **cisgenderism** is defined as the culture and system, constituted by both ideology and practice, that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned sex at birth; furthermore, in addition to denigrating diverse expressions of gender identity, cisgenderism depreciates associated behavior, expression, and community.⁷

Cisgenderism creates a system of power and privilege that endorses and perpetuates the belief that cisgender identities and expression are valued more than transgender identities.⁷ As a framework for analysis, cisgenderism emphasizes the cultural and legal institutions that penalize gender variance and enable prejudice and discrimination against the transgender community.⁷ Cisgenderism offers a full system analysis of the interplay of sex, gender, race, and embodiment. Thus, for this assessment of the work done by and effects of anti-transgender stigma, cisgenderism will be the lens from which asymmetries of power that lead to violence and discrimination against transgender people in both legal and healthcare domains will be assessed.

Intersectionality, Sexual Hierarchies, and the Stratified Work of Cisgenderism:

Although cisgenderism will be the primary focus of this work on anti-transgender stigma and discrimination, it would be remiss to not acknowledge and incorporate the multiple lines of oppression that operate in alignment with cisgenderism to differentially harm transgender people. As cisgenderism is stratified across hierarchies, the intersectionality framework will be key in the subsequent analysis and discussion on cisgenderism. For the purposes of the definition, it is important to note that sexuality and gender have been historically conflated and marginalized along similar lines of oppression, and thus in this instance, transness will be considered alongside lesbian, gay, and bisexual sexual identities.¹² The intersectionality framework was introduced into law by Kimberlé Crenshaw and now refers to scholarship or politics interested in the ways in which multiple systems of oppression, such as racism, patriarchy, and heteronormativity “impact differently situated individuals differently.”¹⁵ As an analytic tool, intersectionality considers how categories such as race, class, gender, and sexuality are both interrelated and co-constructed, and “...how intersecting power relations influence social relations” across diverse societies and everyday individual experiences.⁴⁷

Race and transness: When approaching issues of racial bias and discrimination from cisgenderist viewpoints, unless transness is explicitly stated, or deviation from the gender norm is overtly expressed, cisgender identities might be presumed.¹⁵ This, in turn, erases the oppression of transgender people and transgender people of color, and precludes them from receiving the “activism and creative analysis of anti-racist theorists and activists.”¹⁵ Race and transness can be assessed not only at the micro level, as they pertain to the experiences of individuals, but also at the macro level, by which racial and sexual discourses can be used to investigate how systems of racial and sexual oppression intersect to predispose transgender people to both racially and gender-motivated violence.¹⁵ The intersection of race and transness is particularly important considering the co-constitutive nature of both race and gender, alternatively stated as the ways in which race informs our understandings of gender and gender informs our understandings of race.¹⁵

Whiteness: Foundational to any discussion on race within an American context is an understanding of whiteness and the ways in which constructions of gender sustain racialized hierarchies of leadership, authority, and credibility; from a cisgenderist and intersectional perspective, this would be expressed through constructions of gender centered around being white, being perceived as white, or upholding white standards of beauty.¹⁶ The racialization of acceptable expressions of gender expression can be likened to that of a sexual hierarchy, similarly intersecting with race, class, and gender, by which varying expressions of gender are ranked from the “most normative and socially approved” to the “most stigmatized and despised,” based on their relation to whiteness.¹⁸ Although the transgender identity is disruptive to norms around sex and gender, it is less disruptive and more acceptable when embodied by a person with race privilege, such as a white person in the United States.¹⁵

For instance, popular discourses around transness and its related biology, psychology, and involvement with medicine within the United States erupted in the 1950s upon the return of Christine Jorgenson, a white, heterosexual woman, assigned male at birth, from her sex change surgery in Denmark.⁴ Jorgenson was described as “the personification of glamour, akin to a Hollywood starlet on the rise,” and her journey was granted 50,000 words across the three major wire services.⁴ This stands in contrast to the experience of Delisa Newton, a Black transgender woman who had received a sex change operation in the same period; in contrast to Jorgenson’s presence in the mainstream media and characterization as a celebrity, Newton only appeared in tabloids or publications catering to Black communities, with the tone being more salacious than sympathetic.¹⁵

The emergence of the mainstream discussion on transness within the United States centering around Jorgenson, a “safe” white trans woman who disavowed homosexuality and emphasized her aspirations to marriage and domesticity, tracks with the notion of a racist, cisgenderist society willing to accept the least transgressive of a transgressive group.¹⁵ This stands in contrast to Newton’s blackness and the ways in which Black sexuality, in the context of homosexuality, has been associated with “culpability and pathology” whereas white sexuality has been associated with “victimhood and innocence.”^{4,15} Historically, perceptions of legitimate transness demanded that gendered attributes of maleness or femaleness align with standards of whiteness such as the being perceived as white, acting white, and subscribing to white standards of beauty.¹⁶ For instance, in the 1960s and 1970s, Puerto Ricans were unintelligible as trans but instead dismissed to be “fags,”; similarly, Black transgender individuals, who subscribed to Black standards of beauty, did not receive the same recognition as Jorgenson in spite of enunciating their desires to transition before her.^{15,16}

Embodiment: Embodiment refers to how we humans biologically incorporate, or embody, our social and ecological context.⁴⁷ Embodiment advances claims that bodies tell stories about the conditions of existence, including those stories that people will not tell or do not tell because, “they are unable, forbidden, or choose not to tell.”⁴⁸ Embodiment can be conceptualized as an analytic tool to challenge “dominant narratives of disembodied genes and decontextualized behaviors.”⁴⁷ Nancy Krieger introduced the embodiment of social systems and interactions to public health as part of her 1994 ecosocial theory of disease distribution, which emphasizes the importance of, “multilevel spatiotemporal processes of embodying (in)justice, across the lifecourse and historical generations, as shaped by the political economy and political ecology of the societies in which people live.”⁴⁸ Embodiment rejects notions of biological determinism and instead embraces “embodied integration” which emphasizes that the drivers patterning unjust disease distributions and health inequities are external to individual bodies.^{47,49} Ecosocial theory is focused on evaluating whether health inequities are avoidable, preventable, and produced by unjust systems.⁴⁷ In other words, transgender health disparities can be understood as the embodiment of a lifetime living in a highly stigmatizing, cisgenderist context. Instances of stigma and discrimination can thus be understood to be incorporated in the very bodies of transgender people to impact their health differentially.⁴⁷

Figure One: Key Terms for Consideration

Key Term	Definition
Sex	Biological construct premised upon biological characteristics enabling sexual reproduction, which people categorize variously in relation to secondary sex-characteristics, such as sex chromosomes and genitalia. ¹
Gender	The conducting of one’s self in accordance to activities and attitudes deemed normatively acceptable for an individual’s sex category. ⁶
Transgender	Persons whose gender identity does not correspond with their sex assigned at birth. ²
Cisgender	Persons whose experience of gender aligns with their sex assigned at birth. ²
Cisgenderism	The cultural and systemic ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behavior, expression, and community. ⁷
Intersectionality	A framework of analysis for the scholarship or politics interested in the ways in which multiple systems of oppression, such as racism patriarchy, and heteronormativity “impact differently situated individuals differently.” ¹⁵
Whiteness	The ways in which constructions of gender sustain racialized hierarchies of leadership, authority, and credibility. Within the U.S., it is “an economy of value around light-skinned trans people.” ¹⁶
Embodiment	How we humans biologically incorporate, or embody, our social and ecological context. ⁴⁷

III. Conceptualizing Anti-Transgender Stigma: What is it and How Does it Work?

Cisgenderism is the pervasive cultural and systemic ideology, embedded within the framework of legal and healthcare domains, that enforces a hierarchy by which individuals are expected to conform to cis gender norms and punished if they do not; it is through an analysis of the power asymmetries, inequality, and violence foundational to cisgenderism that this pervasive ideology, and its related manifestations, can be identified, conceptualized, and addressed.^{2,7}

Multidisciplinary research on stigma proliferated after the publication of Goffman's 1963 book *Stigma: Notes on the Management of Spoiled Identity*, in which stigma is explicitly defined as a deeply discrediting attribute that reduces the bearer "from a whole and usual person to a tainted, discounted one."⁹ Stigma, a concept employed and variably defined in many multidisciplinary works, has been synthesized and defined by social epidemiologists Link and Phelan as the co-occurrence of four components: labeling, stereotyping, separation, and status loss and discrimination, all in the context of power exercised by hegemonic groups.⁹ Per Link and Phelan's typology, stigma is operationalized by hegemonic groups to serve three functions: exploitation and domination, norm enforcement, and disease avoidance.¹⁰ Anti-transgender stigma can also be conceptualized via Jones and colleagues' dimensional conceptualization of stigma, by which stigmatized attributes can be understood via concealability, course, disruptiveness, aesthetics, origin, and peril.¹⁰

This work ensures that stigma is not treated as an internal, individually subjective experience but catalogued for its structural and interpersonal operation—in this way stigmatizing practices can be mapped and made the subject of reform and redress. From the vantage point of cisgenderism, the components of anti-transgender stigma can manifest in legal and health-related domains to exert cisgender dominance over transgender people, to enforce cis-gender norms, and

reflect hegemonic pressures to avoid purported illness vis-à-vis the pathologization of gender divergence.¹⁰ From an intersectional perspective, stigma can operate through cisgenderism to uphold whiteness, culturally and institutionally, and sanction non-white expressions of gender.

The first component of Link and Phelan's conceptualization of stigma is that of *labeling*, by which differences are socially selected for salience and a label is affixed.⁹ It is through the notion that there is a gender norm from which identities and expressions can either vary or depart, that differences in expression or self-identification can become salient and affixed a label.² This first instance of labeling initiates the lifelong involvement with a legal gender system that directs people into "pre-existing gender channels," through a "dense mesh of documentation," such as birth, death, and marriage certificates, state-issued identification documents and government forms, medical reports, military records, educational certificates and diplomas.¹⁹ It is this mesh of documentation that constitutes a cis-gendering system that constructs social relations based on such gender categorizations and "corrects" or eradicates that which does not conform to cis-gender norms and expectations.¹⁹

Given that gender is the conducting of one's self in accordance to activities and attitudes deemed normatively acceptable for an individual's sex assigned at birth, it is fundamentally through interactions and institutions that the initial assignment of sex and normative expectations for sexed behavior are created, and that deviance from these expectations is sanctioned.⁶ The gender system can be conceptualized as part of the machinery through which our bodies are rendered fit for the, "state, society, and capital formation."¹⁹ It is through this administrative machinery that gender variance becomes a pathology to be fixed, with actors within healthcare domains establishing themselves to be the normalizing power to produce men and women and eliminate deviation from gender norms.¹⁹ Thus, anti-transgender stigma begins at birth through

labeling via the assignment of a sex at birth and the following expectation for conformity to gender norms in child rearing settings.⁵ This notion of “correcting” gender nonconformity appears in historical medical constructions of gender identity disorder of childhood within International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) codes.¹² These constructions uphold the notion of a normative childhood gender and subsequently produce deviant expressions of childhood gender.⁵ Through the assignment of a sex at birth and its corresponding behavioral expectations, the gender nonconformity expressed among “tomboys and sissies” might be pathologized and constitute the diagnosis of gender identity disorder of childhood.⁵

In addition to labeling gender variance, the historical inclusion of gender identity disorders within diagnostic codes is also reflective of stereotyping due to its associations with illness.¹² It is through deviance from anticipated gender norms that trans expressions of gender are selected for salience, affixed a label, *stereotyped*, denigrated and pathologized.¹² Pathologizing and stereotyping create distinctions between the purported “us” and “them,” and are reflected through depictions within scholarly journals characterizing trans people as having illnesses and being in need of treatment.⁴ This relates to the third component of anti-transgender stigma, which is the *separation* of transgender people due to the labeling of gender variance and its associations with illness.⁹ This is reflective of stigma’s functions of both norm enforcement and disease avoidance.⁹ This separation of a transgender ‘other’ is also seen in the binary sexing of legal documents that underpin everyday interactions, such as the requirement on birth certificates, passports, drivers licenses and the resulting “uncategorization” when gender conventions and expectations are not met.¹⁹ Stereotyping and separation can be also be indicated in historical portrayals of transgender people as “freaks and perverts” in various media.⁴ This

creation of a transgender “other” erases the diversity of transgender identities and individuals, homogenizing them into a deviant, monolithic mass on a mission to “attack normalcy” and defy a “god-given natural order.”²⁴

This relates to both the *course and origin* components of Jones’ and colleagues’ dimensional conceptualization of stigma. Course is the extent to which a stigma persists over time and origin is whether the stigma is believed to be present at birth, accidental, or deliberate.⁵⁵ Origin is tied to the construct of onset controllability, which is the extent to which a stigmatizing status is perceived to be a choice that could have been avoided.⁵⁵ Onset controllability is relevant because stigmatized attributes perceived to be onset controllable, meaning perceived to be avoidable, elicit hostility and avoidance.⁵⁵ Attributes perceived to be onset-uncontrollable, or unavoidable, such as physical disabilities or cancer, tend to elicit pity and helping behaviors.⁵⁵

With regard to Jones’ and colleagues’ dimensional conceptualization, gender nonconformity may be perceived as having higher onset controllability and thus evoke feelings of coldness and aggression.¹⁰ Given that some transgender people feel they have to, or choose to present themselves in a way that departs from gender norms, transphobia is a common encounter and is expressed in forms of violence, discrimination, disgust, and aggressive behavior.¹⁹ This also relates to the aesthetics component of Jones and colleagues’ dimensional conceptualization of stigma, which is the potential for stigma to evoke a disease-avoidant disgust reaction.¹²

The concealability component of Jones and colleagues’ dimensional conceptualization of stigma is the extent to which a stigmatizing attribute is visible to others.¹⁰ Although concealability can be beneficial in certain circumstances by enabling trans people to “pass,” and avoid disease-avoidant reactions, its role in transgender history is that of erasure by which

gender in legal documents was determined by genitals.⁴ This led to the endorsement of sex-change surgeries by physicians to conform to binary gender norms to evade mistreatment and to allow for legal sex change, bolstering the medical establishment's authority as gatekeepers of transness.⁴ The historical medical push to "cure" gender variance through sex-reassignment surgeries and requirements for sex reassignment surgery to permit sex-changes on legal documents jointly reinforce binary gender norms and render both transitioned people and other forms of gender variance invisible.^{5,20} The movement towards medicalized gender conformity aimed to enable gender variant people to pass from one socially acceptable binary expression of gender to another; although this may seem progressive, it upholds an exclusive, medicalized, framework of conceiving transness at the expense of non-medicalized, culturally diverse expressions of gender variance.^{20,25}

The fourth component of Link and Phelan's conceptualization of stigma is that of *discrimination and status loss*, with an understanding that discrimination can occur at individual and structural levels. Structural discrimination encompasses institutional practices that uphold cisgenderism and work to disadvantage gender diverse groups; individual discrimination is whether an individual's labeling and stereotyping of another person leads to mistreating them.⁹ In the context of cisgenderism, a transgender person's deviance from gender norms that leads to the labeling of their deviance and association with negative attributes, constructs the rationale for the devaluing, rejecting, and excluding them.⁹ This relates to dimensions of disruptiveness and peril. Disruptiveness is the extent to which stigma interferes with smooth interactions and peril is the extent to which stigma poses a personal threat or potential for contagion.¹⁰ For instance, the gendering of common identifying documents such as passports and drivers licenses can increase opportunities for experiences of violence and discrimination when cisnormative expectations for

gender norms are not met.⁵ When denied identity documents accurately reflecting their gender identity, transgender people are cut off from work opportunities, denied public services, and are subject to systematic, underreported discrimination in a variety of domains.¹⁹ Considering the disruptiveness of presentation not in alignment with cis expectations for gender expression and the structuring of everyday institutions around gender, not only can common interactions elicit negative reactions, but they may be perceived as threats to the structuring of the very institutions themselves and elicit violent reactions.¹⁹

The Stigma-Sickness Slope

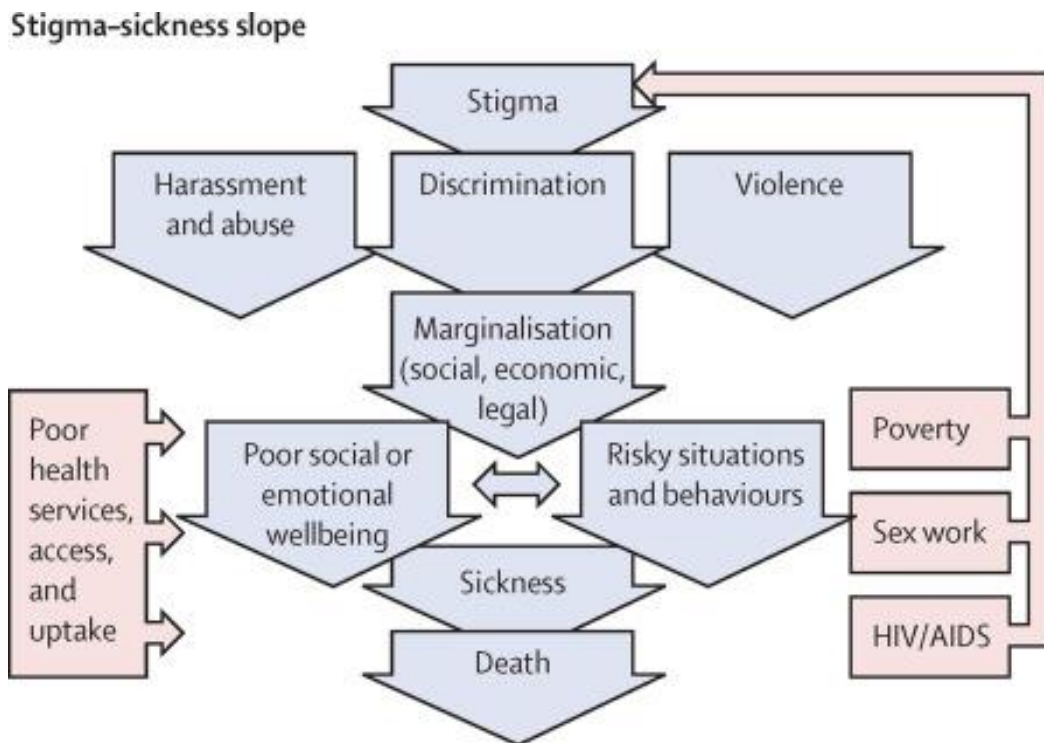
The complex relationship linking stigma and discrimination to adverse health outcomes has been illustrated through the stigma-sickness slope.²² The stigma-sickness slope, which was developed by the United Nations Development Program, has been conceptualized as a slope that transgender people are placed on by stigma and prejudice that prompts patterns of discrimination, harassment, and abuse in family, school, work, the provision of services, and in broader society.²¹ This marginalization and discrimination places transgender individuals at risk for poverty and engagement in high risk behaviors, such as risky sex and substance use, that eventually lead to ‘sickness’ or negative health and social outcomes, such as poor mental health, HIV infection, and poverty.²² The stigma-sickness slope exemplifies the embodiment of discrimination, which refers to how people incorporate, biologically, “the material and social world in which we live” across the lifecourse.^{23,47} It is through this embodiment of a highly stigmatized social context that vast health inequities arise, such as “significant levels of psychological distress and a disproportionate burden of poor mental and physical health concerns” arising from the instances of discrimination, harassment, maltreatment, and victimization that many transgender people face on a daily basis.²²

Experiences of rejection at an early age, such as bullying in school, may place gender non-conforming youth at risk for “isolation, school academic performance issues and school dropout.”⁵⁰ For instance, 36% of respondents to a national study of transgender individuals reported having to leave school because of gender identity-based harassment.⁵³ In addition to issues at school, transgender youth are subsequently placed at risk of “homelessness, substance use, and suicide.”⁵⁰ Thus, discrimination at school leading to poor academic performance or drop-out may place trans people “at a crucial disadvantage when they enter the workforce.”²² Furthermore, even if transgender people are qualified, they are often faced with employment discrimination when seeking work.²²

Thus, many transgender people are compelled to work in illicit economies and perform sex work or sell illegal drugs to make ends meet.^{22,51,53} Due to exclusion from “legitimate economies,” trans people are at “significantly increased risk of acquiring HIV” and being arrested and detained.⁵⁴ Furthermore, many transgender people face harassment and assault for not conforming to cis gender norms, which are “forms of victimization associated with depression, anxiety, somatic symptoms, posttraumatic stress disorder (PTSD), suicidality and substance use.”^{53,54} As external stressors are faced along the increasing gradient of the stigma-sickness slope, transgender people are exposed to increased risks for HIV infection.²² The disproportionate rate of HIV diagnoses among transgender people, particularly transgender women, reflects the embodiment of a lifetime of discrimination placing them on a slope to increased risk of infection.²² For instance, transgender Americans were three times more likely to be diagnosed with HIV than the general population; furthermore transgender women are 49 times more likely to be living with HIV infection worldwide.²²

The multiple levels and forms of discrimination faced by transgender people and their related impact on health reflect how distributions of health are driven by power, including power constraints, and the ways in which it structures people’s engagement with the world “and their exposures to material and psychosocial health hazards.”²³ Thus, when conceptualizing stigma, discrimination, and transgender health, causal pathways involving exposure, susceptibility, and resistance should be understood under the auspices of both societal arrangements of power, property, and patterns of production in addition to the constraints and possibilities of biology, which are shaped by evolutionary history, ecologic context, and individual history.²³

Figure Two: The Stigma Sickness Slope²⁸



IV: Exploring Repression and Resistance Through Practices of Cisgenderism in the Sites of Medico-Legal Control

It is through the four interrelated components that the various dimensions of anti-transgender stigma are expressed, and cisgenderism operates to perpetuate and enforce binary gender norms, both structurally and interpersonally, leading to the experiences of rejection, exclusion, and violence against transgender people. However, with the emergence of sites of controls, sites of resistance also emerged, by which “homosexuality,” then conflated with gender variance, could speak on its own behalf and demand that its legitimacy be acknowledged, using the same vocabulary by which it was being disqualified.¹⁴ Although legal manifestations of the gender binary, upheld by the medical model of transness, produced a category of deviation and increased anti-transgender stigma, decades of political activism by transgender people fostered conditions in which transgender people could speak and advocate as experts on themselves.^{5,19} Thus, the aim of the following discussion is to trace the historical and theoretical origins of recent constructions of transness and how they came to be subject to pathologization and medical control.

The Productive Nature of Power

In describing the productive nature of power, Foucault refers to the ways that “sexuality is organized in law, medicine, and sexology” and how sexual identities have been manufactured through institutional and cultural practices.^{14,32} The productive nature of power stands in contrast to sexual essentialism, in which sex is understood as an ahistorical and “...natural force that exists prior to social life and shapes institutions.”³⁵ As an alternative to sexual essentialism, Foucault suggests a discursive determinism as, “...we are judged, condemned, classified, determined in our undertakings, destined to a certain mode of living or dying, as a function of the true discourses which are the bearers of the specific effects of power.”^{34,35} In the *History of Sexuality*, Foucault argues against a natural, libido-centered understanding of sexuality to one

that is produced through "...historically specific social practices" and discourse.^{34,35} Simply put, Foucault argues that the way matters pertaining to sexuality are discussed, such as sex and gender, determine the parameters of acceptability and destiny of people who embody particular understandings of sex and gender.

Through the construction and acceptance of normative sexualities, non-normative expressions of gender and sexuality are concurrently produced and subject to formal and informal sanctioning. For instance, when conceptualizing the construction of normative sexualities through dichotomies, "resistance is the "other" of power-just as sickness is the "other" of health, madness is the "other" of reason, and deviance is the "other" of normality."³⁴ Similarly, "a biopolitics of health produces disease...and as we search for normal sexuality we uncover only ever more perversion."³⁴ It is from this understanding that deviance is constructed concurrently with normative standards that we can trace how our recent constructions of gender and sexual norms came to be and thus, how cisgenderism in its contemporary form came to take its shape. Understanding the recent construction of heterosexuality is vital to understanding how our modern constructions of transness have been produced, through the definition of a norm and the subsequent conceptions of deviation from it. It is through critical analysis of how contemporary constructions of acceptable sexualities came to be that the origins of cisgenderism can be traced and its contemporary form understood.

The Invention of Heterosexuality

In his 1995 book *The Invention of Heterosexuality*, Katz outlines the "time-bound and culturally-specific" recent developments in sexual categorization and how heterosexuality came to uphold proper, normative cis-gender relations within the United States.³³ Katz begins by describing the Early Victorian True Love era in the United States (1820-1860), in which sexuality demonstrated through procreation and marriage was the standard for proper manhood

and womanhood.³³ The True Love era was characterized by an essential manhood and womanhood characterized predicated on a “purity” attained through freedom from sensuality, reproduction, and “producing a new set of correctly gendered women and men.”³³ It was between 1860 and 1892, in what Katz deems the Late Victorian Sex-Love era, that family was transformed from a “producer to consumer unit,” and the body was understood from being an instrument of work” to a “means of consumption and pleasure.”³³ This fostering of a pleasure ethic corresponded with the growth in the consumer economy; it also corresponded with a shift in sexual and economic ethics from values of economic production and human reproduction to those that extolled economic consumption and an “erotic pleasure principle” for women and men.³³

During this era, medical doctors rose in power and prestige and began defining new standards for male-female relationships.³³ Through the medical model of Normal Love, male-female relationships were characterized by and privileged as having a “normal eroticism” and “healthy libido” in purportedly morally neutral, medically descriptive terms.³³ It was through constructing this new sexual ethic that the groundwork for sex and gender norms were jointly created, along with new categories for deviance and perversion.³³ Per Katz, 1892 to 1900 defined the “heterosexual epoch,” which occurred in the wake of the deliberations and formulations of heterosexuality and homosexuality by U.S. doctors in the Late Victorian Sex-Love era.³³ It was in this epoch that early constructions of heterosexuality and homosexuality appeared in medical publications, upholding a medical standard for appropriate sexual and gender norms.³³

Heterosexuals were first defined by American psychologist James Kiernan in a medical journal article “read before the city’s medical society” in 1892.³³ Before settling on the contemporary understanding of opposite-sex attraction, heterosexuality was constructed by

Kiernan as a non-normative pathology and characterized by “psychical hermaphroditism,” which was defined as an “inclinations to both sexes” and inclinations to “methods of gratification” without procreative intent.³³ Kiernan also first defined “pure homosexuals” as people whose “general mental state is that of the opposite sex.”³³ The construction of psychical hermaphroditism and homosexuality reflect increasing medical scrutiny, judgement, and assuming of authority over norms pertaining to gender and sexuality.³³

Although there was early variation in definitions of heterosexuality in this period, doctors gradually settled on a new standard-model of heterosexuality. Krafft-Ebing’s *Psychopathia Sexualis*, first published in the United States in 1882 with periodic updates, which was a catalog of “sexual abnormalities” and pathologies at the time, first described heterosexuality as “...an erotic feeling for a different sex,” breaking from a purely procreative standard of normative sex to one that incorporates pleasure.^{24,33} Krafft-Ebing defined “homo-sexual” as an “erotic feeling for a same sex.”³³ Heterosexuality as standardized model for organizing “other-sex eros” paralleled similar attempts to standardize masculinity.³³ It was this construction of a heterosexual norm, encompassing “biological sex, masculinity or femininity, and the pleasure of actors” and the assumption of an inherent procreative drive motivating sexual acts, that strict boundaries for eroticism and its corresponding gendered connotations were erected, and a sexual apartheid separating sexual deviants began.³³

Medicalization and the Repressive Potential of Power

Although power can be constructive, Foucault considers its repressive potential, which “...represents power in its most frustrated and extreme form.”³² When 19th century psychiatry, jurisprudence, and academic discourses first conceived homosexuality through “psychical hermaphroditism” a new category of deviance and area for medical control were jointly produced.¹⁴ It is through the repressive potential of institutional power that new medical

standards and norms can be created; as norms are defined, new dichotomies of “healthy/ill, sane/mad, and legal/delinquent,” are also produced, contributing to medicine’s potential for “normalization and social control.”³² Medicine’s repressive potential can function to “...secure adherence to social norms...” by minimizing, eliminating, or normalizing deviant behavior by medical means.²⁴ It was through 19th century medical discourses on healthy sexuality that pathologizing processes towards gender variance were initiated. Subsequently, deviant expressions of gender and sexuality were stigmatized and placed under medical jurisdiction and control.

Medicine can be conceptualized as an agent of social control through its “jurisdictional mandate” over anything it deems as illness.²⁴ Medicalization pertains to “the process and outcome of human problems entering the jurisdiction of the medical profession...” by defining an attribute as an illness and granting the medical profession authority to administer treatment for it.³⁶ Medicine can act as an agent of social control to secure adherence to social norms and, by medical means, “minimize, eliminate, or normalize deviant behavior,” in the name of health for the benefit of the dominant interests of a society, such as the upholding of cisgenderist ideologies.²⁴ It is through medicalization that a stigmatized attribute, such as gender-diverse identities, expressions, and behaviors, becomes medical and subject to control.

Medicalization occurs at three levels: the conceptual, the institutional, and the interactional levels.³⁶ At the conceptual level, medical language or models are used to define a problem and bring it within the medical jurisdiction.³⁶ This can be understood through 19th century scientific discourses about normative versus deviant sexualities and the eventual codification of gender variance into the DSM and ICD diagnostic manuals. At the institutional level, organizations adopt a medical approach to treating a particular problem; consequentially,

as issues become medicalized, physicians act as gatekeepers that legitimate access to benefits that can only be obtained through their authorization.³⁶ At the interactional level, such as doctor-patient interactions, the physician defines a problem as medical and prescribes a medical treatment for it.³⁶ In the context of cisgenderism, the institutional and interactional levels are exemplified through the legitimation of proper transness through medical diagnosis by a medical provider to obtain access to gender affirming treatments.³⁷ Thus, through applying a medical framework to gender variance, defining it in medical terminology, and administering treatment for it, gender variance has been pathologized, granting medicine the authority to adjudicate the parameters of normative gender expression and mediate the means of attaining it.

The Sequential Model of the Medicalization of Deviance

The five-step sequential model of the medicalization of deviance is an inductive theoretical model outlined by sociologists Conrad & Schneider in their 1983 book *Deviance and Medicalization: From Badness to Sickness*.²⁴ The five-step sequential model provides a highly generalized framework outlining the process through which “highly undesirable” or stigmatized nonmedical attributes become defined and treated as medical problems.^{24,36} The five steps of the model include: the definition of an attribute as deviant, the “discovery” and definition of the attribute in medical journals, claims-making by medical and non-medical interests to promote a medical deviance designation, appeals to the state to legitimate a medical deviance designation, and codification of a deviance designation into medical and legal classification systems.²⁴ Through the labeling of difference, association with disease and unhealthy characteristics, the resulting separation of healthy from unhealthy individuals, and resulting discrimination, the sequential model can demonstrate how medicine embeds stigmatizing attitudes outside of medical domains within its own practices.⁹ It is through this model that the processes of

stigmatization of transness, and subsequent pathologization via placement under medical control, can be traced and understood.

The first step of the sequential model, the definition of an attribute as deviant, begins when negative or stigmatizing attitudes exist in the community and precede medical explanations and definitions of the attribute.²⁴ This can be understood through the sexual mores of the Early Victorian True Love era (1820-1860), which occurred before our contemporary understanding of heterosexuality was constructed.³³ It was in this era that binary gender was understood through a normative sexuality characterized by procreation and marriage as a means of upholding proper womanhood and manhood.³³ Because the body was understood as a means of procreation with limited energy, the only form of legitimate natural desire was for reproduction, which was organized through the auspices of an essentialized manhood and womanhood.³³

The next step of the medicalization of deviance is when the “discovery” of a medical conception of deviant attribute appears in a medical journal and subsequently forms the description of a new diagnosis.²⁴ This stage also incorporates the proposal of medical etiologies for deviant behavior.²⁴ The prominence of 19th century Darwinian theory, which regards non-procreative sexual behaviors as forms of psychopathology, within scientific works on sexuality are reflective of denigrating attitudes towards non-procreative expressions of gender and sexuality.³⁸ Furthermore, the conception of homosexuality as both an expression of gender diversity and same-sex desire, followed by subsequent debates of etiology and pathology, are reflective of existing stigmatizing attitudes permeating the scientific discourses of the late 19th century.^{33,38}

Following the “discovery” of a medicalized conception of a deviant attribute is the claims-making stage, in which medical and non-medical stakeholders make claims for the new

deviance designation and attempt to “expand the medical social control turf.”²⁴ It is important to note that in this stage, some advocates for transgender people promoted a medical model due to its “accrued social and ideological benefits,” as doctors can potentially assist as information providers and gatekeepers to provide access to care.³⁶ For instance, in the 1970s, professional advocates of the “medical model of transsexualism” endorsed a model of illness to shift the medical discourses away from models of mental disturbance.³¹ These advocates intended to expand professional awareness of “gender identity and sex reassignment” and were successful in changing psychiatric and medical opinions on the “authenticity of trans subjectivities.”³¹

Furthermore, this advocacy increased opportunities for “anatomically dysphoric transgender individuals” to obtain gender affirming transitioning treatment but ironically helped bring about a medical category for transsexualism through the IDC and DSM.³¹ An example of this is well-meaning attempts of advocates to lessen the stigma faced by transgender people by turning “sinners into patients” in need of “therapeutic compassion” instead of religious judgement and condemnation.^{36,39} This is because psychiatric classification can increase empathy for people perceived to be suffering from a disease and thus enable more humane treatment.³⁹ Furthermore, it removes the blame of an “ill person” from being the cause of their own symptoms.³⁹

In the next stage, proponents of medical deviance designation appeal to the state as an arbiter of jurisdictional disputes and legitimator of deviance to pass laws in support of a medical model.²⁴ A medical victory in this stage grants medicine the official jurisdiction and social control over the category of deviance.²⁴ The reliance on medical evidence of sex change surgery to establish gender identity and sex change designation, bolstering the medical establishment’s

position as authorities and gatekeepers on transness, reflects a kind of “medical victory” in the medicalization of gender variance.^{4,5,24}

The final stage in the sequential model of the cisgender regulation through the medicalization of deviance is that of the *institutionalization* of a medical deviance designation, by which the designation reaches a state of “fixity and semipermanence” as the medical viewpoint and a category in the official order.²⁴ Institutionalization is achieved via processes of *codification*, when a deviance designation is part of the official medical and legal classification system, and *bureaucratization* which is the creation of large-scale organizations that provide institutionalized support for medicalization.²⁴ This is reflected in the evolving codes for gender variance within the ICD and DSM diagnostic manuals and insurance-related reimbursement for gender affirming care.^{12,13}

Pathologization: Tracing the Inclusion of Gender Variance in the ICD and DSM

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) are the most important international disease systems of classifications.⁴⁰ The DSM is published by the American Psychiatric Organization (APA), which is a private, professional organization based in the United States with extensive international influence through its network of publications, including the revenue-generating DSM.⁴⁰ The ICD is developed by the World Health Organization (WHO) and is revised nearly every 20 years.⁴⁰

Homosexuality

The modern version of the IDC was first published by WHO as ICD-6 in 1948.⁴⁰ Prior to ICD-6, the ICD was exclusively a mortality classification; ICD-6 was the first to include a classification of mental disorders, which included the first appearance of homosexuality found under the chapter for mental, psychoneurotic, and personality disorders, among ‘categories specifically related to sexual functioning or sexual disorders’, further sub-classified as

‘pathologic personality’ under a category classified as a ‘sexual deviation,’ then grouped with several paraphilias.³⁸ Homosexuality also appears unchanged in ICD-7 (1955); in ICD-8 (1965), the ‘pathological personality’ subcategory was removed, although homosexuality remained a ‘sexual deviation.’³⁸ The inclusion of codes for homosexuality are important to note as sexual orientation and gender identity were often conflated at the time.

Guided by theories regarding heterosexuality as an essential norm and homosexuality as pathological, the APA included “homosexuality” in DSM-I (1952) as a sexual deviation, under a subcategory of ‘sociopathic personality disturbance,’ which was housed under the overarching category of ‘personality disorder.’³⁸ In DSM-II (1968), homosexuality remained classified as a ‘sexual deviation’ and clustered under ‘personality disorders and certain other non-psychotic mental disorders,’ but was no longer classified as ‘sociopathic.’³⁸ After publication of DSM-II, gay activists forcefully challenged the APA’s pathologizing position, with the initial encounter beginning with disruptive protests at the APA’s 1970 annual meeting.³⁸ After internal debates deliberation within the APA, homosexuality was replaced by ‘sexual orientation disturbance’ in the sixth printing of the DSM-II in 1973.³⁸

Trans-Specific Diagnoses

It was in ICD-8 (1965) that ‘transvestitism,’ although undefined, first appeared as a ‘sexual deviation.’³⁸ This was the first instance in which gender variance was explicitly pathologized in the ICD and occurred in the wake of the media uproar, scientific debates, and increased awareness of “transsexualism” and its clinical presentation following Christine Jorgensen’s sex change in 1952.^{4,12,38} A decade later in ICD-9 (1975), transvestitism was replaced by two new diagnoses: ‘transvestism,’ which was the deriving of sexual pleasure from cross-dressing, and ‘trans-sexualism,’ which accommodated the growing research about “transsexualism” in the previous two decades.³⁸

The first explicit codes pertaining to gender variance appeared in the DSM-III (1980) as ‘gender dysphoria of childhood’ (GIDC) and ‘transsexualism’ to be used among adolescents and adults.³¹ The inclusion of GIDC and transsexualism may have been in response to an increased demand of people seeking hormone therapies and sex-change operations since the 1960s.⁴² In ICD-10 (1990), a new category of gender identity disorders was created under disorders of adult behavior and personality.³⁸ This new category included five diagnoses: ‘transsexualism,’ ‘dual-role transvestism,’ ‘gender identity disorder of childhood,’ ‘other gender identity disorders,’ and ‘gender identity disorder, unspecified.’³⁸ Gender identity disorder of adolescence and adulthood, nontranssexual type was included in the 1987 DSM-III-R but removed in the 1994 DSM-IV.³¹ Additionally, GIDC and transsexualism were merged into a singular diagnosis of “gender identity disorder” in DSM-IV with different criteria for adults, adolescents, and children.³¹

Gender identity disorder was renamed gender dysphoria in the 2013 DSM-5 and emphasizes “the distress caused by gender incongruence rather than gender identity.”⁴² Text revisions within DSM-5-TR includes further textual changes to the description of gender dysphoria, such as changing the term “desired gender” to “experienced gender,” “cross-sex medical procedure” updated to “gender-affirming medical procedure,” and the terms “natal male” and “natal female” changed to “assigned male/female at birth.”⁴³ Furthermore, ICD-11, which was approved by the WHO in 2018 and enacted on January 1 2022, now labels gender variance as ‘gender incongruence’ under conditions related to sexual health.⁴¹

Year	ICD	DSM	Parent category	Diagnosis name
1948	ICD-6	–	N/A	N/A
1952	–	DSM-I	N/A	N/A
1955	ICD-7	–	N/A	N/A
1965	ICD-8	–	Sexual deviations	Transvestitism
1968	–	DSM-II	Sexual deviations	Transvestitism
1975	ICD-9	–	Sexual deviations	Transvestism Trans-sexualism
1980	–	DSM-III	Psychosexual disorders	Transsexualism
1987	–	DSM-III-R	Disorders usually first evident in infancy, childhood or adolescence	Gender identity disorder of childhood Transsexualism
1990	ICD-10	–	Gender identity disorders	Gender identity disorder of adolescence and adulthood, non-transsexual type Transsexualism
1994	–	DSM-IV	Sexual and gender identity disorders	Dual-role transvestism Gender identity disorder of childhood Other gender identity disorders Gender identity disorder, unspecified
2000	–	DSM-IV-TR	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults Gender identity disorder in children
2013	–	DSM-5	Gender dysphoria	Gender identity disorder in adolescents or adults Gender identity disorder in children
2017	ICD-11	–	Conditions related to sexual health(proposed)	Gender dysphoria in adolescents or adults Gender dysphoria in children Gender incongruence of adolescents and adults Gender incongruence of children (proposed)

Figure Two: Gender Identity Diagnoses in the ICD and DSM^{38*}

*ICD-11 was published in 2019 and includes gender incongruence of children.

Demedicalization and Depathologization

Demedicalization

Demedicalization occurs when a problem is no longer defined in medical terms and when medical treatments are no longer deemed appropriate solutions; however, demedicalization does not necessarily entail deprofessionalization.³⁶ For instance, childbirth can be reconceptualized as a “family event with lay attendants.”³⁶ In the case of gender variance, demedicalization would entail a reconceptualizing of gender affirming care as a “health care process not related with disorders or illness.”²⁷ Demedicalization involves a reversal of the process of pathologization that characterizes “bodily characteristics, habits, practices, living forms, gestures, people, and groups of people as mentally disordered, ill, abnormal, or malformed.”²⁷

In American society, a classic example of overt conflict between politics and medicine leading to demedicalization is that of the removal of homosexuality from DSM-III in response to protests and picketing from gay activists.³⁶ It was through this move that the APA was no longer

officially involved with pathologizing gay and lesbian people and was followed by an era of gradual increased social acceptance.¹² The diagnosis of homosexuality played an obstructive role in the lives of gays and lesbians, but some argue that trans diagnostic categories in the DSM and ICD increase opportunities for the social acceptance of transgender people and have not prevented the flourishing of a transgender rights movement worldwide, as evidenced by the expansion of legal protections for trans people.³⁹ Although the removal of homosexuality from the DSM led to a “cure” for gays and lesbians, some argue that the same approach might have detrimental consequences for transgender people, such as lack of access to healthcare and legal gender recognition.³⁹

Amid parallel reviews of the DSM and ICD diagnostic manuals in the 2010s, an “international trans depathologization activism” emerged, most popularly demanding for the removal of processes related to gender affirming care as a mental disorder from the ICD and DSM, and for a change in the trans health care model, “from a psychiatric assessment process towards an informed decision-making approach.”²⁷

Discourses among transgender scholars and activists deliberate the tension between removing ICD and DSM codes to depathologize transness, while still acknowledging the codes as a gateway to funding for gender affirming care.¹³ In addition to being a gateway to funding for gender affirming care, gender diagnoses have been successfully used in American court battles to secure access to care for transgender prisoners from government insurers.³⁸ Thus, to some, maintaining trans codes in ICD and DSM offer practical benefits.

Revisions for the DSM and ICD

In constructing a depathologizing perspective without risking access to gender affirming care and legal gender recognition in countries that require diagnosis, activists considered possibilities for the DSM and ICD. With regard to the DSM, activists demanded a complete

removal of trans-related diagnostic categories.²⁷ For ICD, a proposal was considered for a non-pathologizing reference in ICD-11, with an understanding of transition-related care as a process not related to illness or disorder.^{25,27} The Global Action for Trans* Equality, an international transgender advocacy organization, advocated for a starfish model in which a trans-specific code would be placed in a section of the ICD that also contains health phenomena such as uncomplicated pregnancy, which would refer out to other non-trans specific codes in other parts of the ICD, such as “Testosterone Deficiency” or “Absence/Presence of Vagina.”¹³ The proposals to maintain trans-specific codes within the ICD, however upholds the medical establishment’s problematic gatekeeping of both transness and the right to funded gender-affirming healthcare; furthermore, this relationship is oppressive considering that medical care is inaccessible to most transgender people who may lack employment and financial ability to fund care due to economic marginalization.^{5,13,21,26}

In 2019, the WHO approved ICD-11 wherein trans-related diagnostic codes were removed from the chapter for “Mental and Behavioral Disorders,” and the code ‘gender incongruence’ was placed in the new chapter “Conditions related to sexual health.”²⁷ In spite of this, trans people continue to receive psychiatric diagnoses, are forced to undergo therapies to modify their gender expressions or identities, or must undergo a binary, heteronormative psychiatric assessment processes to gain access to gender-affirmative care.²⁷ Additionally, the new “progressive” ICD codes continue the involvement of the medical establishment as prerequisite to establishing legal gender recognition.²⁷

Although maintaining codes in the ICD and DSM offer some transgender people a route to gender-affirming care, this access to gender-affirming technology and legal recognition depends on whether a psychiatrist decides that the patient meets particular criteria to an “extent

that warrants referrals for treatments or payments from insurance companies.”⁴² Furthermore, the psychiatrist’s interpretation of this criteria may determine whether the patient’s gender dysphoria matches a criteria to warrant providing documentation for a legal sex change.”⁴² With regard to the DSM-5, inconsistencies in the definition pertaining to the experience of distress caused by gender incongruence may jointly “cause confusion among psychiatrists tasked with attempting to diagnose GD” and cause trans people to uphold narratives of distress to meet specific guidelines.⁴²

Other Possibilities

Although the ICD and DSM are the gateway to funding gender affirming care for some transgender people, other approaches to legitimizing transness must be realized to disentangle the multiple levels of gatekeeping in medicine and law. The imposition of an evaluation process and subsequent involvement of a triadic model of diagnosis, hormone treatment, and surgery not only limits the “decisional autonomy” of transgender people but perpetuates the medicalization of transness and reduces the diversity of gender transition processes and healthcare paths, thus potentially reinforcing the gender binary.²⁵

In spite of the growing activism and resistance around ICD pathologization, some transgender people may accept ICD out of fear for loss of medical access and thus gender-affirming care.²⁹ Thus, in line with this argument, it is considered in the best interest of transgender people to be considered ill, considering most states depend on an ICD-based diagnosis to provide care.²⁹ Although this argument may seem compelling due to the far-reaching negative consequences associated with loss of care, the negative effects of trans depathologization do not extend to the many people benefiting from its positive effects.²⁹ This is because ‘transgender’ as an umbrella term refers to a broad category of gender variant people and groups whose identities are not mediated by medical intervention.²⁹

As pathologization refers to all transgender people and not just individuals seeking gender affirming healthcare, the majority of transgender people do not wish to seek medical intervention to affirm their identities.²⁹ The mental health effects of trans people suffering from pathologization are the same as those being denied gender affirming medical care: depression, anxiety, and suicidality.²⁹ Furthermore, existing psychiatric classifications impose an exclusive framework for conceiving gender identity, thus situating themselves at odds with diverse expressions of gender that do not involve medicalized transition processes and potentially perpetuating Western modalities of acceptable gender expression.^{25,27} The exportation of the Western medical model of transness emphasizes an acceptable, binarized, and medicalized expression of transness at the expense of non-Western cultures that celebrate gender diversity without any conception of illness or medicalized gender transition process.²⁷ Thus, although the notion that transgenderism and “desire for an operation” are not necessarily closely linked, an effective depathologization framework would advocate for trans-specific healthcare to be considered its own human right.²⁹

V. Law and Legal Practices as Liberatory Gender Doorways

Legal gender recognition is of particular importance in consideration with the ways in which gendered bodies become the categories through which “citizenship flows through, that rights are founded, that social structure is built on, that kinship systems are organized around, and that perform particular kinds of labor.”¹⁹ Lack of documents that match a person’s true gender identity, in name and gender expression, can “obstruct access to education, employment, social welfare, and health care.”⁴⁶ Although the loss of legal gender recognition can be likened akin to losing one’s humanity, and one’s, “access to and claims upon human status,” many transgender people forego official procedures due to discriminatory medical practices as

prerequisites for legal gender recognition or receiving individualized gender affirming care.^{19,46} Historically, trans people would have to satisfy particular conditions, including medical sterilization, transitioning surgery, and forced divorce, before obtaining the right to legal gender recognition.⁴⁵ These barriers to the realization of the right to legal gender recognition contribute to experiences of distress due to “incongruence in identification documents or anxiety because of the public’s reaction to their gender expression,” thus introducing opportunities for increased discrimination.⁴⁵ Thus, it is the obligation of the State to uphold gender diversity in law to uphold full trans citizenship, to allow trans people to enjoy full legal capacity and equality in human and civil rights.⁴⁶ In line with notions of embodiment, equitable and eased access to legal gender recognition, without medical gatekeeping, may structurally ameliorate institutionalized forms of discrimination and lessen the gradient of the stigma-sickness slope.

A Human Rights Approach to Depathologization

Just as there is a right to health and a right to non-discrimination, “States have certain obligations, that is, not to discriminate, not to interfere with health without due justification,” and in the context of trans pathologization, a human right to the depathologization of transness, in line with the right to gender identity.²⁹ Pathologization-based models of legal gender recognition that require medical diagnosis frame gender recognition as a “legal privilege extended to treat a diagnosable medical illness,” and thus renders self-determination irrelevant.⁴⁵ The UN Committee on Economic, Social and Cultural Rights, the only international body to discuss the pathologization of transness states: “The Committee notes with concern that transsexual and inter-sexed persons are often considered to be persons with mental illness and that the State party’s policies, legislative or otherwise, have led to discrimination against these persons as well as to violations of their sexual and reproductive health rights. (art. 12, 2.2)” Thus, the right to

health, including the right to depathologization, is in alignment with States' obligation to respect, protect, and fulfill.²⁹

Considering that medical practitioners hold the “social power to determine what is considered sick or health,” one might consider it to be an obligation of the State to take action against medical institutions that perpetuate the notion of transgender pathology.²⁹ Per the Yogyakarta Principles, the obligation to protect is stated as such: “States shall ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed.”²⁹ The Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity challenge the joint gatekeeping of transness by medicine and law.¹⁹ The Yogyakarta Principles, first published in 2007 and extended with the Yogyakarta Principles plus 10, establish an “application of international human rights law in relation to sexual orientation, gender expression, gender identity, and sex characteristics.”¹⁹ The Yogyakarta Principles, which claim to synthesize the current status of international human rights law, frame depathologization in the language of human rights and claim that gender identity may not be treated as a medical condition.²⁹ The trans depathologization framework offers a paradigm shift from gender diversity as a pathology in need of medicalized intervention to recognizing it as a human right and expression of human diversity.²⁵ Thus, when the right to depathologization and the right to healthcare are conceived as fundamental human rights, creative strategies can be implemented to “facilitate access to state-covered trans health care within a depathologization framework.”²⁵

Legal Models of Self-Determination and Self-Declaration

Due to its instrumental role in the fulfillment of rights to health, healthcare, and fulfillment of social determinants of health, legal gender recognition is a fundamental human

right.⁴⁶ Thus, legal approaches that acknowledge gender diversity and uphold the right to self-determination by allowing transgender people to self-declare their gender identity without discriminatory legal or medical prerequisites offer an alternative to medical models.⁴⁶ Self-declaration models are in line with the Yogyakarta Principles which establish the right to recognition before the law and explicitly obligate states to provide a “clear, efficient, fair, and nondiscriminatory” means of recognizing non-cisgender identities.^{27,46}

Per the Yogyakarta Principle 3, “gender identity is integral to a person’s personality and is one of the most basic aspects of self-determination, dignity, and freedom.”⁴⁶ In line with the notion of a “right to identity” as modeled in the Yogyakarta Principles, The Argentinian Gender Identity Law is an exemplary piece of legislation that models self-determination for transgender people without legal or medical prerequisites, besides the legal capacity for making decisions.⁴⁶ The Argentinian Gender Identity Law, which was passed in 2012, allows for legal gender recognition of children, adolescents, and adults without medical permission or control.²⁷ This Argentinian federal law allows gender to be self-defined and state-recognized without any medicalization or pathologization, and is considered by some to be a gold standard for other countries to aspire to.¹⁹ Argentina’s Gender Identity Law was particularly noteworthy as it guarantees the right to change name and gender markers in identifying documents, the right to free and universal trans-specific health via a nonjudicial and non-pathologizing procedure, and due to it being the result of the “political and intellectual work of trans* people.”³⁰ In following the Argentinian Gender Identity Law as a reference point, Denmark, Mexico City, Colombia, Ireland, Malta, Bolivia, France, Norway, Portugal, Costa Rica, Chile, and Uruguay similarly approved gender recognition laws without medical requirements.²⁷ The Argentinian Gender

Identity Law serves as a legal model and potential solution to the pathologization and subsequent discrimination faced by transgender people.

VI. Conclusion

Cisgenderism, operationalized via the stigma process in a multitude of contexts, is embedded jointly within the structures of law and public health.^{7,5} It is through the labeling of transness and its subsequent association with stereotypes that a form of deviance is conceived and sanctioned via violence and discrimination.⁹ Within the medical establishment, the identification and pathologization of gender variance is reflective of anti-transgender stigma and upholds a history of the gatekeeping of transness, the reinforcement of the gender binary, and the erasure of transgender people via the medical push for binary sex-change operations and resulting invisibility and exclusion of non-binary people.^{4,5,20}

Although transgender people have been excluded, pathologized, and erased throughout history, the emergence of models for self-determination and its adoption in countries with vastly different cultural contexts offers a starting point for an approach to transgender inclusion in the absence of medical and legal gatekeeping.²⁷ The legal recognition of trans- gender identities and access to gender-affirming care in the absence of pathologization has the potential to remediate and lessen the grave intensity of the stigma-sickness slope, by which transgender people embody the unjust political and social environments around them, leading to negative social and health outcomes.^{22,23}

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