

# (Dys) Functional Diagnosing: Mental Health Diagnosis, Medicalization, and the Making of Transgender Patients

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## Abstract

This article contributes to the burgeoning literatures on the sociology of diagnosis and transgender studies by examining the relationship between diagnostic processes and the legitimization of gender identity—the medicalization of transgender people. In order for trans-identified people to access medical and surgical services, they must submit to a complex mental health diagnostic process that relies on criteria set by the American Psychiatric Association and the World Professional Association of Transgender Health (WPATH). By focusing on provider experiences of using the Gender Identity Disorder (GID) diagnosis in the *Diagnostic Statistical Manual of Mental Health Disorders*, Fourth edition, text revision (DSM-IV-TR) to meet the requirements of WPATH's Standards of Care (SOC-6), we show that diagnostic processes can both support and inhibit a transpatient's abilities to access services. Participants reveal how deeply held cultural views pertaining to gender, mental health, and patient competency are entrenched in diagnostic categories. While the new DSM-5 has relabeled GID as Gender Dysphoria and the SOC-7 has somewhat

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lessened the requirements for accessing hormone treatments, our data suggest that these changes will not be enough to alter the underlying structure of social control and power that diagnostic categories have over transpeople and their providers.

### **Keywords**

diagnosis, medicalization, transvariance

### **Personal Reflexive Statements**

*Jodie M. Dewey: In previous research, I found that transvariant individuals' most troubling experiences of discrimination were in navigating the medical and psychiatric systems. Due to this recurring theme and the paucity of research in this area, I decided to investigate the medicalization and psychopathologization of transpatients from the perspectives of medical and therapeutic professionals. Medical knowledge is often thought to be objective, static, and based on "scientific" findings. However, in the area of transgender health care, we find psychiatric and medical knowledge is hotly debated and continually revised. So many changes have occurred in the last 30 years that we can see the social construction of transgender medical knowledge unfold before our eyes. Stereotypes about gendered and sexed embodiments, as well as the benevolence we attribute to doctoring, often obscure the historical processes through which they are produced. To ensure human rights and cease the dehumanization of transpeople, we need to critically analyze how medical knowledge and the ways providers make decisions further regulate transbodies even while simultaneously providing transpeople with much desired legitimacy.*

*Melissa M. Gesbeck: I believe that we have a fundamental human right to the means to live healthfully (e.g., nutritious food, safe environments, good quality health care). I have conducted research on diabetes care from the standpoint of diabetes care workers, family food choices as an avenue for preventing childhood obesity in a community setting, and women's perceived access to health care services, especially for sexual minority women. I am particularly drawn to topics that illuminate the experiences of marginalized peoples in the context of the larger health care system. I use my privilege as a white, cis-woman researcher to do work that furthers our knowledge about the needs of people who are often left out of the conversation and to identify structural processes that sustain inequalities. My hope is this type of research will contribute to efforts toward reconstructing a more just society.*

Lesbian, gay, bisexual, transgender, and queer (LGBTQ)-identified people have been, and continue to be, criminalized and pathologized, and are often labeled deviants, perverts, mentally unstable, and hypersexualized. These meanings, referred to as archetypes because they are "recurring, culturally ingrained representations that evoke strong, often subterranean emotional associations or responses" (Mogul,

Ritchi, and Whitlock 2012), direct not only preconceptions of sexual minority persons but also the kinds of responses believed to be required of the criminal, legal, psychiatric, and medical systems to address their deviance. In this sense, psychiatry and medicine have been instrumental, powerful systems in the ways crime and deviance are defined and handled in our society (Mogul et al. 2012). Cultural views about sexual perversity are used to justify the dehumanization and human rights violations of many marginalized people by the scientific and legal communities (Hill-Collins 1990; Mogul et al. 2012). In this study of the diagnostic processes and categories that legitimate gender in the medical system, we uncover their influence on providers' perceptions of transgender-identified people—a necessary step toward promoting social justice for gender expression and sexual minority persons, in particular, and society as a whole.

The visibility of transgender-identified people in popular culture and academic interest in transgender issues are growing. Although the very term *transgender* is becoming more mundane, trans<sup>1</sup> individuals' political, economic, legal, and medical struggles—although often successful—continue (Stryker 2008). In order to make progress in those arenas or to employ the protections of antidiscrimination statutes, transgender people are required to navigate a complicated system of gender legitimation that depends largely on medical and psychiatric diagnoses (Meadow 2011). As P. Brown (1990) puts it, the diagnostic process is an arena of struggle over the politics of definition. This process can assist or impede patients' access to medical treatment, and in some cases further medicalizes them (Bryant 2011; Dewey 2008; Rose 2007; Tone 2012). Diagnosis is a language of social control, drawing the line between normal and abnormal, and giving power to medical professionals to deal with deviant individuals on behalf of society at large (Arney and Bergen 1983; P. Brown 1995).

In this article, we investigate the diagnostic category *Gender Identity Disorder* (GID) as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition, text revision (DSM-IV-TR; American Psychiatric Association [APA] 2000) and its relationship to Harry Benjamin's SOC-6 (Meyer et al. 2002), a clinical document that standardizes the treatment of trans-identified patients. Furthermore, by studying provider experiences of diagnosing and treating transpatients, the data show that GID can both support and inhibit patients' abilities to access services. Through the process of diagnosing, practitioners reveal how deeply held cultural views pertaining to gender, mental health, and patient competency are entrenched in diagnostic categories. Recently, the DSM-5 (APA 2013) has changed GID to *Gender Dysphoria* (GD; see Table 1), following a change in the SOC-7 (Coleman et al. 2011) that removed formal diagnosis as a requirement for receiving some treatments for patients (see Table 2). Our data shed some light on whether these changes to the diagnostic process are likely to achieve the intended goals of depsychopathologizing and increasing agency for patients (Drescher 2014).

First, we discuss the literature on the sociology of diagnosis and the rise of medicalization. Next, we discuss the history of transgender-related diagnoses and care as specified in the DSM-IV-TR and the SOC-6. Then, we present the data, which

**Table I.** Evolution of Transgender Diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; Winters 2005).

Year	Version	Categorical changes	Significance
1980	III	Two diagnostic categories appear under psychosexual disorders: Transexualism and Gender Identity Disorder of Childhood (GIDC)	Transexualism: persistent sense of discomfort with one's anatomic sex, desire to remove one's genitals, and living as the desired sex for at least two years. GIDC: persistent that one is the other sex, onset before puberty, and emphasizes the performative aspects of gender nonconformity (e.g., dress, play, affect) for males.
1987	III-R	Gender identity disorders (GIDs) are reclassified under disorders usually first evident in infancy, children, or adolescence. Transexualism is split into gender identity disorder of adolescence or adulthood, nontransexual type (GIDDANT) and transvestic fetishism.	GIDDANT: persistent sense of discomfort with one's natal sex and living as the desired sex for at least two years. Expands access to nonsurgical gender therapies to those not experiencing distress regarding their genitals. Transvestic fetishism: heterosexual men who cross-dress for sexual purposes (not appropriate for gender-related services). These changes separate gender from sexuality, but codifies gender nonconformity as a disorder itself. They also begin to focus on the performative aspects of gender nonconformity for girls and stresses childhood onset of symptoms.
1994	IV	Transexualism, GIDC, and GIDDANT are combined into a new category: GID and reclassified under sexual disorders.	GID: patient presents significant distress or impairment. This marks an early distinction between diagnosing gender variation and diagnosing the stress caused by gender variation.
2000	IV-TR	Autogynephilia is added as a subtype of GID.	Autogynephilia: either a fetishistic obsession with oneself as a woman or internalized homophobia as the main motivation to undergo gender-related surgeries. Autogynephilia and transvestic fetishism diagnoses limit access to gender-related treatments and pathologize otherwise normal individuals.

(continued)

**Table 1.** (continued)

Year	Version	Categorical changes	Significance
2013	5	Gender dysphoria (GD) replaces GID and is removed from the section on Sexual Dysfunction and Paraphilic Disorders.	<p>Patients limit their disclosure to providers in order to not appear to be eroticized.</p> <p>GD: an attempt to depathologize transgender by shifting focus to the distress associated with current physical sex characteristics or with birth-assigned gender roles, not the experience of gender incongruence itself.</p> <p>GD is no longer labeled a disorder; however, it remains listed in the DSM and its criteria still used to secure gender-related therapies.</p>

demonstrate how these documents are used in providing care and the ways that they shape provider experiences of caring for transgender patients. Finally, we discuss whether more recent revisions to the DSM and SOC are likely to succeed in depathologizing and destigmatizing transpeople, while also increasing access to services—goals espoused by the DSM-5 work group created by the APA (Drescher 2014). This study is relevant to the future health care of transpeople and the professionals who treat them. We argue that the seemingly progressive changes to the recent DSM-5 and SOC-7 may not be enough to alter the underlying structure of social control and power that diagnostic categories have over transpeople, but rather work to further deepen and normalize non-normative gender expressions as deviant and pathological.

By placing the meaning-making of medical and therapeutic professionals who treat the transpatients at the center of our investigation, we analyze the interaction of medical knowledge with cultural archetypes and investigate providers' power in medicalizing significant areas of transpatients' lives. Moreover, due to the paucity of research in this area, we offer empirical evidence to an area of study that is often based on anecdotal evidence and opinion (Drescher 2014:10). In this article, our aims are to analyze the categorical and procedural utility of the GID diagnosis as a tool for serving the needs of transpatients and to discuss the potential for recent changes in diagnostic criteria to improve care and access to care for transpatients. This study contributes to sociological knowledge of the diagnostic process and the ways the diagnostic categories shape the experiences of health care providers and transpatients, as they navigate the process of legitimating gender identities through the medical system. Furthermore, we critically analyze how deeply held cultural views surrounding gender, mental health, and patient competency are entrenched in diagnostic categories and reproduced within the process of medicalization.

**Table 2.** Comparison of SOC-6 and SOC-7.

	SOC-6 (2005)	SOC-7 (2011)
Stated purpose	“To articulate this international organizations’ professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders.” (p. 3).	“To promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.” (p. 1)
Diagnostic/assessment criteria	<p>Accurate diagnosis of gender disorder.</p> <p>Patient must live in chosen gender (real-life experience) three months prior to hormone treatment and 12 months prior to sexual reassignment surgery.</p> <p>The SOC-6 also mentions readiness criteria are “more complicated because it rests upon the clinician and the patient’s judgment.” (p. 13)</p>	<p>Assessment of clients’ gender identity disorder and gender dysphoria by MHP evaluation of their psychosocial development. MHPs “need to have functioning working relationships with their clients and sufficient information about them.” (p. 25)</p> <p>Assessment of gender identity disorder and gender dysphoria is to include:</p> <ul style="list-style-type: none"> <li>● History and development of gender dysphoric feelings</li> <li>● The impact of stigma attached to gender nonconformity on mental health</li> <li>● Availability of support from family, friends, and peers</li> </ul> <p>Specific criteria for hormone therapy:</p> <ul style="list-style-type: none"> <li>● Persistent, well-documented gender dysphoria</li> <li>● Capacity to make informed decision</li> <li>● Age of majority</li> <li>● If significant medical or mental health concerns are present, they must be reasonably controlled</li> </ul>
Letter of recommendation	<p>One letter required for hormone therapy and breast surgery.</p> <p>Two letters required for genital surgery, one coming from a psychiatrist or PhD clinical psychologist to evaluate</p>	A referral letter is required from the provider who conducted the psychosocial assessment, unless the assessment is completed by a hormone provider qualified in this area, assuming there are no

(continued)

**Table 2.** (continued)

	SOC-6 (2005)	SOC-7 (2011)
	<p>comorbid psychiatric conditions.</p> <p>Letter content must include:</p> <ul style="list-style-type: none"> <li>• The client’s general identifying characteristics</li> <li>• The initial and evolving gender, sexual, and other psychiatric diagnoses</li> <li>• Duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent</li> <li>• Eligibility criteria have been met and the MHP’s rationale for hormone therapy or surgery</li> <li>• Degree to which the patient followed the SOC and likelihood of future compliance</li> <li>• MHP on a gender team</li> <li>• MHP willing to verify the authenticity of the letter via phone, if required</li> </ul>	<p>coexisting mental health concerns.</p> <p>Letter content must include:</p> <ul style="list-style-type: none"> <li>• The client’s general identifying characteristics</li> <li>• Results of the client’s psychosocial assessment, including any diagnoses</li> <li>• The duration for the referring health professional’s relationship with the client, including evaluation and therapy to date</li> <li>• Explanation that the criteria for hormone therapy have been met, including provider rationale</li> <li>• A statement of informed consent from patient</li> <li>• A statement that the MHP is available for coordination of care and welcomes a phone call to establish this</li> </ul>
MHP Expected Education	<p>Master’s degree or equivalent in a clinical behavioral science field.</p> <p>Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders, not just gender identity disorders.</p> <p>Documented supervised training and competence in psychotherapy.</p>	<p>Master’s degree or equivalent in a clinical behavior science field.</p> <p>Competence in using the DSM and/ or the ICD for diagnostic purposes.</p> <p>Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.</p> <p>Documented supervised training and competence in psychotherapy or counseling.</p> <p>Knowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.</p>

Note: DSM = *Diagnostic and Statistical Manual of Mental Disorders*; ICD = *International Classification of Diseases*; MHP = mental health professional; SOC = *Standards of Care*.

## Literature Review: Medicalization, Diagnosis, and Social Control

First appearing in the sociological literature in the 1970s, medicalization is a “process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad 1992:209). By this widely accepted definition, anything described or associated with illness falls under the purview of the medical profession, which, over time, becomes the dominant authority over how bodies should behaviorally, socially, and psychologically function. Medicine has increasingly become a powerful agent in establishing and sustaining cultural norms by eliminating or normalizing what many in society deem aberrant behavior (Conrad 1979). In the process, economic, political, and social beliefs become shrouded within the legitimizing power of science and through medicine’s socially constructed “facts” (Riessman 1983). Medical and psychiatric discourses, rather than merely responding to observable facts, may actually transform subjects into objects of a perpetual gaze, where certain bodies are increasingly under more surveillance both physically and socially (Armstrong 2003; P. Brown 1995; Conrad 1997, 2005; Foucault 1963, 1997; Riessman 1983; Zola 1972). In the process, bodies that persistently deviate from the norm become overmedicalized (Figert 1995; Halpern 1990; Kress, Hoffman, and Eriksen 2010; Lock 2004). This is even further complicated as more and more conditions have been recategorized as diagnosable and treatable illnesses through technoscientific developments in the health care market. Terms such as biomedicalization and pharmaceuticalization have emerged to bring attention to these interdependent processes that work together to reconstruct people into patients through processes of diagnosis (Bell and Figert 2015; Clarke et al. 2010; Esposito and Perez 2014; Figert and Bell 2012).

Diagnosis, the act of “giving a name” and thereby establishing social control (P. Brown 1990), gained increasing significance with the proliferation of medications in the 1950s. The diagnosing process provides formal, standardized categories through which institutions and their agents confirm norms and perform social control functions within society (Berg and Bowker 2005; P. Brown 1995; Bryant 2011; Burke 2011; Chambliss 1996; Conrad and Schneider 1992; Denton 1989; Foucault 1963, 1977, 1984; Gans 1995; Goffman 1963; McGann 2011; Parsons 1951; Zola 1983). A major problem with the requirement of formal diagnosis is that it opens the path for further medicalization and psychopathologization, where one’s life comes to be increasingly understood and controlled by medicine and psychiatry, and where “healthy” and “ill” take on significant, yet depoliticized meanings (Conrad 1975, 1992, 2005; Fausto-Sterling 2000; Szasz 1970; Tone 2012; Wakefield 2013; Zola 1972).

Like medical diagnoses, psychiatric diagnoses have historically been used to socially control those seen as a threat to the political, economic, and religious order of society (P. Brown 1990). For example, former black slaves who ran away from their violent masters were diagnosed with drapetomania and women who have



resisted or refused to perform traditional femininity have been diagnosed with hysteria. Psychiatry has been used to regulate people, and for this reason has been heavily critiqued (P. Brown 1990; Conrad 1979). Beginning in the 1970s, under even more criticism, psychiatry entered a phase of crises due to the emergence of competing mental health approaches, including the harsh criticism of psychoanalysis (the therapy of choice during this time) and the antipsychiatry movement that focused on harsh images of life inside psychiatric asylums (Whooley 2010). In response to these criticisms, the APA attempted to professionalize the field of psychiatry by aligning the contents of the 1980 release of the DSM-III, a text designed to provide etiological uniformity and standardization for mental health professionals, with biomedicine.<sup>2</sup> They accomplished this by standardizing what were considered “real” pathologies into disease categories with specific diagnostic criteria (Horwitz 2002; Rogler 1997). This move further legitimized psychiatry by linking it to the already powerful biomedical model.

The use of the diagnostic process and the role of diagnosis in controlling deviant behaviors within the legal system assisted in the rise of medicalization. Termed the *scientifico-juridical complex*, Foucault states that our legal system is interested in assessing and diagnosing the criminal and that this process is so entrenched that it seems it has always been a part of the penal framework (1977). The only judgment that has historically allowed one to evade criminal punishment for a crime has been being viewed as insane by the courts, since one could not be deemed both insane and guilty (Foucault 1977). However, beginning in the nineteenth century, the courts began to accept criminal accountability despite an offender’s perceived insanity. The process of including psychiatric testimony to ascertain an offender’s level of sanity—whether they were considered sick and/or dangerous—not only allowed the offender’s life before and after the crime to be judged, but it also introduced a new bureaucratic system of control into the already expansive legal one (Foucault 1977). This new *medico-judicial treatment* enmeshes the judicial and the medical systems, providing more power to an ever increasing number of social control agents, extending their power over more areas of a perceived deviant’s life (Foucault 1977:22). As Zola so presciently wrote, “medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts” (1972:487). Adding to the medico-judicial system is the more recent inclusion of pharmaceutical companies’ power to create a diseased market out of a need to sell particular medications and the role insurance companies’ play in the medical-industrial complex by requiring formal diagnosis prior to services (Graham 2011).

Medicalization and the role of diagnosing are employed by various agents and institutions to regulate cultural meanings pertaining to gender and sexuality. In this sense, gender nonconforming bodies are medicalized even before a formal diagnosis, such as in the case of gender variant youth (Bryant 2011; Burke 2011). Diagnosis supports medicalization, as it becomes the rationale for particular treatments and

professional decision making (Conrad 1979; McGann 2011). The cultural need to control gender nonconformity sparks the creation of new diagnoses, where kinds of patients are *created* (Bryant 2011; Conrad 2007; Esposito and Perez 2014; Wakefield 2013). For example, a girl who engaged in male-typical behavior and dress was considered a tomboy until the DSM-IV formalized a diagnostic category that pathologized such behaviors (McGann 2006:373). Cultural, political, and moral struggles lay the foundation for medical “truths” that appear as scientifically based, codified categories that in turn, become embedded into research and practice (Fausto-Sterling 2000). As a result, it is often difficult to think critically about these social constructs that become reified and taken for granted in the process (McGann 2011), a challenge we address by engaging with the sociologies of medicalization, diagnosis, and social control with respect to transgender health care.

The regulation of sexual and gendered identities and behaviors is seen in how medicalization has become intertwined with broader social life, such as the ways medical and psychiatric experts are called upon to share their knowledge and make decisions in legal, educational, academic, and even other medical arenas (Bowker and Star 1999; Bryant 2011; Conrad 1979; McGann 2011; Meadow 2010). For example, as the courts are facing an increase in petitions for reclassification of gender, the centrality of gender classifications—and their unstable boundaries—are most clearly seen when gender is contested. Meadow (2010) observed:

Despite reliance by courts on medical corroboration, medicine produces no singular definition of maleness or femaleness. Instead, courts engage in projects of excavation; they enumerate constellations of bodily and psychological indicia and then provide social rationales for why some of gender’s indicia matter more than others. What emerges is a relational construct; law actively constructs the fabric of the gendered body and ties it to relationships with others. While no courts treat gender solely as an elective property of individuals, almost half of the courts allow for movement between gender statuses. The process of legitimation relies most heavily on medical procedures associated with treating transsexuality (efforts to surgically and hormonally align the physical and psychological gender of the litigant). (P. 823)

One’s access to medical and surgical interventions propels the legal construction of sex (Khan 2011). The courts confirm and strengthen medicalized truths about sexed and gendered differences, where providers, by applying particular treatments, assist in the mythical notion of gendered and sexed dichotomies as natural and normal (Fausto-Sterling 2000). The self is constructed through a political, social, and medical struggle that essentially gets inscribed into the body (Fausto-Sterling 2000). Moreover, it is the investment and steps taken to affirm a culturally acceptable presentation of gender that secures one’s status as transgender and legal recognition of one’s felt gender. Those who choose to refrain from physically altering their body remain invisible (Khan 2011).

In this sense, the medical and psychological providers, those who allow access to these medical interventions, are essentially *captive professionals*, agents of our cultural institutions working to help patients adjust to a world that, we are told by science, only includes two genders (Conrad 1979). For many transgender people, medical diagnoses and the medical treatments they choose or are allowed to access, are the key to the legitimation that they need in order to obtain state identification documents; to gain protections from sexual discrimination; to gain the social and economic benefits of legal marriage; and to enter gender-segregated spaces (e.g., athletics, schools, restrooms, and workplaces). Therefore, it is vital that we investigate the *process* through which diagnostic categories are applied, perpetuating sexism and heterosexism. We must pay special attention to the multidirectional complexity of these processes that include multiple actors and particular contexts—and that create *patients* with both medical diagnoses and social diagnoses (political, cultural, and social conditions; L. Brown and Jenkins 2011).

## Diagnosing Transgenderism

### *Diagnostic Statistical Manual of Mental Health Disorders*

Transgender identities became medicalized and associated with mental illness long before they formally appeared as diagnostic categories in the DSM. Under the medical model, since “sickness” is the necessary condition to access medical intervention, transgendered presentations were first recognized as a result of mental illness or a physical malady (Stryker 2008). In 1931, Magnus Hirschfeld, an early advocate for social reform for “sexual intermediaries,” was the first to coin the term “transvestite” to describe people who desire to dress in the clothing of the opposite sex. He was also the first to explore genital transformative surgery (Stryker 2008). However, it was Harry Benjamin who became known as the leading medical authority on transsexuality (Ekins 2005; Stryker 2008). A German-born, American endocrinologist and sexologist, Benjamin believed that, for some patients, psychoanalysis was not sufficient for treating transsexuality and therefore pushed for surgical interventions. This was a bold move that came about during a turf war over how to handle transsexualism. In 1952, Christine Jorgensen’s sex reassignment surgery sparked a media frenzy. The only public medical response to the event appeared in the *Journal of the American Medical Association* and was written by two psychiatrists who criticized the medical experts who assisted Jorgensen. Wiedeman, one responder, stated, “The difficulty of getting the patient into psychiatric treatment should not lead us to compliance with the patient’s demands, which are based on his sexual perversion” (1953:1167). As an advocate for transsexuals, Benjamin argued that appropriate patients should receive hormones and sex reassignment surgery (Bullough 2007). It was through Benjamin that transsexualism, the diagnostic term used in earlier versions of the DSM, became a “distinguishable clinical entity—a diagnosis with a treatment program,” and, thus, a legitimate medical problem (Ekins 2005:309).

It was not until 1980, with the release of the DSM-III, that GIDs first emerged, at the same time, as mentioned previously, that the APA incorporated the biomedical model into the document's diagnostic criteria. Since then, the diagnostic criteria and the language around transgender have shifted several times, reflecting dominant attitudes about gender and sexual expression as diagnosable conditions (see Table 1). Two issues have persisted over three decades: the separation of "true" gender incongruence from sexually motivated cross-dressing and the importance of the degree to which one experiences distress from living with one's natal sex. At the time of this study, the providers were working with the diagnostic categories of the DSM-IV-TR. According to this version, in order to obtain a mental health diagnosis of GID, a patient must present significant distress or impairment as a result of their gender incongruence, without necessarily wishing to undergo gender confirmation surgery. This GID category replaced three distinct, more specific categories and marked the early distinction between diagnosing *gender variation* and diagnosing the *stress* caused by gender variation (Winters 2005). This goal remained with the change of GID to GD and the removal of GD from the section on Sexual Dysfunctions and Paraphilic Disorders in the most recent revision in the DSM-5 (APA 2013).

The name change to GD is meant to destigmatize and depathologize patients by only focusing on the distress caused by gender nonconformity rather than diagnosing and stigmatizing all people who experience gender incongruence. Moving GD out of the section on Sexual Dysfunctions and Paraphilic Disorders is an attempt to decouple gender from sexual deviance, while still providing a diagnostic category so that patients can access treatments. Regardless of these technical changes, the diagnostic criteria remain quite similar (Wakefield 2013). Within this treating community of professionals, some acknowledged that diagnosing gender can pathologize otherwise healthy bodies (P. Brown 1995; Lev 2013), while other providers viewed one's gender incongruence as a sign of disorder unto itself (Winters 2005).

While the less specific language of GID could theoretically expand access to a wider array of gender-related interventions, the addition of the new diagnostic category Autogynephilia created a new way for providers to limit access. If a provider believed their patient was motivated to undergo gender-related hormonal or surgical interventions due to a fetishistic obsession of oneself as a woman or internalized homophobia (see Blanchard 2005), the autogynephilia diagnosis could designate that patient inappropriate for such services. In combination with the heterosexual male-focused transvestic fetishism (TF) category, these diagnoses serve to stigmatize some transidentities and experiences, limit medical access for some, and affect what patients will disclose with doctors and therapists in order to not appear eroticized by being a particular gender. What is most evident with these diagnostic changes is that the shift to clarify categories results in allowing treatments for some while denying them for others.

### *Harry Benjamin's International Gender Dysphoria Association's SOC*

In 1979, the Harry Benjamin International Gender Dysphoria Association, the first professional organization based on Benjamin's views, formed. In this same year, members of this group, now known as the World Professional Association of Transgender Health (WPATH), crafted the first SOC, a document to guide clinicians in the medical and therapeutic treatment of trans-identified patients. Similar to the DSM, the SOC was developed to increase data collection and communication of findings through standardization, lessening tensions between clinical practitioners versus researchers and national versus international interests. Also, like the DSM, earlier versions of the SOC were based on a combination of expert consensus and idiosyncratic provider experiences with transpatients, rather than on sound empirical evidence (Coleman 2009). The SOC is a product of the changing context of American medicine and psychiatry, specifically gender-related diagnostic criteria found in the DSM. Arguably, the SOC assists in further medicalizing trans-identified individuals because it has, since its inception, required either a formal DSM diagnosis and/or therapeutic assessment prior to administering any hormonal or surgical interventions and therefore, contributes to the rise of biomedicalization.

While the SOC is meant to provide "flexible directions on how to treat persons with gender identity disorders" (Meyer et al. 2002:3), both the sixth and seventh versions of the SOC (see Table 2) specify minimum requirements. Referred to as the Triadic Therapy (Meyer et al. 2002:3), the SOC-6 requires that eligibility and readiness requirements be met which require a therapeutic assessment and/or relationship with a mental health practitioner, evaluation, and diagnosis based on DSM criteria prior to undergoing any transitioning services,<sup>3</sup> education and psychotherapy. It also includes referral for hormones, if applicable, and continual monitoring of gender transition, especially in educating family, friends, and colleagues (Meyer et al. 2002:12). Furthermore, the SOC-6 also states that patients must live in their chosen gender (referred to as the real-life experience or RLE) for at least three months before receiving hormones, and at least 12 months before accessing sexual reassignment surgery. To meet the third requirement, patients must obtain one letter indicating their GID diagnosis from a psychologist or psychiatrist for reversible surgeries and hormones, or two letters, at least one from a PhD-level therapist, to obtain sexual reassignment surgery (more recently known as gender confirmation surgery). The letters, which also include information pertaining to the patients' readiness to transition and preparedness to undergo surgery and a new gender role, are presented to the surgeon, who then decides whether the patient will receive their services (Meyer et al. 2002).

The most significant changes with the release of the SOC-7 are the removal of the requirement of a formal DSM diagnosis prior to treatment and the elimination of the letter of recommendation for hormones under some conditions. While the removal of the DSM diagnosis is meant to provide more fluidity in treatment and to reduce pathologization of gendered identities, essentially recognizing dysphoria

or discomfort with one's gender as different from gender nonconformity, it still requires formal psychological assessment (Coleman et al. 2011). The intent of the elimination of the letter requirement in some circumstances is to reduce patients' requirements to navigate both medical and therapeutic systems and, seemingly, to decouple gender incongruence from mental illness. The SOC-7 no longer requires a letter for access to hormone treatments, however, it still requires that patients must experience persistent GD, that it is well documented, and that patients undergo a psychosocial assessment by a qualified health professional (Coleman et al. 2011:34). To receive surgeries, patients still must obtain recommendation letters from therapeutic professionals, and therefore, under both cases, must continue to navigate both mental health and medical systems. They still must submit to psychopathologization by engaging in a relationship with a mental health worker who is "competent in using the DSM" and has earned a degree in the clinical behavioral sciences (Coleman et al. 2011:22). While providers no longer must decide who has GID, as previously required in the SOC-6, they are still required to ensure that patients have the "capacity to make informed decisions," a psychiatric or cognitive assessment (Coleman et al. 2011:42).

## Methods

The data presented in this article come from qualitative interviews<sup>4</sup> of U.S.-practicing medical and mental health professionals ( $N = 20$ ) conducted in 2008 and semi-structured interviews with trans-identified patients ( $N = 24$ ) conducted in 2007 and 2008. Since the focus of this article is on medical and mental health professionals and the key documents that coordinate their activities, the analysis is based on the interviews with professionals. We include excerpts from the patient interviews to demonstrate professional attitudes and activities and their effects on patients.

Results were presented at WPATH professional conferences and to transorganizations in the Midwest, the site where data were collected. This project was conducted with institutional review board approval. All interviews and audio recordings were destroyed upon completion of the project, and we use pseudonyms throughout in order to protect the confidentiality of the interview participants.

### *Medical and Mental Health Professionals*

For obvious ethical reasons, we could not observe patient-provider interactions and had to rely on interviews with practitioners, asking them to share specific details about their treatment decisions in recent interactions with patients and colleagues. A sample was compiled from the member list of WPATH, the only organization that identifies providers who specifically treat transpatients. The first author gained the approval of the organization president and was instructed to post an invitation to participate in the research to the member Listserv. This first approach elicited only 10 responses, at which point the WPATH president suggested sending e-mails to

individual members whose contact information was posted in the member section of the website. Only U.S. clinicians were included in order to best compare idiosyncratic professional responses to patients with all providers practicing under similar cultural, medical, and psychiatric systems. This small sample ( $N = 20$ ) is limited because provider respondents are a form of opportunity sample (Conrad 1987). The sample is also limited in that it does not include the many other professionals who treat transpatients who are not members of WPATH. Despite these limitations, this study begins to address the large gaps in the literatures on transgender health and the sociology of diagnosis.

Recruitment yielded 22 responses to the invitation, and two practitioners declined to be interviewed because they did not feel as if they treated enough transpatients to offer any insight into the project. The sample of providers includes 10 therapists/psychiatrists and 10 medical practitioners. Specifically, they include a sex/gender therapist, an infectious disease specialist, an urologist, an emergency room physician, two licensed clinical social workers, two psychiatrists, two primary care physicians, five clinical psychologists, and five plastic surgeons, all of whom treat both transmen and transwomen, although the majority of their trans-identified patients were transwomen. These providers were chosen because the SOC-6 stipulates that transpatients who desire hormonal and surgical transition must seek mental health approval to access medical interventions. The participants perform the various transition-related services sought out by transpatients who desire to physically alter their bodies (e.g., facial feminization, breast surgery, and gender confirmation surgery), and this cross-disciplinary relationship is created and maintained by the clinical guidelines. Although psychiatrists are technically medical doctors, we include them as mental health professionals because they are asked to *assess* patients for hormonal and surgical services, not to perform these services. Psychiatrists that were interviewed spoke most about being sought out for a second letter of recommendation as required by the SOC-6 for those patients seeking gender confirmation surgery. In order to ensure participant confidentiality, we only indicate if they are medical or mental health providers, rather than specifying their particular areas of practice.

In each provider interview, respondents were asked nine open-ended questions in order to gain insight into their professional knowledge of treating transpeople. Questions centered on three key themes: (1) how they saw their role in treating transpeople; (2) what they believed to be the benefits and challenges of using the DSM and SOC; and (3) and what they considered to be successful treatment. Of the 20 interviews, 10 were conducted in person and 12 were conducted by phone to accommodate disparate locations. The interviews lasted one to two hours.

### *Transpatients*

Some of the supporting excerpts presented in this article come from interviews with self-identified trans individuals that occurred during the course of a year-long

observation of three trans-focused organizations in the Midwest. The first author gained the approval of each organization's president and announced her presence and research to the entire group upon arrival to the meetings. These observations elicited a convenience sample of 24 participants willing to speak to their general experiences of transitioning, as well as issues concerning discrimination and harassment. All interviewees were white with a mean age of 48 years. Twenty-two respondents identified as women, 20 of whom indicated that they were birth-assigned male, while 2 stated they were assigned intersex. The remaining two identified as men having been assigned female at birth. In each interview with trans-identified individuals, respondents were asked to describe their experiences with discrimination and harassment in various contexts, such as the legal and medical systems. All interviews were conducted in person and lasted one to two hours.

### *Data Collection and Analysis*

Qualitative interviewing allows social researchers to investigate the ways people come to understand the world around them, especially when events and settings may be off limits to most of us, such as in the case of the doctor–patient interaction (Weiss 1994). In data collection, coding, and analysis, the first author employed a grounded theory approach (Charmaz 2008; Strauss and Corbin 1998). Grounded theory evolves systematically and inductively, creating theory from the actual experiences of those being studied. Grounded theory is an *emergent method*; a process by which the interviewer conducts, transcribes, and analyzes interviews while still collecting data, allowing the interviews to evolve based on what the interviewer learns in the process. The first author used various strategies of coding such as open, axial, and selective coding (Strauss and Corbin 1998). Starting with line-by-line analysis of the data, the first author identified particular themes of interest. Then, in a more focused analysis, began to look for thematic repetition. The first author also wrote down initial jottings which are memos that reflect the interviewee's responses and self-evaluation of what was learned from them (Charmaz 2008). Then, those experiences were compared in order to learn how individual responses differed or were similar to those of other interviewees. Through issues-focused description, providers' experiences were logically connected, thereby sorting and integrating the data (Weiss 1994). Sociological theory was built inductively through an iterative process of reevaluation of notes and transcripts that revealed recurrent themes (Charmaz 2008; Emerson, Fretz, and Shaw 1995; Weiss 1994).

## **Findings**

### *GID Is Categorically Problematic*

GID is categorically problematic because it impedes some patients from accessing health care and it often does not assist providers in understanding and providing care to their patients. The SOC-6 required a diagnosis of GID based on DSM criteria prior



to administering treatment. Of the 20 providers, 13 specifically spoke about the problem this creates because insurers often refuse to cover medical or mental health treatments related to transgender. Trans-identified interviewees often know more about their insurance coverage than practitioners and are aware that a diagnosis of GID can exclude them from coverage. Sometimes patients discuss this with their providers to negotiate diagnostic coding while others, such as Joan a trans-identified woman, use this knowledge to strategize how to approach their therapists:

They [insurers] don't want to touch me . . . psychological services are only covered if it is not related to transgender issues. I don't think that a transgender therapist would be covered. It's like going to confess to a priest. You're careful with what you say. (Joan, trans-identified woman)

Although GID is often not covered by insurance, insurers still require that providers apply a DSM diagnosis in order to secure reimbursement for their services. Therapeutic professionals must adhere to strict coding as outlined in the DSM in order to receive payment for the treatments they provide and to reduce out-of-pocket costs for patients. This is complicated, however, because not all diagnostic codes are covered.

Eight providers made specific references to applying alternate diagnoses, such as depression or anxiety, in order to ensure coverage. Joseph, a therapist, states "And the mental health treatment was covered but the diagnosis was not GID, but depression. Yes, I learned from the beginning that you do not put down that [GID] diagnosis." Natalie, a therapist, agrees:

Now I will not give anybody a diagnosis of Gender Identity Disorder. Most of the time it is not covered by insurance; so most of the time they either are depressed or anxious. So that way they can use their insurance, I get paid, and they get their treatment.

Rita, a therapist, shares a similar process of alternative diagnosing:

Your whole gender identity is in question and that is going to make you anxious so let's do that. A person who is dealing with gender dysphoria is also dealing with a whole lot and so they are anxious or depressed or having panic attacks or having problems managing anger which definitely fold into gender identity. If we live in [a large city], we could fall in that category.

Rita's response supports Wakefield's (2013) argument that flawed DSM criteria, especially for depression, creates the potential for more people being subsumed under its label rather than the more specific GID label. By administratively connecting the conditions through alternative diagnosing, gender incongruence is conflated with mental health disorders, a point we will revisit later in this article.

While insurers require a DSM diagnosis to cover mental health treatments, they also need a medical diagnosis to cover medical interventions, such as hormones or surgery. However, a GID diagnosis does not guarantee that insurers will provide medical coverage. Joseph, a mental health provider, elaborates:

The problem with the GID diagnosis is that once you get that [diagnosed with GID], they [insurers] can keep saying ‘well this is a mental disorder and therefore, they need mental health treatment and not surgery or hormones.’

Insurers defend their decision to refuse claims on the basis that GID is a psychiatric, rather than a medical, diagnosis. While many surgeons who perform elective surgeries are paid directly by patients, a few doctors could access insurance coverage for their patients by creating a narrative that fits with alternative medical diagnoses. Joseph elaborates:

... the best way to get the insurance reimbursement is to frame it as a medical condition and not a psychiatric condition. Right, so if you can argue that there was an intersex condition or some hormonal condition ... if you can make a purely medical argument for it, you are more likely to get reimbursement for the [gender confirmation] surgery. But it actually has to exist. You need the evidence.

However, there are some arguments that can secure coverage for hormone therapies that do not actually require evidence. For instance, Eric, a physician, shares how he uses a precocious puberty diagnosis to ensure coverage for puberty blocking medications. He says, “I think parents have tried [getting insurance to cover puberty blockers for their transgender child] depending on the diagnosis. Certainly for stuff like precocious puberty it would be accepted ... Oh, sure. We’ll do it.”

As we see, GID as a diagnosis provides no guarantee of medical or therapeutic insurance benefits to patients who may fall under its symptomology. In some cases, a GID diagnosis actually *limits* access to care. By not accepting GID as a coverable diagnosis for mental health or medical treatment, insurers force professionals to use alternative DSM or medical diagnoses in order to secure payment for the services they provide to their transpatients. Insurance restrictions compel providers to construct a narrative in order to fit the patient into alternative (covered) categories. This further conflates gender issues with mental health problems, deepening patient pathologization and psychopathologization, and further harming patients.

Patients are also aware that a GID diagnosis can further stigmatize them and affect their ability to receive treatments, secure current and future insurance coverage, and, if found out by their employer, can result in their termination. Rita, a therapist, although referring to the diagnostic label of GID as “dysphoria,” a term now used in the DSM-5, describes how patients assist in deciding if using formal DSM coding is appropriate:

On occasion I will use gender dysphoria [GID] but now I don't want to run the risk. Based on self-report from the person in therapy . . . sometimes people will say 'please don't put dysphoria [GID]. Don't identify me in any sort of way [as] dealing with this.'

To ensure that the diagnosis does not create future problems, patients also work with clinicians to separate coverable services under their male name, as Patty, a transwoman, explains. "My current physician has two file folders. Everything that is transgender is run through my female name, but my male medical treatment is given to the insurance." This strategic move avoids the potential for being denied mental health or medical care just because one is transgender, even if the services requested have nothing to do with transitioning. This also ensures that any services that might give away that she is transgender will not be associated with her male name, which is important since she still must present as male at work. Vicky, another transwoman with similar issues, calls this "dual citizenship."

Often, through a process of discussion and negotiation, therapists and patients together arrive at a decision about alternative diagnosing. Natalie, a therapist, explains:

It is more like a hoop. For instance, the way I deal with the client is, I will discuss it with them and I'll tell them I will not use GID as your diagnosis and sometimes I will ask 'do you want to be depressed or anxious?' Pick your malady because there is enough overlapping and many trans folks are savvy to this.

In this sense, transpatients become a part of their own pathologization and medicalization in order to access services, secure insurance coverage, and control information about their gender that may put them at risk if discovered. The requirement to label a patient with an alternative diagnosis in order to secure health care for transgender people can also work to erase them as an identifiable group in need of medical and therapeutic attention. However, this situation also shows that through negotiation, providers are dedicated to meeting patient needs. Even if some did link having GID to other mental health issues, others, such as Susan, a surgeon, describe the requirement of a mental health diagnosis as one of the "biggest abuses in the system":

People are telling me that this is the way they have felt since they were three, four, and five years old, and we're being told it's a psychological condition; in other words, they're half-crazy kind of thing. It's hard-wired in the individual. It's not psychological.

Susan's response attempts to delineate gender nonconformity from patient psychology by using a biomedical argument. This narrative is useful for justifying the provision of services to transpeople in a culture that requires scientific "proof" of their sickness. However, the requirement that gender incongruence must be experienced early in life inadvertently limits services and frames gender incongruence as a

preexisting condition giving insurance companies the argument for noncoverage (Khan 2011). Joseph, a therapeutic professional, underscores the central struggle around the GID diagnosis in the DSM:

Is this a disorder or not? And the dilemma is that there are advantages to having it labeled as disorder mainly to get treatment covered and there are disadvantages to having it called a disorder because people don't like to be told they are nuts.

As Joseph reveals, many providers do not see gender variance as a mental health disorder, but they also see the benefits of using the GID diagnosis. However, the data show there is no real advantage for *patients* in having the GID diagnosis in the DSM. Moreover, Joseph's response that patients "don't like to be told they are nuts," appears to minimize the harmful reality that transpatients experience when they are needlessly diagnosed or when their gender identity becomes synonymous with mental illness. Therefore, despite believing that gender variance is not a mental health disorder, professionals are forced to use GID or alternative diagnoses to effectively treat their patients. Even if GID is an ineffectual diagnosis, its existence and insurers' requirement for a formal diagnosis forces providers to engage in a process that further medicalizes and psychopathologizes their patients.

### *GID Is Procedurally Problematic*

The SOC-6 outlines a general process that professionals use when treating patients who desire to transition through hormones and/or surgery. It states that in order for a patient to access these services, they must be accurately diagnosed as having GID (Meyer et al. 2002:12). While the SOC-6 claims that it can be used fluidly, it also states that all eligibility requirements are to be met including obtaining one or two recommendation letters (Meyer et al. 2002:3). The recommendation letter is the formal diagnosis and narrative that serves as proof that one is appropriate for surgical and hormonal treatments. Prior to genital surgery, the SOC-6 requires patients to obtain two letters of recommendation from mental health workers, one of which must be from a PhD-level therapist.

All respondents shared the importance of obtaining approval prior to administering services. Diane, a therapist, explains:

I don't understand how doctors could perform surgery without [the recommendation letter] because there is no test. I mean doctors and therapists put so much on the line with these surgeries. You are messing with people's reproductive rights . . . and in most cultures if you remove somebody's penis it is the worst possible thing that could happen.

In this way, the letter becomes something more than documentation of a diagnosis. It relieves professional liability, serving as proof in the absence of a definitive medical

test. It also relieves cultural liability, an important function since providers are often perceived to be going against a biological/natural order that is reduced to sexual reproduction. Unfortunately, the social mandate to protect reproductive rights makes it much more difficult for providers to honor the patient's right to exercise their own reproductive freedom through access to transition services.

Joseph, a mental health professional, affirms the importance of the letter:

I think the surgeons were worried that well we should have seen this person was crazy, right, and I shouldn't do surgery on someone who is crazy. So again if they have a letter from a psychologist saying they are appropriate, it releases their liability.

More than releasing the liability for surgeons, the letter confirms that one is mentally stable and not crazy. The fear is that a transpatient might sneak past them that they should have seen was mentally ill. This quote reveals the inherent belief that while mental illness and gender variance are intimately intertwined, they can also somehow be separated.

Similar to Foucault's description of the expanding legal system, the recommendation letter becomes the point where professionals further immerse transindividuals into the medical and psychiatric systems. Susan, a surgeon, discusses the problem of a lukewarm recommendation letter:

If the therapist says 'this person is psychologically stable and ready to move forward with surgery,' or whatever, [then] they need to give us a little more than that. We need to hear about their history, the details of their life, and what's really going on . . . It's kind of like the unsaid stuff. [If] It just doesn't read as authentic, I'm more likely to question it.

From this quote, we see that a narrative is created to prove that one is appropriate for services. Diane, a therapist, explains the depth and scope of the areas of the patient's life that are subject to investigation:

First paragraph, how long we have been seeing each other. Then the rest is about who they are, like this person was born in this place with this many siblings, something about the relationships with their family and then something about the work that they do and their career goals and then a bit about their gender development from childhood. It is usually that they had reported fairly early awareness and lifelong desire. And then what they have done so far, like if someone is expressing themselves as males all the time or part of the time. And I do comment whether or not they fit a diagnosis because most doctors go 'oh, good.' It makes the letter more strong.

What is apparent thus far is that while the letter confirms and justifies the GID diagnosis, a strong letter that conveys an approved narrative, which maps onto the diagnostic criteria set forth in the DSM, is preferable. A lengthy therapeutic relationship is highly valued and demonstrated through disclosure of intimate details of the

patient's personal and social life. Instead of the diagnosis leading to medicalization, the patient's life must be framed through a medicalized lens in order to prove, through diagnosis, that they have a legitimate claim to medical services.

Perhaps because of the need to reduce liability, providers use the letter to produce a patient who is a model of rationality and normality, especially as information about their family life is presented. The letter is developed through a cross-professional process of telling a truth about a transperson that includes every aspect of their life in hopes of showing that patients appear as normally gendered, sexed, and mentally competent people; the default assumption is that they are not. Patients are forced to appear normal and of sound mind while, simultaneously submitting to a mental health diagnosis. Specifically, although with much variation, we found all providers evaluated the normality of their patients based on two general themes: gender presentation and mental health.

### *Having a Real Gender Issue*

For 11 of the 20 respondents, diagnosing is about ensuring that the patient has a real GID, which is often based on pervasive, problematic cultural understandings of femininity/masculinity that are also heterosexual or asexual (Epstein 2007:253). To reiterate, the GID diagnosis pertains to a lifelong, persistent desire to be the gender not assigned at birth and rid of one's genitals. This is in contrast to the TF diagnosis, which is reserved for heterosexual men who are sexually aroused by wearing feminine attire. TF is considered a paraphilia in the DSM-IV-TR, a category that would restrict the patients' ability to access hormones and surgery. Janice, a mental health worker, explains how she decides if a patient has a real gender issue:

And then when I say to them 'okay if I could waive a magic wand and turn you into a woman full-time and you had to go through A, B, C, D, E, and risk all this fallout would you do that?' Cross-dressers would say, 'absolutely not. I am totally fine being a male. I just like [to] dress up and get off being a woman once in a while.' A transgender person would say, 'I'll do anything. I'll do anything to be my true gender.'

This provider views real transgender people as those willing to do anything to transition. Because there is no scientific test to prove gender and because, as Meadow (2011) states, medicine lacks a clear definition of what it means to be male or female, it is the motivation of the patient to meet culturally accepted presentations of being male or female that stand in as the test. This logic and the difference in diagnostic criteria in the DSM-IV-TR pit these two diagnostic categories against one another where GID is seen as consistent, based on real gender concerns, worthy of services while those labeled with TF are devalued, and their behaviors are dismissed as periodic, sexually motivated dressing, inappropriate for services. Joseph, a therapeutic professional, furthers this distinction:

There are two kinds of men who want to become women. The androphyllic type are the homosexual type. They are attracted to males and sort of had a gay lifestyle orientation for a while but they don't want to be with a male who is interested in them as a male but they want to be with a male, preferably a straight male who wants to be with them as female. The autogynephilic type, masculine play behavior, dress as a child . . . do it because it was soothing . . . cross-dressing with mother's, sister's panties. Fantasies of being female are eroticized. This is what is behind the majority of cross-dressing. This is what transvestites have, right? And some of those people also want to change their gender and this is the majority of the MTF (male to female) transgender folk. I believe it is a combination of the identity issue and a sexual phenomenon.

While appearing to endorse a fluid understanding of gender identity in combination with sexual phenomena, Joseph attributes transgender experience to either internalized homophobia or as a progression from having TF. While Joseph, like most interviewed, does not believe that the sexual component should be reduced to a paraphilia or that services should be denied to those who experience a sexual component to their identity, one can see how other providers upon hearing such a statement, especially with the rigidity of the categories in the DSM, can interpret it this way. Because the DSM has already created these identities as opposed to one another, valuing GID over TF, Joseph may be attempting to integrate these diagnoses, but this nuance is lost and can also be understood as reducing some patient's GID diagnosis to autogynepheilia or TF.

The above respondents were the only individuals who were specific about recognizing definitive identities. Most respondents indicated their understanding of various transgender experiences and their willingness to work with their patients; however, the ways they spoke about specific patients reveals their personal biases on gender. Sarah, a therapist, demonstrates:

She is androgynous, balding, no effort to change hairstyle to look feminine, fingernails dirty, has ringing in ears, history of back trauma. She is on disability and I just don't think, I won't push her for surgery. She is disabled, pathological, pathetic looking person. I am no gorgeous girl but if you give no effort to be feminine are you doing the right thing?

As evident here, the provider does not see gender as fluid, but rather as deeply tied to a strict binary of gender presentation. Again, patient motivation to present as "appropriately" gendered serves as the evidence to the provider that one should receive services. One must appear as culturally recognizable men and women before accessing medical services that would greatly assist in this process. While Sarah is bothered by this patient, she does still provide hormones to her. Kathy, also a therapeutic provider, shares an analogous comment:

Sometimes he feels like he really is a woman and would like to transition into more of being a woman. Sometimes he talks about pursuing it medically in terms of hormone

therapy, looking at surgery but hasn't gotten that far but has from time to time varying degrees of cross-dressing, body hair removal, makeup, haircuts so he sort of plays with it. He dabbles. In some ways he doesn't progress.

Kathy later states that for her patient to progress was to get out of his "limbo state" and "become more comfortable with his identity." Most interestingly, Kathy uses male pronouns, further revealing her inability to accept her patient's gender fluidity or that the patient identifies as anything but male.

As the above quotes show, dichotomous gender presentation is used as an indicator of the patient's motivation to transition, placing one firmly within a diagnosis of either GID or TF. Even when speaking about patients who they feel should continue with their transition, there is a continued focus on appearance as Eric, a medical provider, discusses:

Like the transgender patient that says 'I got to have surgery.' Who cares. Put your money into your body. Put it into your face, facial feminization. Get your breasts augmented. Learn something about fashion.

If trans-identified individuals want hormones and surgery, they are often compelled to perceive themselves through the narrow lens of GID criteria, and, perhaps more importantly, through the strict cultural meanings around gendered embodiments and experiences. Like the women in Werner and Malterud's (2003) study who had to work in order to appear sick so that they would be taken seriously by their doctors, transpatients may feel pressure to appear just right. For Vicky, a trans-identified woman, this means appearing as a culturally readable woman:

First off you have to have the therapist decide whether you are, yes or no, the real thing. And they do that through talking to you at your visits. In any case, my therapist knew from the second or third meeting session that I was the real thing. I did everything that she wanted me to do.

This quote reveals the power the professional has in deciding who will have access to services and how part of that decision making is based on professional expectations of compliant patient behavior. Joan, another trans-identified person, discusses her gender in a manner that is readable through a biomedical lens:

Talking about labels. Crossdressing? Yes I dress, but not for sexual pleasure. I'm past that. It feels good. It makes me feel good but not sexual.

In order to avoid the TF diagnosis, transpatients must speak about their identity as one that is asexual or present their desire to dress in opposite gendered attire as non-sexually motivated. If sexual activity must be included in the discussion, then transpatients may certainly feel pressured to speak of themselves in a heteronormative way. Diane, a transwoman, shares, "We are not sexual deviants. Most are married



and heterosexual.” In this sense, transpatients are “doing transgender” where they are reinterpreted in therapeutic and medical encounters (Connell 2010). Professionals are aware of pressure experienced by patients to present in readable ways. As Eric, a physician, commented, “Yes and well I can’t blame them [patients]. They are creating a story of themselves that they believe fits with the identity.” Judy, a surgeon, also shows her awareness to this fact: “People tell therapists what they want to.”

One must present as a culturally readable man or woman to access services that can physically alter one’s body to achieve gender transition. Pitting GID and TF against one another, patients must be willing to progress through their transition and present as either heterosexual or asexual in order to ensure the diagnosis of GID (a mental illness), rather than TF (a paraphilia), the only two options available. Regardless of how one is diagnosed, patients must submit to psychopathologization before they prove their mental stability. It is the personal responsibility of the patient to proceed through the mental health system in the correct way—investing substantial resources into the process—in order to demonstrate that they are able to lead a fulfilling, productive life as a result of the medical interventions. According to Esposito and Perez, “Failure to take this sort of ‘personal responsibility’ typically reinforces that person’s presumed pathology” (2014:9).

### *Being Mentally Competent*

The SOC-6 requires that professionals confirm patients’ mental stability prior to administering hormones. How providers interpret and do this, and how patients respond, vary considerably. For some, mental health is tied into gender presentation as Sarah, a therapeutic provider, further explains regarding her client:

I have not confronted her about not being feminine but I do give her hormones, small doses to be supported but she bothers me. Borderline personality. She’s a mess but making some strides. They took inadequate personality out of the DSM III and they should have kept it. There are people that are just not going to make it.

Similar to the last theme, where appropriate gender presentation resulted in the increased likelihood of accessing services, presenting as readable men and women also signifies patients’ mental health—another important piece of establishing whether a patient is appropriate for services.

Assessing mental stability does not just ensure that patients are free from other mental health diagnoses; it extends beyond the DSM and incorporates subjective interpretations of patient competency and rationality. Fifteen of the 20 providers rely on a mental health discourse when speaking about their patients and their decision making about treatment. Joseph, a therapist, demonstrates:

I’ve come to a very different view, which is essentially that if someone comes into my office and as long as they are mentally competent to make decisions about their life,

that they are not mentally incompetent, not committable, that is a pretty high standard. It is their choice as to what they do.

Providers support patient choice as long as the patient appears competent based on the provider's subjective assessment. Frank, a medical practitioner, also shows the importance of mental stability when he states, "But if I see a patient who does not impress me with their psychological stability, I'll send them back to the therapist." These quotes show that the burden of proof is on the patients; therapists do not diagnose observable mental health issues, rather patients must prove mental stability. For Bill, a medical professional, being a true transperson is synonymous with being mentally healthy:

I am not worried about a true trans suing me . . . So if you get somebody who isn't a true trans or that has some sort of underlying psychological issue, it's not the true trans I am worried about. That's why I sit on the psychological evaluations. I want to make sure this is a true trans and not somebody who is confused or has some psychosis or something else going on.

Bill's comment further demonstrates that while gender variance and mental illness are intertwined, they are also, in some ways, mutually exclusive. That is, this provider believes that patients with true GID are not mentally ill, while at the same time applying the criteria for the GID mental health diagnosis in deciding which patients have real gender issues. In the end, Bill's biggest concern comes down to liability and protection from future lawsuits.

While some providers withhold transitioning services when a mental illness is present, for therapists like Joseph, treating the mental illness to the point of subjective stability was sufficient to continue transition treatments:

The only times I have not supported surgery is when the individual had a serious mental disorder, like serious depression . . . my approach in that situation is to treat the underlying mental conditions to the point of some stability and then re-evaluate.

The connection established by medicine between mental illness and gender variance, without a doubt, affects how patients present themselves to providers, as Natalie shares a therapeutic interaction:

And so fairly soon we will have to start working on her surgery [recommendation] letter and [the patient] said 'Sometimes I'm really paranoid that people are reading me . . . it really pisses me off . . .' and then she just kind of stopped and said, 'Well you know it is not that bad. It doesn't happen a whole lot.' I just stayed with her and said 'Yeah you know sometimes triggers [occur] and it really gets you, but you don't go through life that way in general. You are not walking around paranoid all the time.' And she said "Right, right." [She was assuming that I thought] [t]hat she was walking

around way too paranoid and had not gotten to a place inside where she was mentally healthy enough to go through SRS [sex reassignment surgery].

The above patient is keenly aware that appearing to be mentally unhealthy can hinder her ability to access treatments. While the therapist is cognizant of this, she still presents a narrative to the patient that essentially confirms the patients' belief that her services can be at risk if she appears to be unstable. Most providers felt that mental health problems should be addressed prior to accessing services. In contrast, two respondents supported administering hormones to *make* one mentally stable, though they were verbally admonished for this by colleagues. Alex, a physician, shares his experience:

I'm not telling you how to practice psychiatry but treating the gender dysphoria may help this patient become more compliant and would improve this patient's prognosis. [The psychiatrist] basically told me to F off in a nice way. "Oh, no, I'm not doing that until this patient complies." It's an arrogant control issue. [Colleagues] don't understand that if you begin hormones you may alleviate some of the other problems.

What is apparent here is that this relatively small community of transcare providers has differing views and treatment approaches, pulling in gender and mental health components to make decisions about who should receive transitioning services. The diagnostic process discussed here is further complicated because it is undertaken in order to craft a recommendation letter or letters so that patients can access hormonal and surgical treatments.

### *The Recommendation Letter Is Procedurally Problematic*

In addition to increasing providers' power in medicalizing patients, the recommendation letter forges a particular kind of relationship between treating professionals that regulates their work and further medicalizes transpatients. For various reasons, 14 providers with whom I spoke shared their concerns with the one or two letter requirement. The burden to obtain letters from two different therapeutic professionals requires patients to commit significant time and money in order to access medical interventions. While including more professionals in the decision-making process and stretching it out over time reduces the perceived risk to providers for treating patients, it often does not make sense for the patient. As Kathy reveals, this creates work-related challenges for therapists:

In other words I don't want to be the one making that judgment. It seems like in some ways it is a sham. In other words, the person sitting with me is there to basically convince me that this is a good idea and there are no problems and I only know what people tell me and so it is not particularly meaningful. Well because that is what they tell me, you know "my doctor said I have to do this and I don't know why I should have to," and there is a part of me that agrees with that.

Kathy shows that the requirement for the letter forces a particular kind of interaction between her and her patients. Patients perhaps see obtaining the letter as an onerous task and therefore present in predictable ways to quicken the process. Under these conditions, Kathy, like other therapists cannot use her therapeutic tools to assist her patients. Brett, a mental health worker also illustrates this point:

My job position was changed from sort of a generalist practice to gender specialist. And I wasn't pleased with that . . . Because I was only doing assessments for hormones. I wasn't doing psychotherapy which is what I do . . . I tell my clients, "Check with the surgeon about what the surgeon wants [in the letter] and then tell me."

Brett shows that the letter requirement means that he is not applying his therapeutic skills but instead is merely making patient assessments to begin hormones. This task is further diminished when he must simply produce what the surgeon requests. Letters are often scrutinized and dictated by doctors, as Frank explains:

And I would actually call the therapist and say, "Look, I know you wrote this letter [approving surgery], but I'm getting this vibe from this patient and I think the patient needs more work." And I can do it easily by saying, "Look, I got this letter but it's not exactly what we need. So I'm going to talk to your therapist . . . when she clears you the way I need you to be cleared, we'll go forward."

When doctors are uncomfortable with providing services, they may contact the therapist as Frank shows. They may also request to sit in on psychological evaluations, as Bill, a physician, describes.

They came to me first and they wanted an orchiectomy so they could require less medication to suppress their male hormones, which is a legitimate thing and I listened. I took a history. I went over with them that this is not standard of care and that this was irreversible, that I would want to sit in on their psychological evaluation, to see if I was comfortable with this, but I would be willing to proceed.

Other medical professionals, such as Eric, require patients to obtain a letter of approval from a mental health professional with whom they are already familiar and who they believe has significant experience in treating trans-identified patients:

So generally even if someone is under the care of a psychologist/psychiatrist we will often ask for confirmatory consultation with someone who has had experience with patients with gender dysphoria, transgendered individuals.

What appear to be steps taken to ensure quality health care for patients or reducing the liability for providers can also be interpreted as what Foucault calls *disciplinary power*, where more and more agents of social control are required to intervene

adding to the already regulatory and expansive nature of the medical system. This is most obvious in Eric's explanation of how he as a physician interacts with therapists:

We have discussions about all of these patients. Which makes it that much richer and the ability to follow patients well and are they ready for the next step? Where are they at? Where are they at maturity wise? Mentally, physically, that is the piece I'll give to (the therapist).

These excerpts show that medical professionals do not just accept letters of recommendation but are actively involved in constructing them. This is most evident when they contact therapists, sit in on psychological evaluations, and request to use the therapeutic professional of their choosing to conduct an evaluation. The therapist, the person perceived to be the one educated and qualified to decide if one has GID and is mentally competent to undergo surgery, often finds that they are merely making assessments based on contrived patient behavior and/or writing letters aligned with surgeons' expectations. Medical providers, on the other hand, are judging the mental, social, and personal competency of patients when, arguably, they lack the therapeutic tools and knowledge to do so. One has to consider the extreme regulatory and expansive nature of the health care system that transpatients must navigate in order to access services, when medical professionals share their subjective views about patient maturity and give their advice about the mental stability of patients with colleagues.

## Discussion

The data presented here show that GID, as both a diagnostic category and as used in the process of treating transgender patients, is problematic. GID does not expand access to insurance coverage for transgender services; instead, mental health workers are forced to work around the diagnosis. In order to secure reimbursement for their services and to ensure their patients can access some health services, providers are required by insurance companies to rely on alternative diagnoses, resulting in further pathologizing patients. Arguably, providers' requirement to use alternative diagnoses may work to decouple gender incongruence from mental illness (e.g., by diagnosing with depression or anxiety instead of GID) but because providers are forced to describe transgender identities within a biomedical model that frames patients as disordered forcing them to use alternative diagnoses, they inadvertently deepen the cultural belief that gender nonconforming individuals are inherently mentally and/or physically disordered (Khan 2011). Connecting gender incongruence with disorder in this way can continue to strengthen the importance of considering one's mental health as the deciding factor in gatekeeping medical interventions for transpeople. In the process, patients are further medicalized and psychopathologized when broad diagnostic criteria, such as that found in depression, become a catchall for transpatients (Wakefield 2013). Furthermore, when patients negotiate diagnoses with professionals, they certainly become participants in their own pathologization (Foucault 1997).

As a category, GID is required through the treatment process outlined in the SOC-6. GID is a way for professionals to communicate with each other about patient appropriateness for services. While most participants spoke about moving away from strict decisions that rely on GID criteria, many providers continued to base their evaluations of patients on those criteria. Moreover, medicalization occurs before a formal diagnosis, where strict cultural beliefs about gender, sexual motivation, and mental stability, and competence become the proof required for the letter of recommendation to access services. This process also further delineates GID from TF so that patients who identify as transwomen, for example, must work to appear as competent, mentally healthy decision makers and as real women who are both appropriately feminine and simultaneously heterosexual and asexual. In this sense, the SOC reveals how it is more than a mere product of the changing context of American medicine and psychiatry, but is also the product of cultural archetypes that need to be reevaluated. When gender is viewed as oppositional and transgender identities are tied to mental disorders, patients are at a severe disadvantage: They must prove they are something that culture and diagnostic categories tell them they cannot possibly be. Similarly, in offering solutions to those struggling against gendered and sexist ideologies, the SOC inadvertently reproduces them.

To secure a recommendation letter to access medical services for transitioning, patients realize the need to present themselves within the DSM and SOC frameworks, as specified by providers. The letter, which is to be written by the therapist and presented to the surgeon, must reflect that a patient is appropriate for medical interventions, specifically that they present in alignment with the requirements of the GID diagnosis, express appropriate motivations for transition, and exude good mental health. However, mental health participants tell us that medical professionals often dictate the contents of the letter and if they have any reservations about patient appropriateness, regardless of their lack of training in mental health, reject the letter. The letter fashions a particular kind of professional interaction that diminishes the work of therapeutic professionals while extending the power of medical providers, especially when doctors tell therapists specifically what they require. The letter is also a truth that imposes itself upon patient's body. The letter, similar to a medical record, a history, or a formal doctor's order, becomes reified. The letter does not merely reflect a life lived but tells a narrative that makes a life livable and recognizable. In this way, the clinical diagnosis is also a social diagnosis, where the interaction between multiple players and knowledge forms intersect, revealing how the diagnostic process reflects cultural, political, and other social conditions (L. Brown and Jenkins 2011).

While this burgeoning and relatively new field of medicine is perceived to reflect diversity and advancement in medicine, its progress may be illusory as it continually relies on and perpetuates outmoded gendered and sexual ideologies and equates variance in such identities with deviance, mental illness, and incompetency. Despite medicine's inability to define or fully accept gender fluidity, it provides services that legitimize the gender identities for those who will rely on medical interventions in order to transition and present their gender in culturally acceptable ways. In this sense, medicine affirms gender identity and cultural norms by enforcing adherence to them. Like

the courts in Meadow's study, medicine and psychiatry fail to see "gender solely as an elective property of individuals" even while providers may espouse it at times (2010:823) and, in turn, work to *create*, rather than merely respond to, what society deems as acceptably gendered and sexed bodies. When medical knowledge and diagnostic processes create an arena where individual choices are not truly valued, patients will continue to be medicalized, potentially violating their human rights.

## Implications for New Diagnostic Criteria and SOC

The participants in this study worked under the DSM-IV-TR and the SOC-6 guidelines. Since then, new versions—DSM-5 and SOC-7—have been released. The change of GID to GD may not meet the intended goals of destigmatization and depathologization. Since GD criteria in the DSM-5 state that those whose current gender identity is contrary to gender assigned at birth should also be diagnosed with GD, the emphasis on diagnosing the *distress* becomes moot. Merely moving GD out of the section on Sexual Dysfunctions and Paraphilic Disorders does not mean that professionals will not still use these two diagnostic categories as tools to determine who should receive services and who should not. For example, Transvestic Disorder, formerly TF, remains within the sexual disorder chapter of the DSM-5. Because it is still viewed as a paraphilia, it can be used to refuse transitioning treatments for some transpatients. Through increased clarification of terms, and in some cases the proliferation of diagnostic categories, medicine takes an expansive approach as it increasingly labels normal variations of human behavior as mental disorders (Wakefield 2013). While the stigmatizing word *disorder* has been removed from the diagnostic name, perhaps reflecting a more accurate medical diagnosis, GD still remains in the DSM-5, a manual of mental health disorders. Therefore, it remains classed as a mental disorder by the APA.

As mentioned, the SOC-7 indicates that formal diagnosis is no longer required to access services and medical providers can now perform the assessment for appropriateness for hormones. Whether a patient desires hormones or surgery, therapeutic professionals are required to decide who is appropriate for particular services. In the case where medical professionals can make their own assessment, we argue that their decisions will likely draw upon the same therapeutic and cultural language as seen in our data. We predict that patients will still work to appear as competent decision makers which, as we have shown, is deeply entrenched with appearing appropriately gendered and mentally stable. Even if a formal diagnosis of GID has been removed, the process of judging these aspects of patients' lives is left intact. Although patients may no longer need a letter from a therapist for hormones, our data show the immense gatekeeping power medical professionals have had all along in deciding who is competent to receive services. The burden to prove mental stability and competency remains on the patient.

Even as the diagnostic category has changed, by keeping the mental health component in place, little is done to change the process of diagnosing. Doctors and therapists have incredible power to mold a patient into an object they can define. To access services, patients must present as particular kinds of people, readable by

cultural, medical, and psychiatric definitions. In the process, they become the empirical evidence that justifies their regulation. In this sense, the medical and therapeutic systems create the problem they purport to solve. Through the use of empirical data, sociologists can critically analyze institutional structures vis-à-vis the daily meaning-making of those who must navigate within them. We call for a more intricate study that examines whether treatment differences exist between transmen, transwomen, and those who identify as gender queer. It is through this research that we can begin a new conversation about health care for trans-identified people—one that focuses on the deeply engrained gender structures that, even in the appearance of change, maintain norms and the social order. **As we have demonstrated, the sociological study of diagnosis is a powerful tool for revealing the structural underpinnings of social control and inequality, not just for trans-identified people, but for our society as a whole.**

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### **Notes**

1. We refer to transgender-identified persons by the terms transgender and trans interchangeably.
2. The first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was developed in 1952 in response to the then prevalent International Classification of Diseases (ICD-6), the World Health Organization–endorsed list of general diseases, which was perceived by many U.S. critics to lack empirical backing (First and Tasman 2004). The American Psychiatric Association strategically decided to assist in creating the section on Mental Disorders in the ICD-8 around the same time that the DSM-II was to be released, thereby legitimizing psychiatry within medicine and furthering the power American psychiatry would have internationally (Matte, Devor, and Vladicka 2009).
3. Providers could also diagnose using ICD criteria; however, most if not all U.S. practicing therapists at this time used DSM criteria.
4. All interviews were conducted by the first author.



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