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**Transnormativity in the psy disciplines:  
Constructing pathology in the *Diagnostic and Statistical Manual*  
and *Standards of Care***

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### **Abstract**

The psy disciplines (i.e., psychiatry, psychology, psychoanalysis, and psychotherapy) have played a significant role in shaping understandings of transgender people's lives in ways that are transnormative (i.e., by emphasizing one particular account of what it means to be transgender). This paper documents 1) how the rise of the psy disciplines created opportunities for transgender people to access treatment (but that such access often required tacit acceptance of transnormativity), and 2) how transgender people have resisted transnormative accounts within the psy disciplines. More specifically, this paper explores how both the American Psychiatric Association's *Diagnostic and Statistical Manual*, and what is now the World Professional Association for Transgender Health's *Standards of Care*, have often enshrined highly regulatory accounts of transgender people's lives, while also changing over time, in part due to the contributions of transgender people. The paper concludes by considering recent contributions by transgender people in terms of the use of informed consent models of care and clinical research, and highlights the ongoing marginalization of transgender people in terms of access to ethical, trans-competent care.

**Keywords:** clinical care, history, pathologization, psy disciplines, transgender, transnormativity

### **Public Significance Statement**

This paper examines some of the histories of interactions between the mental health professions and transgender people. It argues that these interactions are shaped by norms regarding what it means to be transgender. The paper examines such norms in relation to two different mental health diagnostic and treatment documents, finding that they promote norms as much as they potentially facilitate access to services.

**Transnormativity in the psy disciplines: Constructing pathology in the  
*Diagnostic and Statistical Manual and Standards of Care***

In this paper we explore how what Rose (1998) termed the “psy disciplines” (i.e., psychiatry, psychology, psychoanalysis, and psychotherapy) have created and perpetuated forms of normativity with regard to the clinical care of transgender<sup>1</sup> people. In order to do so we present a reading of both the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* and the World Professional Association for Transgender Health’s *Standards of Care*. In so doing, we argue that the psy disciplines have sought to enforce a particular version of life for transgender people that may be characterized as “transnormative” (Latham, 2019; Vipond, 2015). By transnormative, we refer to the ways in which dominant narratives about what it means to be transgender emphasize a particular and narrow set of tropes to which all transgender people are expected to adhere. These include expectations that 1) all transgender people conform to a “wrong body narrative”<sup>2</sup> when describing their gender (Latham, 2019), 2) all transgender people require medical treatment, and 3) all transgender people should seek to present and be perceived as cisgender. As such, while transnormative narratives may be used to justify medical interventions such as hormone therapy and surgeries when these are requested by transgender

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<sup>1</sup> We note that “transgender” is a contemporary term that was popularized in its current form from the 1990s onwards (Stryker, 2008). We recognize that our use of the term may therefore be somewhat anachronistic; however, we use it in this paper to emphasize continuities in experience, practice and the construction of transnormativity over time. Where relevant, we also use clinical terms such as “sexual invert” and “transsexual” to acknowledge how certain individuals we might now recognize as transgender were described within the psy disciplines in the past.

<sup>2</sup>The “wrong body” narrative frames transgender experience as being “born in the wrong body.” This concept is implicitly present in diagnoses such as Transsexualism (ICD-10) and Gender Dysphoria (*DSM-5*), and explicitly referred to in the *DSM-IV-TR* diagnosis Gender Identity Disorder (Engdahl, 2014). For critiques, see Bettcher (2014) and Lester (2017).

people, they can also underpin “reparative” approaches which place in question a person’s gender.

In terms of the psy disciplines, then, and as Austin (2016) notes, healthcare “should be understood as [a conduit] of transnormativity, a regulatory normative ideology that structures interactions in every arena of social life” (p. 466). The power of the psy disciplines in terms of contributing to normative and indeed pathologizing accounts of transgender people is also evident in broader cultural narratives.

Examples of this are legion, including: accounts that position the growing number of children disclosing that they are transgender as a form of “social contagion” (Ashley, 2019); and the denial of transgender people’s existence altogether (Kennedy, 2020).

These cultural narratives often draw heavily on the psy disciplines in their pathologization of transgender people’s lives. Such cultural narratives serve to justify a transnormative account, drawing as they do on authoritative psy disciplinary accounts of what are constructed as transgender people’s supposed best interests.

Importantly, however, in this paper we seek not simply to suggest that pathologization and transnormativity, as oppressive regimes of power, control transgender people’s lives absolutely. Rather, we situate historical accounts of clinical care and the development of clinical guidelines alongside the actions of transgender people to demonstrate the traffic between clinicians, guidelines, and transgender communities. This adds complexity to a history that can too easily appear monolithic. Indeed, some transgender people have taken up normative accounts of their lives and, in turn, such accounts have been adopted and standardized in the realm of clinical care. In other contexts, transgender people have resisted normative accounts, calling for radical revisions to what constitutes ethical and competent clinical care. In some contexts, such calls have been successful; in others, the dominance of transnormative

(and moreover pathologizing) accounts within the psy disciplines have had (and continue to have) a significant and negative impact on transgender people's lives. It is these points of tension, intersection, and divergence that this paper highlights.

### **Competing Pathways to the Recognition and Pathologization of Trans People**

In order to situate the development of transnormativity within the psy disciplines, it is important to explore the historical roots of transnormativity. With the emergence of the psy disciplines in the 19<sup>th</sup> century, increased scientific attention was paid to the lives of gender-diverse people in North American and European societies. Writers such as Austro-German psychiatrist Richard von Krafft-Ebing and English sexologist Havelock Ellis sought to define and delineate what was seen as “sexual deviance.” Behaviors that transgressed social sex roles (such as cross-dressing) were positioned as pathological, as were intersex bodies and various forms of sexual desire (including homosexuality) (Stryker, 2008). The “wrong body” narrative, now so typically associated with transgender histories, certainly played a role in the early pathologization of people we might now describe as lesbian, gay, bisexual, and/or transgender (who at the time were often described as “sexual inverts”). For example, Krafft-Ebing (1927, p. 399) described “female inverts” (that is, individuals assigned female at birth who were perceived as possessing male behavioral traits) as possessing “[t]he masculine soul, heaving in the female bosom [sic].” However, as we will show, transnormativity evolved over time. Early treatment pathways were arguably influenced as much by eugenicist logics and experimental attempts to reverse human aging as they were by the notion that a person's physical sex might be remade to reflect their gender or sexual soul (Amin, 2018).

In associating particular forms of behavior, desire, and embodiment with illness or degeneracy, early sexologists simultaneously worked to construct, reinforce, *and question* sexual and gender norms (Gill-Peterson, 2018a; Stryker, 2008). Researchers have described how constructions of binary sex and gender, and “normal” and “abnormal” womanhood, evolved alongside the pathologization of gender-diverse people, through the emergence of diagnoses such as hysteria, borderline personality disorder, and masochism in the psy disciplines (Hyde, Bigler, Joel, Tate, & van Anders, 2019; Tosh, 2016). Chesler (2005) and Tosh (2016) have argued that such diagnoses worked to pathologize both femininity *and* sexual nonconformity, with women positioned as “mentally ill” if their behavior conformed too closely to feminine stereotypes *or* strayed too far from them. However, sexology also worked to create visibility for sexual diversity and inspired those who sought recognition: for example, self-ascribed “invert” Radclyffe Hall prominently referred to Ellis’ work in her 1928 novel, *The Well of Loneliness* (Pearce, 2018).

The pathologization of supposed sexual deviance also relied on logics of racialization (Amin, 2018; Gill-Peterson, 2018b; Snorton, 2017). For example, Honkasalo (2020, p. 20) notes that the supposed effeminacy of Jewish men was “thought to be an external sign of pathology” by anti-Semitic scientists. Similarly, Havelock Ellis positioned Black women’s physiology as inferior to that of white women in his 1900 book *Studies of the Psychology of Sex Vol. 2.*, and described “the question of sex—with the racial question that rests on it” as “a chief problem for solution” in the introduction to *Sexual Inversion* (Ellis & Symonds, 1897, cited in Snorton, 2017, p. 4). Like many white Western thinkers in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, including feminists, socialists, and liberals, as well as conservatives and fascists, Ellis believed in eugenics: the principle of improving humanity through

selective breeding. While Ellis was broadly sympathetic to “inverts,” eugenic “science” provided an ideological rationale for modifying bodies in order to contain supposed sexual and racial deviancy, and therefore preserve the health of the “white race.” Consequently, many “hysterical” and working-class women, disabled people, and people of color were targeted for sterilization in North America and many European societies (Honkasalo, 2020).

It was in this context that German sexologist Magnus Hirschfeld “appealed to eugenic science to legitimise genitoplasties under the Weimar Republic’s Criminal Code §175, which criminalised deviant forms of sexuality” (Honkasalo, 2020, p. 23). For early patients such as Lili Elbe (1882-1931, treated by Kurt Warnekros, a contemporary of Hirschfeld), surgeries offered an opportunity to elude narratives of degeneracy through “glandular rejuvenation.” With the implantation of donated ovaries, Elbe (for example) might hope to make the transition from sickly middle-aged “male invert” to “an exemplar of youthful, vigorous, feminine European womanhood” (Amin, 2018, p. 598). In this way, her gender transition represented an attempt to fulfill eugenic ideals, through age reversal and improving the health of (white) humanity, at least as much as it represented a physical shift from “male” to “female.” As Amin (2018) observes, this rationale differed substantially from the discourses that were to later underpin normative narratives of “transsexual” desire and embodiment, even as the history of these procedures remains entwined.

Hirschfeld’s *Institut für Sexualwissenschaft* closed in 1933 following a Nazi raid and the burning of its extensive library (Stryker, 2008); Warnekros went on to collaborate with the Nazis, performing involuntary sterilizations (Amin, 2018). In North America, many clinicians initially felt uncomfortable providing the kind of treatments offered through centers such as Hirschfeld’s *Institut*, citing both legal and

ethical constraints (Meyerowitz, 2002). For example, in 1949 David O. Cauldwell wrote of “Earl,” a male-identified patient who requested access to testosterone and chest and genital surgeries. Cauldwell describes Earl’s desires as “impossible,” arguing: “It would be criminal for any surgeon to mutilate a pair of healthy breasts and it would be just as criminal for a surgeon to castrate a woman [sic] with no disease of the ovaries and related glands” (2006, p. 52). With medical transition ruled out, many practitioners assumed the desire to transition was a matter of *psychopathology*. They consequently recommended reparative psychiatric or psychotherapeutic interventions to “cure” individuals of this desire, which proved to be ineffective (Rubin, 2006).

At the same time that individuals such as Earl were being denied access to desired treatment, other people – including individuals we might today recognize as intersex people, gay men, lesbians, and bisexual people – were being subjected to unnecessary medical interventions. For psychiatrists such as Clifford Allen, who worked with intersex patients alongside endocrinologist Lennox Ross Boster in the 1930s and 1940s at Charing Cross Hospital in London, UK (later the location of the UK’s largest Gender Identity Clinic), “biological normality was structured into a binary of male and female bodies, and linked to a strict psychological normality, as measured by heterosexuality” (Griffiths, 2018, p. 479). In practice, this meant that patients were subjected to hormonal and surgical procedures to “normalize” their bodies. Initially, practitioners such as Allen and Boster worked primarily with adults, many of whom were involved in consultative processes and potentially consented to treatment. Over time, however, practitioners such as UK urologist David Innes Williams and American psychologist John Money facilitated surgical interventions on infants to conform their bodies to binary sex norms (Griffiths, 2018). Concurrently,



from the 1930s through to the 1950s, endocrinologists and psy professionals attempted to “cure” “inverts” through the involuntary administration of hormonal treatments (Rubin, 2006).

In these early years, the limited access to affirmative, consensual medical transition for non-intersex people was driven largely by patient demand (Meyerowitz, 2002). Through press reports on “sex change” operations, prospective patients “found a language in which to express their feelings of having been raised as the wrong sex” (Griffiths, 2018, p. 481). For example, Cauldwell (2006) reports receiving numerous letters from people seeking to transition, and Gill-Peterson (2018b, p. 609) describes how many prospective patients “strategically adopted intersex rhetoric to describe themselves, hoping that would legitimate their request.” German-American sexologist and endocrinologist Harry Benjamin, a former colleague of Hirschfeld, was influential in arguing that these desires be taken seriously.<sup>3</sup> Importantly, while Benjamin acknowledged that psy professionals could offer constructive guidance and support for those he described as transsexuals, he observed that this approach did not offer an actual *cure* for the desire to transition. By contrast, surgeries and hormone treatments could provide measurable relief. However, Benjamin insisted that an important role remained for psychiatric assessment: “The psychiatrist must have the last word [on the matter of physical interventions]. He [sic] has to evaluate the personality in regard to possible future consequences and also as to the likelihood of somehow making life bearable under the status quo” (Benjamin, 1954, p. 229).

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<sup>3</sup> Notably, Benjamin was originally better-known for his work on glandular rejuvenation than his writings on transsexualism (Amin, 2018). It was his demonstrable success in the latter field that sealed his legacy.

**Institutionalization of the Psy Disciplines and the Invention of Transnormativity**

From the mid-20<sup>th</sup> century, the evolution of specialist clinical practice for transgender people sat alongside autobiographical accounts of transgender people's lives in which the authors were more or less compelled to take up what quickly became transnormative narratives. An example of this can be seen in the psy disciplines' injunction for transgender people to present a desexualized image of their subjectivity. The life of Christine Jorgensen, a transgender woman whose story was reported widely in the North American press from 1952 onward, provides a clear example of the intersections between the experiences of transgender people and the use of their experiences by the psy disciplines to authorize particular transnormative responses. Jorgensen felt it necessary to present herself as non-sexual in early self-representations, so as to combat the conflation of (homo)sexuality and gender in early sexological accounts (Meyerowitz, 2002; Serlin, 2004). This type of non-sexual imagery was then (re)incorporated into transnormative representations of transgender women within the psy disciplines, to the extent that clinical teams were reticent to accept women who presented narratives involving interest in active sexual futures, and most certainly functioned to exclude women who reported non-heterosexual orientations (Meyerowitz, 2002).

As Rose (1998) notes, the institutionalization of the psy disciplines involved a process whereby individuals were drawn into a network of power relations in which they were encouraged to self-monitor according to standards rapidly established by the psy disciplines themselves. This can be seen clearly in the examples of Elbe and Jorgensen, and as Pyne (2014) notes specifically with regard to transgender children, *may* be framed as a form of recognition – with transgender being seen as a “phenomenon” worthy of engagement. Yet such recognition typically comes at a cost.

With recognition comes self-regulation and the social demand to hold oneself accountable to existing norms, be these the eugenic logics of the early 20<sup>th</sup> century, the particular forms of sexism, racism, and homophobia that prevailed in the 1950s, and those that prevail today. “Recognition” by the psy disciplines for transgender people from the mid 20<sup>th</sup> century was, then, not necessarily recognition of the diversity of transgender people’s lives, but rather recognition of a culturally mediated, psy-inflected account of what it meant to be transgender. It is at this period of time, we suggest, that contemporary transnormative accounts began to cohere and publicly circulate.

The proliferation of transnormative accounts is further evident in narratives made public by Jorgensen, her European clinical team, and the interpretations of these accounts in the press in the early 1950s. Specifically, it has been suggested that Jorgensen enacted self-determination according to a very specific set of rules about what it meant to be a (white) woman (Meyerowitz, 2002; Serlin, 2004; Snorton, 2017). Jorgensen’s appearance and personality were a frequent topic of commentary at the time, emphasizing her normative femininity in a context wherein this was paramount for women. Importantly, this is not to suggest that Jorgensen was a dupe of her time. Rather, it is to highlight that staking a claim to freedom (in Jorgensen’s case, to live as her gender in postwar America) both enacted the American dream of “choice,” and did so within the constraints of the racialized, heteromasculinist logics considered socially acceptable during this time (Serlin, 2004). More broadly, the reporting of Jorgensen’s life set the stage for a transnormative narrative that was taken up within the psy disciplines, as we shall see in the following sections. This is an important point to reiterate in the context of this paper: As much as Jorgensen’s expression of her gender was structured by dominant discourses of the time, which

were in many ways shaped by the psy disciplines and individual clinicians' responses to and accounts of her life, Jorgensen (and other women whose narratives later became public) very much shaped *how* the psy disciplines came to understand and engage with transgender people more broadly.

### **The American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)***

In this section we consider how clinical and professional debates have led to highly-consequential understandings and prescriptions for engaging with gender and sexually-diverse people (for more on this see Hegarty, 2018). While our primary focus is on detailing the psy disciplines' engagement with gender diversity, in order to do so we must also understand the entangled history of the psy disciplines' engagement with sexual diversity. We suggest that the struggle to define and control some of the most marginal members of society is always also a struggle for dominance and authority among its most privileged. This is perhaps most readily evident in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

First published in 1952, the *DSM* is now in its fifth edition, though it has undergone numerous revisions and printings across its nearly seven-decade life. The *DSM* is intended to name and describe various mental disorders, serving as the key clinical diagnostic tool for the psy-disciplines. The first edition of the *DSM* was 132 pages, outlining 128 distinct diagnoses. The current edition is 947 pages with 541 diagnoses (Blashfield, Kelley, Flanagan, & Miles, 2014). Diagnosing mental disorders is a profitable enterprise, with revenue from the *DSM* in the hundreds of millions of dollars. As a result, those involved in writing various editions of the *DSM* have faced their share of controversy (Blashfield, Kelley, Flanagan, & Miles, 2014).

Non-normative gender and sexuality have been a focus across all editions in the nearly 70-year history of the *DSM* (for a comprehensive overview, see Drescher, 2010).

“Transvestism” was listed in only the *DSM-I* and *DSM-II*. “Gender Identity Disorders” were first listed with two main types – Gender Identity Disorder of Childhood (GIDC) and Transsexualism – in the *DSM III* (American Psychiatric Association, 1980). In the *DSM-III-R*, a third type was added – Gender Identity Disorder of Adolescence and Adulthood, Nontranssexual Type (American Psychiatric Association, 1987). In the *DSM-IV* (American Psychiatric Association, 1994), the diagnostic name changed to “Gender Identity Disorder” (GID). In the *DSM-IV-TR* (American Psychiatric Association, 2000), the GID diagnosis required that the individual experience distress or impaired functioning. In the *DSM-5* (American Psychiatric Association, 2013), the diagnosis of “Gender Identity Disorder” was removed and replaced with the diagnosis of “Gender Dysphoria,” the logic being to shift the focus away from seeing gender diversity as a disorder, and to instead focus on the distress arising from the experience of dysphoria.

Diagnosis within the *DSM* has always held potential promise and peril for transgender communities, and queer people more broadly. Characterization of queer people within the *DSM* across time has varied from disordered to deviant, fetishistic, developmentally-arrested, immature, socially maladjusted, dysfunctional, and distressed (Bryant, 2006; Drescher, 2010, 2015; Hegarty, 2018). For some transgender people in the 21st century, official diagnoses of “Gender Identity Disorder” or “Gender Dysphoria” could provide a productive gateway to accessing hormones and surgeries that may even be fully or partially covered by medical insurance (Davy, 2015). Given the high stakes of diagnosis – which range from social

stigma to redemption, with associated treatments and policy recommendations spanning from punitive to liberative – it is imperative to consider just who is given the power of diagnosis.

Because the *DSM* is an official publication of the APA, psychiatrists have been at the forefront of determining diagnostic categories for mental disorders. For the past century, medicine has been a generally high-status and esteemed profession, yet prestige hierarchies exist internally, with psychiatry typically located near the bottom of such rankings (Norredam & Album, 2007). Since the 1970s, the percentage of men relative to women has been shrinking, with men constituting more than 87% of all psychiatrists in 1973 and only 45% of all psychiatric residents by 2013 (Scher, 1973; Willis, 2013). Historically, however, most diagnostic decision-making around gender and sexually non-conforming people has been made by white, cisgender, heterosexual men within the field of psychiatry (see Ansara & Hegarty, 2012 on the “invisible college” informing these diagnoses).

Importantly, these decisions and struggles have not been made without pushback.

In the same period of time as the *DSM-I* and *DSM-II* were being written and published, social activists and movements grew louder and more insistent in their demands for social justice. The 1966 Compton’s Cafeteria uprising in the Tenderloin district of San Francisco and the 1969 Stonewall Inn rebellion in New York City demonstrated the irrepressibility of queer people’s rage and frustration over state and institutional violence and oppression, particularly among its most likely targets – poor, trans, women of color (Stryker, 2008). Contributing precursors to the removal of homosexuality from the *DSM III* include disruptions of the annual meeting of the American Medical Association (AMA) and APA by queer people engaging in protest

as members of the public and sometimes as members from within these organizations (e.g. John Fryer aka “Dr. Henry Anonymous,” who appeared disguised at the 1972 APA meeting) (Cotten & Ridings, 2011; Pillard, 2009). During this same time, Black and Latinx transgender rights activists, such as Marsha P. Johnson and Sylvia Rivera, focused on the rights of some of the most disaffected members of queer communities – such as poor, homeless, queer, and trans people of color – through formation of groups such as *Street Transvestite Action Revolutionaries* (Stryker, 2008). These social activist engagements, however, were likely more distant from psy community awareness due to the racial, class, and cisgender privilege of their leading authorities.

Despite the success of advocates in terms of the removal of homosexuality from the *DSM III*, it has been argued that this then opened the door for the introduction of other diagnostic categories that produced similar regulatory effects. Karl Bryant (2006; 2008), for example, offers a compelling account of the emergence of diagnostic categories around non-normative genders, particularly among children positioned as effeminate boys. Bryant argues that the emergence of GIDC in the *DSM-III*, for example, provides evidence for how diagnoses are not only manufactured to provide rationalization for existing clinical practices, but also may be deployed to recuperate marginalized social subjects who have attained broader sociocultural acceptance while targeting others for greater regulation and intervention (2006, 2008). In this way, shifting diagnostic categories hold both generative and repressive potentials for already-marginalized groups. As homosexuality gained greater social acceptance, clinical classifications focusing on these groups needed to shift as well. Bryant (2006; 2008) details how the diagnosis of GIDC, authored primarily by Richard Green (1987), produced two distinct normative outcomes targeting (primarily) effeminate boys (who were seen as either pre-homosexual or

pre-transsexual) for diagnosis and treatment: 1) producing socially-acceptable, masculine, gay men and 2) limiting the potential for future adult trans womanhood. Indeed, some clinicians who utilized now-defunct diagnoses for gay and lesbian people then refocused their diagnoses and therapeutic interventions (some of which have been described as “gender-reparative therapies”) on transgender and gender non-conforming patients (Lev, 2013, p. 293).

Despite this renewed focus within the psy disciplines on the pathologization of diversity, at the same time the AIDS crisis of the 1980s disproportionately impacted gender-nonconforming gay men and transgender women, further igniting activism and galvanizing queer people to, quite literally, fight for their lives (Epstein, 1996; Hegarty, 2018). Throughout the 1990s and 2000s, students and researchers also challenged medical authority and its relationship to social justice and equity (Metzl & Kirkland, 2010). From the 1990s a growing proportion of transgender people told their own stories through published autobiographies, describing and sometimes resisting clinical gatekeeping practices and transnormative expectations (Pfeffer, 2017). However, these narratives, as well as social-science scholarship published by feminist and transgender scholars, were largely ignored by those crafting the DSM (Davy, 2015). Nonetheless, transgender rights initiatives and organizations such as *GID Reform Advocates*, *Stop Transgender Pathologization*, and *Global Action for Trans\* Equality* have been vocal in their resistance to the medicalization of transgender people’s experience (Cabral, Suess, Ehrt, Seehole, & Wong, 2016; Davy, 2015).

Part of such resistance to medicalization has been a robust critique of the empirical literature on gender diversity: a literature largely written by white, cisgender, heterosexual men, which has targeted gender non-conforming behaviors,



especially among children, who are often characterized as more clinically malleable (see overviews by Bryant, 2006, 2008 and Hegarty, 2018). Such critiques emphasize that even in instances where diagnosticians attempted to resist a pathologizing focus on gender non-conforming people, they tended to focus upon subjective feelings of isolation and social dejection to make diagnostic classifications. Doing so has the effect of displacing responsibility for responding to social injustice: diagnosing a targeted individual as disordered or ill rather than seeking to change the cisgenderist and heterosexist society or social system in which they are embedded.

Yet despite the insights produced by such critiques, they have largely gone unheeded by those central to framing debates within the psy disciplines (Cotten & Ridings, 2011; Davy, 2015; Reicherzer, 2008). Scholarship and clinical practice are rarely solely about one's profession or patients. They are also about being perceived as correct and being seen publicly and among one's peers as right or even righteous, sometimes even sparring and reconciling with one another (or with one's self; see Spitzer, 2012) publicly and protractedly through the pages of paywalled, peer reviewed, major, academic journals (e.g., Bayer & Spitzer, 1982). In this way, the story of transgender people's classification across various iterations of the *DSM* is also the less-examined story of "credibility struggles" (Epstein 1996; Pearce, 2018) and "masculinity crises" (Serlin, 2004) among the disproportionately white, cisgender men working to establish personal and professional authority across shifting social contexts. How this story might change, as the field of power relations that constitutes the psy disciplines continues to transform, has yet to be determined.

**From *The Transsexual Phenomenon* to the *Standards of Care***

The second key text which has historically governed transgender people's relationship with the psy disciplines is the *Standards of Care (SOC)*, first published in 1979. The *SOC* are written by a committee assembled by the World Professional Association for Transgender Health (WPATH), an ostensibly international organization based primarily in the United States (U.S.). Whereas the *DSM* is used to diagnose, the WPATH *SOC* is intended to provide authoritative guidance on how to manage a medical gender transition. Early versions of the *SOC* echoed Harry Benjamin's (1966) influential work, *The Transsexual Phenomenon*, in centering the role of mental health diagnoses and assuming a transition from a "male" sexed embodiment and associated gender role to a "female" sexed embodiment and gender role, or vice-versa, with those who transitioned described as "transsexuals" (Berger et al., 1979). In this way, the *SOC* contributed to the construction of a transnormative narrative that centers particular binary conceptualizations of sexed and gendered possibilities, even as it also helped to open up new pathways for medical transition.

When the *SOC* were first written, surgical and endocrinological interventions designed to facilitate gender transition had already existed within Western medicine for several decades, as a consequence of 1) earlier rejuvenation experiments, 2) affirmative care for transgender people facilitated by pioneers such as Hirschfeld, 3) hormonal interventions for "inverts," and 4) operations on intersex people, as we have outlined earlier in this paper. However, a clinical consensus on treatment pathways for "transsexuality" was only just emerging (Gill-Peterson, 2018a; Meyerowitz, 2002). Meyerowitz describes how "in the 1960s, most roads led to Benjamin" (p. 133) for individuals seeking to medically transition in the U.S.; psy professionals and medical doctors alike increasingly referred patients to Benjamin, as did women such

as Christine Jorgensen and Tamara Rees. In turn, Benjamin worked with other professionals to ensure that his patients underwent mental health assessments as part of the diagnostic process and in order to receive access to services.

In 1966, the year of the Compton's Cafeteria rebellion, Benjamin published *The Transsexual Phenomenon*. This book codified and popularized a medical pathway for gender transition, drawing on clinical experience and evidence of patient satisfaction from research undertaken with Benjamin's clients. There are some interesting parallels and connections between these two very different events, as well as obvious points of departure. Compton's represented an uprising against police raids, led predominantly by transgender sex workers and drag queens. *The Transsexual Phenomenon* represented an intervention from an authority figure who, in contrast to the San Francisco police, sought to make (certain, normative forms of) transgender life more livable (Pearce, 2018). Stryker (2008, p. 74) notes that "some of [Benjamin's] patients were the very Tenderloin street queens who would soon start fighting back [...] the changes in medical-service provision that Benjamin recommended must have been an electrifying call to action." In the wake of Compton's (and later, Stonewall), former protesters worked with minimal funding to successfully campaign for decriminalization and new healthcare services, creating groups and networks for political advocacy and mutual support such as *Conversion Our Goal* and *Vanguard* (Meyerowitz, 2002; Stryker, 2008).

Notably, much of the research Benjamin (1966) drew upon was funded by the Erickson Educational Foundation (EEF), a charitable body founded by a transgender man –Reed Erickson (Meyerowitz, 2002). The aim of the EEF was to finance research on transsexualism and associated clinical interventions. Like the protesters at Compton, Erickson utilized the resources available to him to bring about change;

however, in contrast to the poor and predominantly transfeminine protesters, he was a white man from a wealthy family. In spending millions of dollars through the EEF funding healthcare, research, and education projects from the 1960s through to the 1980s, Erickson played a key role in shaping the contemporary landscape of transgender health and ensuring the availability of services for thousands of people (Devor & Matte, 2007; Gill-Peterson 2018a). However, in contrast to the focus on self-determination in the work of Compton's and Stonewall veterans, Erickson's interventions also effectively worked to support the institutional power and privilege of cisgender researchers and, consequently, the transnormative regulation of transgender patients. Having funded his own transition in the early 1960s, he did not have to contend with medical gatekeeping and the economic insecurity experienced by many people seeking to access services; on the contrary, practitioners sought his support. Hence, while Erickson's contributions and generosity are undeniable, his racial, economic, and gender privilege ensured that he was distanced from many of the challenges faced by the prospective transsexual patients he sought to help.

In the late 1960s, a new generation of healthcare professionals began to facilitate medical transitions, with many inspired by Benjamin and/or directly funded by the EEF (Gill-Peterson, 2018a). In addition to the publication of Benjamin's key work, 1966 saw the opening of the first Gender Identity Clinics (GICs) in the U.S., at Johns Hopkins Hospital and the University of Minnesota Medical School (Meyerowitz, 2002). These were specialist multidisciplinary centers which offered mental health assessment and – for a lucky few – hormone therapy and surgeries for patients who presented as transsexual. In 1969, the year of the Stonewall rebellion, the EEF funded the first International Symposium on Gender Identity in London,

England, as well as the anthology, *Transsexualism and Sex Reassignment*, edited by Richard Green and John Money (Meyerowitz, 2002).

By 1978, approximately 40 specialist clinics offering “surgical sex-reassignment to persons having a multiplicity of behavioral diagnoses” could be found across the Western hemisphere (Berger et al., 1979, p. 1). Building on the work of figures such as Benjamin, Green, and Money, these institutions devised criteria by which psy professionals might assess patients and manage access to hormone therapy and surgery. This enabled them to justify their work when faced with criticism from those who, like Cauldwell (2006), argued that such interventions represented an unnecessary “mutilation” of otherwise “healthy” bodies. However, it had the consequence of creating a gatekeeping system in which patients were expected to conform to transnormative narratives. Similarly, access to the GICs was limited by factors such as race, class, and age (Gill-Peterson, 2018a). To obtain the treatment they sought, patients needed to first articulate their experiences in a manner that would be taken seriously by the predominantly middle-class, white, cisgender, male psychiatrists and clinical psychologists who oversaw these institutions. Consequently, while the first patient to undergo gender-affirming surgery at Johns Hopkins was Avon Wilson, a Black woman (Meyerowitz, 2002), transgender people who experienced intersecting forms of marginalization were less likely to be seen as “conventional” women or men. In this way, the emerging clinical consensus worked both to *enable* new forms of transgender subjectivity through medical transition and to *restrict* the scope of sexed and gendered possibility (Pearce, 2018).

International Symposia on Gender Identity continued to be organized throughout the 1970s. In 1975, attendees of the Fourth International Symposium appointed committees to draft overarching guidance for practitioners working with

transsexuals (Meyerowitz, 2002). This was eventually published as what would later be recognized as Version 1 of the *SOC* (Berger et al., 1979), by a new organization known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA), named to honor Benjamin's work in shaping the field (Benjamin himself was not directly involved in the organization). The second, third, and fourth versions of the *SOC* made very few revisions to the original text (Berger et al., 1980, 1981, 1990). All four documents represented a consolidation both of Benjamin's ideas and of the central role of the psy disciplines, now positioned as key gatekeepers for treatment. Evaluation was originally to be undertaken by any licensed psychiatrist or psychologist (Berger et al., 1979), but from 1981 the *SOC* specified that "[p]ersons recommending sex reassignment surgery or hormone therapy should have the documented training and experience to diagnose a broad range of sexual conditions" and "proven competence in general psychotherapy, sex therapy, and gender counseling/therapy" (Berger et al., 1981, p. 3). The role of these practitioners was to "study and evaluate" patients who expressed a desire for medical transition and assess their readiness for treatment through an evaluation of "reasons, motives, attitudes, purposes, etc." (Berger et al., 1979, p. 3). This was to be done in accordance with the Transsexualism and Gender Identity Disorder of Childhood diagnoses in DSM-III; not coincidentally, these diagnoses were authored largely by Richard Green (Bryant, 2006; Meyerowitz, 2002), who also co-authored *SOC* Versions 1-4 and was a consultant on Version 5 (Levine et al., 1995).

The Transsexualism diagnosis required that patients exhibit a persistent desire for medical transition over a period of at least two years; the *SOC* recommended that evidence of this was to be obtained through a long-term therapeutic relationship between patient and professional, and/or through interview(s) with a friend or relative

of the patient. The authority and judgment of the psy-disciplines professional was paramount, with the *SOC* requiring that “the clinical behavioral scientist have knowledge, *independent of the patient’s verbal claim* ... [of] dysphoria, discomfort, sense of inappropriateness and wish to be rid of one’s own genitals” (Berger et al., 1981, p. 7, emphasis added). Patients were required to live full-time in “the social role of the genetically other sex” for at least 12 months prior to the provision of any genital surgery, in a process that was later to be formally known as “Real Life Experience” (Levine et al., 1998). Medical transition was assumed to be a linear process, with desire for surgery being assumed in the assessment for hormone therapy, and a good response to hormone therapy being a prerequisite for surgery.

Patients learned to self-surveil, through presenting certain transnormative narratives and expressing particular kinds of desire. Meyerowitz (2002), Stone (1991), and Latham (2019) have described how a discursive feedback loop emerged, in which psy-discipline professionals assumed that particular behaviors (such as the stated desire to be rid of one’s genitals) were indicative of transsexualism, so patients described and performed these behaviors, leading the professionals to assume that their original presuppositions were correct. Another consequence was that many GICs continued to encourage patients to adhere to normative gender roles and stereotypes, thereby effectively policing both transsexual identity and limiting the scope of imagined possibility. Stone (1991, p. 291) argues that this constituted a fully acculturated, consensual definition of gender and “at the site of their enactment we can locate an actual instance of the apparatus of production of gender.” For example, in an echo of the eugenic histories of transgender medicine, Norwegian health authorities were advised by the gender identity team to require irreversible sterilization as a condition for gender recognition in the late 1980s. Their explicit

intention was “to avoid the potential calamity of a menstruating man, or even worse, a pregnant man, which would bring the hospital into disgrace” (Monro & Van Der Ros, 2018, p. 66).

Nevertheless, it is clear that the authors of the early editions of the *SOC* took their work very seriously indeed. They refer explicitly to “the moral responsibility” of making a decision to recommend hormones and/or surgery (or not) (Berger et al., 1979, p. 5), a sentiment explicitly echoed in Versions 5 and 6 of the *SOC* (Levine et al., 1998; Meyer et al., 2005), as well as more recent publications by contemporary gender specialists, some of whom are themselves transgender (e.g. Richards et al., 2014). This somewhat paternalistic approach ultimately diminishes recognition of decision-making processes undertaken by patients themselves (Davy, 2015; Gill-Peterson, 2018a, Pearce, 2018).

Transgender people’s voices were almost entirely absent from the *SOC* until Version 7 was first published in 2011. The first four versions were based on a document written by six cisgender American men; a proposal to include a transsexual person on this committee was voted down by the (predominantly cisgender) attendees of the Fifth International Symposium on Gender Identity in 1977 (Meyerowitz, 2002, p. 254). Dallas Denny and Jan Roberts (1995, p. 9) describe how “[i]n the early 1980s, Jude Patton, a transsexual man, was the ‘consumer’ representative on the HBIGDA Board of Directors,” but by the 1990s there were no known transgender people on either the HBIGDA Board or the new committee that had been drawn up to revise the *SOC*. Denny, an openly transgender woman, was later listed as a “consultant” for Version 5 of the *SOC*, alongside transgender man Jamison Green and transsexual Anne Lawrence (Levine et al., 1998). For a supposedly “international” organization, the HBIGDA was also deeply US-centric. Only three out of the seven



authors of the Version 5 *SOC* were based outside of the U.S. (in Canada, Germany, and the Netherlands); while more international authors were involved in Versions 6 and 7, these documents still predominantly represent a U.S. perspective.

Having noted the absence of transgender voices within the HBIGDA, Denny and Roberts (1995) conducted a survey of transgender people in the U.S. to explore their views on the *SOC*. They found a majority of their 399 respondents supported the existence of the *SOC*, but also sought a more flexible treatment pathway. Almost 80% of respondents had heard of the *SOC*, and while many of these individuals had heard about the *SOC* from professional sources, others found themselves educating professionals about the existence of the guidance document. These findings reflect an ambivalence towards clinical pathways that can be traced back to the 1960s and remains within transgender communities to this day.

The most recent edition of the *SOC* (Version 7, originally published in 2011) has begun to acknowledge the growing diversity of transgender language and the possibility of non-binary genders, in which the patient's desired sexed embodiment and gender may differ, and indeed depart from presumed "female" or "male" norms (Coleman et al., 2012). The HBIGDA has also undergone changes; in 2006 it became the World Professional Association for Transgender Health (WPATH). In 2007, a British activist and legal scholar, Stephen Whittle, was the first transgender person (and first non-medic) to become President of the organization. Whittle's election represented the culmination of a campaign by transgender professionals to play an active role in HBIGDA/WPATH; he was also one of several transgender people credited with co-authorship of the Version 7 *SOC*.

A growing number of attendees at the biennial WPATH Symposia (successors to the original 1960s and 1970s Symposia on Gender Identity) are transgender, with

many now organizing informally under the banner of TPATH (the Transgender Professional Association for Transgender Health). WPATH also benefits from the philanthropy of the first (known) transgender billionaire, Jennifer Pritzker, echoing Reed Erickson's support for the early GICs in the U.S. However, many scholars and activists continue to criticize the diagnostic framework and assessment models that remain embedded within the *DSM* and *SOC*, arguing that these continue to pathologize transgender bodies, experiences, and desires (Davy, Sørliie, & Schwend, 2018). Others – echoing the politics of those who participated in the Compton's Cafeteria and Stonewall uprisings – prefer to focus on matters such as state violence, social inequalities, and economic insecurity, especially where these are compounded at the intersection of transphobia and racist violence (Raha, 2017).

These debates played out powerfully at the 2018 WPATH Symposium in Buenos Aires. Following a ceremony in which Pritzker was given an award for philanthropy and praised the work of WPATH via video-link, the event saw a series of presentations from working groups drafting chapters for the forthcoming Version 8 *SOC*. In many ways the draft *SOC* document reflects the success of the depathologization movement, as many chapters appear set to center “affirmative” approaches to transgender healthcare, which center patients' decision-making and informed consent rather than gatekeeping (Cavanaugh, Hopwood & Lambert, 2016; Chang, Singh & dickey, 2018; Schulz, 2018). Nevertheless, debates continue over the role of healthcare professionals, especially those in the psy disciplines. More transgender people and international authors than ever before are involved in this process; however, authorship remains overwhelmingly cisgender and U.S.-based.

Draft chapter presentations were followed by an extraordinary questions-and-answers session, in which transgender professionals highlighted community mistrust

of WPATH, concerns regarding a lack of attention to intersex human rights, and language choice – such as a proposed chapter on “eunuchs,” to which some attendees vocally objected. Through these comments, WPATH and the *SOC* were critiqued for centering not only cisgender people’s perspectives, but also a white, Western perspective, a matter that was particularly pertinent given the event’s location. Human rights campaigner Mauro Cabral summarized these frustrations in a speech from the conference floor: “When WPATH decided to come to Argentina, with the most progressive gender identity law in the world, I was excited. But we could only talk among ourselves. You come to this country because of the weather, steak, and wine, but not to learn from us.”

### Discussion

In this paper, we have traced a specific history of interactions between transgender people and the psy disciplines, highlighting the development of transnormativity and its implications in terms of clinical diagnostic guidelines and treatment. In so doing, this paper has argued that at certain key junctures, transgender people have made significant contributions to the framings of their lives. However, historically, these contributions have not always translated into less pathologizing accounts. Indeed, in many ways the histories mapped out in this paper suggest that transnormativity and pathologizing accounts have worked hand-in-hand. Importantly, while offering a predominantly historical account, we have suggested at key points in this paper that both transnormative and pathologizing accounts continue. For example, concepts such as “autogynephelia,” which suggest that transgender women are driven either by a suppressed “homosexual” attraction to men, or a fetishized desire to dress in “women’s clothing,” continue to be used not simply to pathologize,

but also to invalidate transgender women's narratives (Bettcher, 2008). Indeed, Serano (2008) suggests that, as a form of pathologization, invalidation goes beyond the "simple" setting up of transgender women as a "problem," and instead nullifies transgender women's existence altogether. Psy disciplinary approaches that pathologize transgender people's lives are also evident in ongoing attempts that claim to "cure" a person's gender. While, as we noted, clinicians such as Harry Benjamin recognized that "reparative" psychotherapy or psychoanalysis had no role to play in the treatment of transgender people (e.g., Benjamin, 1967), "corrective" or "curative" approaches have continued to prevail in many geographical contexts (even if, at the same time, they have been outlawed in others).

In North America, corrective or curative approaches have been primarily directed at children (Bryant 2006; 2008). Such approaches pathologize families through, for example, suggesting that particular parent-child dynamics "cause" gender non-conformity, which has led clinicians to direct parents to enforce behaviors and interests deemed "appropriate" to their assigned sex (see Pyne, 2014, for a summary of the work of both Rekers and Zucker). In response to such pathologizing accounts, there continue to be significant debates over whether or not gender non-conforming children and adolescents should be subject to diagnosis at all (Cabral, Suess, Ehrt, Seehole, & Wong, 2016; Drescher, 2014). In part, such debates emphasize that clinical diagnosis and treatment of gender non-conforming children may be aimed at preventing future queer adults, given the ongoing stigma attached to such adults in the context of a cisgenderist and heterosexist society (Bryant, 2006, 2008; Drescher, 2010; Hegarty, 2018). While there has been a more recent shift towards affirming approaches to working with transgender children (see Riggs, 2019, for a summary), pathologizing approaches nonetheless continue to dominate much of the literature.

Ansara and Hegarty (2012) examined 94 journal articles published between 1999 and 2008, finding that cisgenderism remained common throughout this time period in articles focused on children. This includes referring to children by their assigned sex rather than their gender, using pathologizing language, and recommending “curative” clinical responses.

In response to ongoing transnormative and pathologizing approaches, transgender people have sought to develop affirming approaches to clinical research and practice that challenge the broader psy disciplinary regulation of their lives. Key to affirming clinical approaches has been the recent development of the informed consent model of care, developed in partnership with transgender people (e.g., Cundill & Wiggins, 2017). Rather than centering clinician diagnosis and authorization for treatment, this model of care emphasizes that transgender people are more than capable of authorizing their own treatment in collaboration with clinicians (Schulz, 2018). Such an approach challenges traditional models of care as outlined in the *DSM* and *SOC*, which in many instances continue to gatekeep access to care. Furthermore, an informed consent model recognizes that in many cases transgender people know more about their needs than many clinicians, given the dearth of training and specialization in the field of transgender health.

Further, a rapidly growing body of research by transgender people has produced a clinical literature that increasingly challenges transnormativity and advocates for a more diverse understanding of transgender people’s lives and pathways through clinical care (e.g., Greatheart, 2013; Nealy, 2017). Most recently, this research has focused on how transgender people may be aware of transnormativity and actively work to resist it in the clinical sphere (Bradford & Syed, 2019). However, because transgender clinicians do not exist outside of social norms

and structures, or the systems of power relations in which they are embedded, some may also endorse and utilize transnormative approaches in their own work.

As such, and even as transgender people are increasingly involved in healthcare provision, it is important to be mindful of who is (and is not) present, and reflect critically on what perspectives they do (and do not) bring to the table. This paper has shown how transnormativity and processes of pathologization are ultimately also constructed through racialization practices, social-class privilege, competitions for professional prestige, and the binary Western norms of gender, sex, and sexuality. The vast majority of transgender people who have been involved in development of the HBIQDA/WPATH and the *SOC*, including key figures such as Patton, Denny, Lawrence, Green, and Whittle, are white, as have been the philanthropists Reed Erickson and Jennifer Pritzker. Of the growing number of transgender clinicians and researchers, a majority are white and/or transmasculine; this is particularly visible within organizing spaces such as TPATH meetings. Moreover, transgender people do remain a minority within professional settings and are absent from the authorship of transgender diagnostic classifications in the *DSM*. This is not a coincidence; rather, it reflects the wider inequalities in which transgender people's struggles are embedded. Those who fail to recognize and account for this are liable to continue reproducing power inequalities and constructing constrained forms of subjectivity through their work (Rose, 1998).

In conclusion, this paper has suggested that while some things change, others stay resolutely the same. Transgender people are much more visible and are increasingly having input into how the psy disciplines understand and engage with their lives. However, the psy disciplines continue to regulate treatment for transgender people, reinforce transnormative approaches, and exclude the most marginalized and

vulnerable from services and professional bodies alike. As such, we must continue to critically examine historical and contemporary practices that enshrine the psy disciplines as the most appropriate arbiters of transgender people's lives.

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