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Stacey Jackson-Roberts
Pushed to the Edge: the Treatment of
Transsexuals through Time.
A Historical Discourse Analysis of the Diagnostic
and Treatment Protocols for Transsexuals and the
Implications for Contemporary Social Work
Practice

ABSTRACT

This article is a historical discourse analysis of the diagnostic and treatment protocols for transsexuals with implications for contemporary social work practice. The article uses the theoretical lens of post-structuralism and its complimentary methodology of historical discourse analysis to trace and critique the history of treatment and the power laden narratives used to regulate access to transition related care—particularly hormones and surgery. By analyzing these historical discourses, the article reveals the historical narratives and scripts that have constructed and pathologized transsexuals, and informed the evolution of the *DSM* and *Standards of Care*. Further, the article examines and critiques this history in relation to the current demographics of marginalization within the transgender community and the failures of clinical social work to meet the need of this vulnerable population.

Keywords: Clinical Social Work, Transsexual, Transgender, Treatment, Surgery, Hormones, Gender Confirmation Surgery, Sex Reassignment, Standards of Care, and DSM

Pushed to the Edge: the Treatment of Transsexuals through Time.

A Historical Discourse Analysis of the Diagnostic and Treatment Protocols for Transsexuals and the
Implications for Contemporary Social Work Practice

A project based upon an independent investigation, submitted in partial
fulfillment of the requirements for the degree of Master of Social Work.

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2013

Dedication

To my mom, Adrie Roberts, for being by my side in the most trying of times and situation,

exemplifying unconditional love and compassion, and

the providing the guidance and pep talks needs to complete this degree.

To my father, John Roberts, for teaching me the values of hard work, perseverance, and love of family, and

for encouraging me to obtain the higher education that

—despite his intellect and endless curiosity—

he was denied.

Acknowledgments

At the culmination of this project, it gives me pause to reflect on the generosity of support and encouragement I have received from professors, professionals, colleagues, family, and friends.

I would especially like to extend my heartfelt gratitude to my advisor and mentor Professor Yoosun Park, Ph.D. Professor Park's diligent efforts to help and encourage me made this article possible. From helping me explore potential topics to editing my final draft, Professor Park has consistently pushed me to set my ambitions and standards higher and dream beyond convention. From countless phone calls talking through challenging points to her extensive and thorough feedback helping me fine tune each draft, she has worked tirelessly to help me enhance my research and writing skills. I owe her a lifetime of gratitude.

I'd also like to thank Jameson Green, Executive Director of WPATH, and Kate Thomas, Ph.D., Clinical Director of Johns Hopkins University Sexual Behaviors Consultation Unit, for their generous offers of support in accessing historical information and materials for this project.

Additional thanks are due to an amazing cadre of friends, family, and colleagues that have offer support, advice, and encouragement throughout this process. Thanks to Jeanne Giberson, LCSW-C (Smith SSW '01) and Karen Taylor, LGSW (Smith SSW '12), for their guidance and encouragement from those that have previously complete a Smith SSW thesis. Thanks to my mother, Adrie Roberts, for her love, words of wisdom, belief in me, and proofing the final draft. Thanks to my father for his expressions of love and pride in my achievements. Thanks to Sharon Brackett for availing me of her professional networks and being a sounding board during the writing process. Thanks to my A'13 colleagues for their support and insight throughout the year.

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Introduction

Juan Contreras. Male. Age 23. At least that is what the admissions documents indicated. As I looked at the woman that sat rubbing her bandaged wrists, I thought surely I must have entered the wrong room—I had not. In fact, had she been more affluent, the woman’s paperwork might have reflected her preferred name and gender identity—Maria Contreras, Female. As she shared the graphic details of her transition, the paperwork became symbolic of the many ways she and other transsexuals are systematically marginalized by society—even by social work and allied professions.

Maria had been admitted to my unit after discharging from the ICU of a community hospital. A few days earlier, she had cut her wrists in a suicide attempt to escape her current life circumstances. She described a childhood filled with distress regarding her gender, and that her effeminate mannerisms had often led to bullying in school. She told me that her suicidal thoughts had started by age 6. She attributed these thoughts to familial and social ostracism. She described in vivid detail her first suicide attempt. It happened while she was in junior high school in the aftermath of a vicious attack by a classmate who repeatedly bashed her head against the tile floor of the boy’s locker room while calling her “faggot.” This is only one example of the sustained acts of violence against Maria from an early age. Despite the ongoing harassment, by the age of 16, Maria decided that the only way to resolve her inner conflict was to transition from male to female. After coming out to her family and expressing her desire to transition, her parents sought counsel from their priest. Following his counsel, Maria's parents evicted her from their home and disowned her. She found herself homeless for the first time.

Unable to find support systems in her small Southwestern town, she spent her limited savings to make her way to a major city in the Northeast in search of community and in hopes of finding resources for trans people. Without access to traditional means of economic support and medical care, Maria became friends with a group of transsexual women that engaged in various forms of illicit means of economic support, and also provided her access to underground medical treatments (e.g. hormones, silicone pumping, & surgeries) to help feminize her body. She told me about finding an underground doctor who provided orchiectomies (i.e. castration) in his office for \$2000 cash. The clinic, she says, doubled as an illegal late-term

abortion clinic, and the lack of sanitation was fairly apparent. During the procedure, when the local anesthesia proved insufficient to dull the pain, her tears and screams of agony were met by the doctor's harsh injunction to "shut up." In the weeks that followed, unable to afford proper medical care and fearful of the way medical providers might treat her, she delayed seeking help for a post-op infection and hematoma.

A few months ago, Maria was arrested for prostitution and held in a men's jail facility where she was repeatedly raped and assaulted by other prisoners for several days. While receiving medical care for her injuries after a particularly brutal attack, they discovered that she was HIV positive. The Department of Corrections determined that "for her own safety" she should be moved to isolation.

After her release, Maria attempted to end her life by cutting her wrists, which is why she was admitted to this hospital for crisis intervention. She tells me she sees no future. She has lost her family. She has no one to turn to for support. She is now living with HIV. She has no legitimate means of income. She doesn't know how she could ever afford Gender Confirmation Surgery/Sex Reassignment Surgery (GCS/SRS) (i.e. surgery to align anatomical sex characteristics with an individual's gender identity). Without GCS/SRS, her legal status as a woman can be challenged, particularly in gender segregated facilities (i.e. restrooms & correctional facilities). If she is raped again, she believes her likelihood of survival—given her partial male anatomy—is not likely, and she is in danger of a horrific death. As our session ended Maria asked, "what hope do I have? The world sees me as neither male nor female, not worthy of human dignity. I am, as many say, an 'it'."

While Maria is a fictional character, whose story is a composite, this narrative is all too familiar for many transsexuals.

Demographics and Background

In 2010, the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force (Task Force) collaborated in producing the first large-scale study of transgender people in the U.S. (Grant, et al, 2010). The National Transgender Discrimination Survey (Survey) was a 6450 participant study that illuminates the scope of disenfranchisement faced by the trans community. A staggering 41% reported having attempted suicide one or more times during their lifetime, as compared to roughly 1.5% of

the general population. Suicidality and other risk factors were strongly correlated with the double bind of multiple minority identities. People of color, lower income individuals, and those with lower levels of education were at higher risk. Suicide attempts were most strongly correlated with experiences of violence. Sixty-one percent were physical assault survivors, and 65% of sexual assault survivors reported attempting suicide.

The Survey documents barriers to health care in the areas of preventative, primary, specialty, and emergency health care, vulnerabilities at the point of health care delivery, lack of coverage for transition related medical procedures, and utilization of transgender related diagnosis to deny coverage for critical care not related to transition. Nineteen percent of participants reported being denied critical care in a medical setting due to their gender identity and expression. In cases where health care services were provided, participants reported a range of discriminatory experiences, including 28% experiencing verbal harassment in a medical setting, and 2% of survey respondents reported being assaulted by medical providers. Even when overt harassment did not occur, 50% of respondents reported having to educate their medical provider about their health care needs. The Survey illustrated that transgender people of color were particularly vulnerable to higher rates of discrimination. Being “out” as transgender to the medical providers, increased the likelihood of experiencing harassment or being refused care. This is significant particularly because non-disclosure of ones status can pose health risks; being trans can be critical health information.

Health care discrimination towards transgender people is a significant factor in the high rate of postponement of necessary and preventative care. Forty-eight percent of participants reported postponing medical attention when they are sick or injured due to fear of discrimination, and 50% postponed preventative care for the same reason. Cost was another reason to postpone care, with 88% of participants delaying care because of inability to pay. Transgender people are significantly less likely to be covered by health insurance than the general population. One of the most salient correlates for lack of access to health care for the transgender community is poverty. The Survey found that transgender people are four times more likely to live in extreme poverty (i.e. < \$10,000/year) as compared to the general population. The Survey also found that transgender individuals were twice as likely to be unemployed as the general

population, with nearly half reporting being fired, not being hired, demoted, or denied a promotion due to their gender identity and/or expression (Grant et al, 2010; NCTE & Task Force, 2011).

Substantial levels of discrimination in housing was reported by Survey participants with nearly one in five transgender individuals having experienced homelessness, and 19% having been evicted or denied housing due to their gender identity or expression. The Survey also found a relationship between housing discrimination, lack of access to legitimate health care services, and increased engagement in high-risk behaviors. Given the circumstances that foster these high-risk behaviors, transsexual individuals are four times more likely to contract HIV.

While these figures are astonishing, they mask the level of discrimination experienced by less privileged members of the transgender community, particularly transgender individuals of color. In all of the above areas of discrimination, the prevalence of discrimination and lack of access to basic necessities (i.e. housing, employment, health care) was most prominent for individuals of color.

For transsexuals that have insurance coverage, insurance companies often deny critical services and claims based on a patient's diagnosis of Gender Dysphoria (GD)—formerly Gender Identity Disorder (GID). For example, this diagnosis has been used to deny coverage for mastectomies for breast cancer and hysterectomy's for uterine or ovarian cancer in trans men (Levasseur, 2010; Lambda Legal, 2010; & GLMA, 2010). Despite the fact that the American Medical Association (AMA, 2013), National Association of Social Work (NASW, 2012), American Psychiatric Association (APA, 2012a & APA, 2012b), World Professional Association on Transgender Health (WPATH, 2008),—among others professional associations (Lambda Legal, 2012)—and the current edition of the WPATH Standards of Care (SoC) (Coleman, et al, 2011) classify transition specific procedures (i.e. hormones, therapy, and GCS/SRS) as medically necessary care, it is highly unusual for insurance companies to cover the costs of these procedures (HRC, 2011). Most individuals that need these procedures lack the ability to pay out of pocket.

One of the reasons most often cited by insurance companies for denial of health insurance coverage for transition-related medical and mental health care is cost. While the cost of access to these medical procedures is substantial for individuals, the City and County of San Francisco developed the initial case study

and related actuarial data that disproved any correlation between higher plan costs and transition-inclusive coverage (HRC, 2009). Given that insurance is based on economic models of pooled risk, the significant costs of transition for an individual becomes a negligible cost when spread across all plan participants.

Further cost savings can be realized through transition-inclusive health insurance by helping to alleviate use of emergent care service in lieu of primary care, and by minimizing the need for transgender patients to engage in higher risk behaviors to access transition related services (Tinuoye, 2011).

In 2001, San Francisco added coverage of transition-related procedures to their employee health care benefits (HRC, 2009). In doing so, they projected the costs of such a benefit as \$1.70 per month for each employee and added this cost as a surcharge to employee-paid premiums. This surcharge was calculated based on presumptions that out of their roughly 100,000 plan members 35 individuals annually would incur \$50,000 each in transition related claims. Within five years, the city had collected nearly \$5.6 million to cover the cost of these benefits. In the same timeframe, they paid out \$386,417 in related claims. As such, there was no correlation between transgender health care coverage and significant health care cost increases, but there is a correlation between access to care and affordability of care when transgender people individually shoulder the full burden of the cost of transition related care. LGBT organizations have been able to use this actuarial data in their advocacy to Fortune 500 companies, law firms, and universities to help increase transgender inclusive coverage through employer and student health insurance (HRC, 2009).

Accessibility of Resources within Professional Journals

A search of EBSCO's Social Work Abstracts Database was conducted to assess the accessibility and extent of relevant research and resources available to social workers from professional journals. The terms used in this query were selected to ensure that the results would be the most relevant research and resource relating to individuals seeking medical treatment for GD/GID in the U.S.

A deliberate choice to use the term transsexual—rather than transgender— as a search term was due to multiple factors. The term transgender is an umbrella term that is used to encapsulate the broad range of gender non-conforming identities (i.e. transsexuals, cross dressers, drag, and genderqueers), which have distinct attributes that differentiate them from one another. Because of this, the term transgender is

frequently used outside the scope and context of this research project, and is particularly used in connection with publications dealing with lesbian, gay, bisexual (LGBT) populations. Additionally, the word transsexual has been historically used to identify individuals that seek medical intervention to alter anatomical sex characteristics to match their gender identity. Lastly, the term transsexual has a clinical history that dates back to the infancy of treatment in the U.S. (Benjamin, 1966), yet the term transgender did not become fashionable until the late 1980's and early 1990's. Given that this research is concerned with individuals attempting to access transition related care, the narrower and historically relevant term was utilized for these queries.

A search of EBSCO's Social Work Abstracts database for the term "transsexual" within the body of the text netted only 33 results. A query using the combination of "transsexual" and "treatment" returned seven results. Only one (Reed, 2005) of these results was published in the past decades, and only an additional two in the past 34 years (Midence & Hargreaves, 1997; Satterfield, 1988). Three of the seven articles were published in 1979 or earlier (Barlow, Abel, & Blanchard, 1979; Oles, 1977; & Wicks, 1977), which was prior to the formation of WPATH and an era when the protocols utilized the most stringent of hegemonic and pathologizing standards for accessing care.

An additional search of the Social Work Abstracts database was conducted using the terms "sex" and "reassignment." This query returned a total of eleven results, which ranged in publication from 1977 through 2012. Of the eight articles published in the past 32 years, five articles dealt with aspects of treatment in countries (i.e. UK, Hong Kong, Turkey, & Serbia) outside of the U.S. (Atamer, 2005; Chong, 1990; King, 2012; Perovic, Stanojevic, & Djordjevic, 2005; Ma, 1999; Midence & Hargreaves, 1997; Satterfield, 1988) and one dealt with the psychosocial impact for parents of transsexuals (Lesser, 1999). Of these eight articles, only one article addresses diagnostic assessment and treatment protocols for transsexuals, and was published over 25 years ago. This article was based on the diagnostic criteria of the DSM-III-R and an assessment scale developed by Harry Benjamin to determine the appropriateness of hormonal and surgical sex reassignment. Of the three articles published between 1977 and 1981, an article by Jon Meyer and Donna Reter (1979) has particular historical bearing for this article given its influence on the closure of the Johns Hopkins Clinic and subsequent closure of other university based gender identity clinics. The remaining two have more modest

implications for this article with regard to the historical use of psychotherapy for treating GD/GID (Oles, 1977 & Braunthal, 1981).

Professional Ethics and Values

The NASW's *Code of Ethics* (2008) serves as the core values and ethical standards that guide the social work profession. Fundamental to these core values and ethical standards, the profession is called to "act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups" (p. 27), nor should we "practice, condone, facilitate, or collaborate with any form of discrimination" (p. 22-23). As part of the NASW's efforts to guide professionals in meeting these ethical obligations, the association publishes *Social Work Speaks*, which is an anthology of policy statements briefing professionals on relevant topic and outlining the steps the profession must take to addressing the issue. Since at least 1999, the NASW has issued a policy statement on *Transgender and Gender Identity Issues*. This policy statement has evolved as the profession has increased its awareness of the systemic ways in which the transgender community is marginalized through various forms of discrimination (i.e. employment, housing, health care access, familial support) that are interconnected. According to the policy statement issued for 2009-2012, "social workers should be partnered with the transgender community to modify laws, medical protocols, research, and policies in ways that preserve and protect the quality of life for transgender, transsexual, and gender nonconforming citizens" (NASW, 2012, p. 345).

The NASW's policy statement is not simply a declaration of broad ideals for the profession. Rather, it provides a road map for action on the most pressing clinical and policy issues facing the trans community, and it illustrates the false dichotomy that separates clinical work from public and private sector advocacy when serving disenfranchised populations. The clinical is political when serving the trans community. Notably, policies that social workers are called to act upon include: 1) ending discrimination and lack of parity in health insurance coverage for transition related care; 2) addressing the dearth of curricular resources and informed faculty in schools of social work and professional development; 3) increasing the availability of competent psychological and social support services; 4) ending the omission of transgender individuals from government and private research; 5) develop resources for addressing public misconceptions; and 6)

advocating for increased legal recognition and discrimination protections. This is by no means a comprehensive list of the work the profession needs to undertake.

This article is a historical analysis and critique of the professions role in treating transsexual individuals. Through the examination of past practices and the implications historical practices have on contemporary clinical work with transsexual clients, this work seeks to draw attention to the challenges the profession continues to face in meeting the needs of this oppressed community and to inform the development of curricula for educating social workers in schools and in the profession that bridge the false dichotomy between clinical and macro practice in addressing the marginalization of trans clients.

Theoretical Approach and Methodology

Feminist and Gender Theories

Two genres of feminist thought are particularly relevant to the treatment of transsexual individuals. While this study will utilize Poststructural Feminism as its theoretical approach, it is critical to understand the historical role and context of Radical Feminist thought as it relates to the medical establishment's treatment of transsexuals. Moreover, Radical Feminism has historical significance given that it came about during the infancy of transsexual treatment in the U.S.

Radical Feminism.

Finding a theoretical framework from which one can simultaneously critically assess the historic role of social work and secure a theoretical foundation for advancing trans affirmative objectives for the profession can be challenging given that many theories have problematic assertions that are often roots in essentialist and conflated notions of sex, gender, and sexuality (Namaste, 2000). As with the *DSM* and *Standards of Care*, the transsexual community often harbors animosity toward feminist theory based on misconceptions of feminism as being monolithic, and the transphobic theories propagated by Radical Feminists. Janice Raymond's treatise, *The Transsexual Empire: The Rise of the She-Male* (1979), is perhaps the most informative example of the violent and transphobic rhetoric infused within Radical Feminism. Raymond is professor emeritus of Medical Ethics and Feminist Theory at the University of Massachusetts at

Amherst. However, given the era (i.e. c. 1979), Raymond and her Radical Feminist contemporaries (Daly, 1978) played a critical contextual role vis-à-vis the evolution of trans health care.

Rather than challenging the medical establishments perpetuation of hegemonic notions of sex, gender, and sexuality vis-à-vis compulsory protocols for accessing transition related medical treatment, Raymond's books identifies transsexual women (i.e. male-to-female) as the affront to women and women's liberation. That is to say that Raymond constructs transsexual women as a patriarchal Trojan horse for men to access and dominate women's space.

Furthermore, Raymond goes as far as asserting that transsexual women rape all women by appropriating the female body. Raymond and Radical Feminist theory are deeply rooted in essentialist "womyn-born-womyn" ideology, which attempts to simultaneously challenge the social construction of gender in relation to gender roles, yet polices the boundaries and borders of sex. These theories are rooted in ideology that there is some inherent or essential quality rooted in biological sex. For Raymond, transsexual women lack this essential quality—acquired only by birth right—and any attempt to acquire a female body is a "taking" for which transsexuals are not entitled. Thus, Raymond asserts that this appropriation is akin to rape. As such, Radical Feminism constructs transsexuals as a tool of patriarchy rather than a direct challenge to hegemonic gender, sex, and sexuality enforced by patriarchy. This locates transsexuals as the "enemy" of women rather than the patriarchal institution that constructed "true" transsexual women within hegemonic ideals of womanhood.

Post-Structuralism.

Post-Structuralism offers a more fruitful theoretical framework to inform trans affirmative clinical practice, public policy advocacy, and revision to the DSM and SoC. The core of this genre of feminism locates gender as a social construction independent of anatomical sex (Namaste, 2000).

In their pioneering work, *Doing Gender*, West and Zimmerman (1987) layout a theoretical model for understanding the social construction of sex, gender, and sex category. This third designation is critical to understanding the relational and functional nature of third parties to sex and gender. They argue that given that in everyday interactions, third parties are unable to view an individual's genitals to delineate one another

as male or female, we use culturally bound gender signifiers (i.e. clothing, hairstyle, voice, social mores, and behaviors) to assign individuals to a sex category, which informs social interactions based on gendered cultural norms.

For West and Zimmerman, while sex, gender, and sex category are distinct from each other, they function in intersecting and interdependent ways. While we might theorize the distinctions between these categories, most individuals do not differentiate between them in everyday interactions. Based on this theoretical framework, one can acquire the qualities of one gender and thus be assigned by a third party to the corresponding sex category despite having the sex characteristics of the opposite sex. For example, one can take on the performative attributes of a woman, and a third party could designate them to a sex category of female despite having or previously having male genitals. While West and Zimmerman's seminal work holds to some conventional and essentialist notions of sex and gender, it is a critical demarcation in feminist thought and laid the foundation for theorizing the relational nature and function of sex and gender.

In *Gender Trouble: Feminism and the Subversion of Identity*, Judith Butler (1990) simultaneously challenges and builds on West and Zimmerman's theory by exploring a Beauvoirian and Foucauldian post-structuralist/post-modernist view of gender and sex as social constructs rooted in performativity. Butler challenges feminisms historical assumptions of universality of woman—of sisterhood. Butler troubles this assumed universality by illustrating that various intersecting factors and identities—including time, place, and intersecting identities of race, sexuality, and class—complicate the category of “woman.” There is no “universal” experience of being a woman.

Butler goes on to challenge feminisms tendency to differentiate between sex and gender in which sex is an inherent trait (i.e. biological) and gender is socially constructed. For Butler, gender functions to signify sex. As such, sexed bodies are dependent on gender to signify and give meaning to sex. Ergo, sex is dependent on gender, and thus sex is a social construct. For Butler, gender is not an arrived state; we get up each day and begin the work of performing gender anew. This performance, moreover, is a constant “failure;” we do not ever arrive at a point where we are now “women” or now “men” where the performance

is complete, and (re)production of gender has been accomplished. Gender, in other words, is an action, a striving, rather than a fact or a state.

Diving deeper, she troubles the concepts of man/male and woman/female. What qualities do individuals need to have to be considered a woman/female or man/male? No matter the response to this question, one can find exceptions to the rule that illustrate the problematic assumptions of essentialised gender. In attempting to answer such questions, one begins to understand how notions of gender rely on fallacies of universality and innate attributes of sex. In exploring this further, Butler draws on the work of Simone de Beauvoir to examine the dynamics of power vis-à-vis the constructs of sex and gender. As such, attempts to answer the question of what constitutes a man/male and/or woman/female illustrate the dynamics of power through the use of phallogocentric discourses of compulsory heterosexuality and reproduction. As such, woman/female is constructed in relation and utility to man/male.

Historical Discourse Analysis

Rooted in poststructuralist theory, historical discourse analysis is a method of reading, writing, and interpreting history using the lens of critique (Park, 2008). “Historical discourse analysis works against the ‘objectivist fallacy’ of traditional positivist historical methods in decentering the authority of the historian as a neutral recorder of facts and the claim of historical writings as objective reconstructions of past events” (Park, 2008, p. 394). Rather than being concerned with documenting historical “truths,” historical discourse analysis is focused on analyzing the discursive production of history and more particularly the dynamics and construction of power.

Historical discourse analysis, informed by the theoretical approach of poststructural feminism, is used to examine and critique the historical professional narratives and standards by which transsexual individuals have received or been denied treatment in the U.S. This study pays particular attention to the discursive production of historical narratives around transsexuality and their relation to the production of hegemonic power and marginalization.

Sources

This research is a historical discourse analysis that focuses primarily on the works of notorious figures in the history of transsexual psychiatric and medical treatment. These works include the “father” of transsexual medicine in the U.S., Harry Benjamin’s treatise *The Transsexual Phenomenon* (1966). Given the significant and historic role Johns Hopkins University’s Gender Identity Clinic played in the treatment of transsexuals, this study pays critical attention to books by this program’s affiliated clinicians. These sources include Richard Green and John Money’s anthology *Transsexualism and Sex Reassignment* (1969) and Green’s 1974 book *Sexual Identity Conflict in Children and Adults*. In contrast with their Johns Hopkins colleagues, Paul McHugh and John Meyer’s publications are examined for the significant role they played in the closure of the Johns Hopkins University Gender Identity Clinic. Richard Stoller’s 1968 book *Sex and Gender* offers additional insight into the systematic way in which transsexual individuals were regarded and pathologized across medical institutions, particularly at UCLA’s Gender Identity Clinic. The published works of Kenneth Zucker and Ray Blanchard will be examined for more contemporary influences on the DSM and SoC.

The study examined the evolution of interdisciplinary professional discourses that have influenced the diagnosis and treatment protocols for the treatment of transsexuals in the U.S. Books, anthologies, and journal articles by these key historic figures in the treatment of transsexuals are the sources for this research. These historically significant books, articles, and other materials were publicly available through archives, rare book proprietors, and online library repositories.

Analysis

The Construction of a Phenomenon

Transsexuality entered the American consciousness in the 1950s via popular media accounts of Christine Jorgensen’s surgical and social transformation from male-to-female in Denmark (Adams, Bell, & Griffin, 2007; Benjamin, 1966). With the public increasingly cognizant of the possibility of changing ones gender individuals began to seek treatment for gender dysphonia.

In tracing and critiquing the professional discourses related to the treatment of transsexuals in the U.S., Harry Benjamin’s 1966 book *The Transsexual Phenomenon* is a particularly informative and relevant starting

point as it demarks pioneering attempts at documenting, formulating, and professionalizing diagnostic and treatment protocols for transsexuals. As indicative of the significant historical role and influence Harry Benjamin and his treatise have played in diagnosing and treating transsexual individuals, the World Professional Association on Transgender Health (WPATH)—the professional authority on the treatment of transsexuals—was known as the Harry Benjamin International Gender Dysphoria Association from its founding in 1979 until 2006 (Coleman, et al, 2011; WPATH, 2008; WPATH, 2011). Given the information vacuum related to transsexuality and the accessibility of *The Transsexual Phenomenon*, Benjamin's book became the central authority for diagnosis and treatment of transsexuals. The book constructed and differentiated “true” transsexuals from those that were not “true” transsexuals through the use of hegemonic ideals of man and woman – male and female. Given the book's intended dual accessibility to the “medical profession and laity” (Green & Money, 1969, p. 7), it influenced scripted narratives that individuals were required to maintain in order for the allied professions—including clinical social workers—to sanction the patient as a “true” transsexual, granting or denying access to hormones and Gender Confirmation Surgery/Sex Reassignment Surgery.

However, in reviewing Benjamin's treatise, one can also see the compassion that Benjamin had for individuals with gender dysphoric distress. In his compassionate attempt to provide a diagnostic foundation to justify transition related care, Benjamin appears unconscious of the ways these constructed narratives are informed by his own subjectivity—as a heterosexual cisgender male— vis-à-vis a patriarchal medical establishment and society. Notwithstanding Benjamin's good intentions, these compulsory narratives that define standards of “true” transsexuality, are instruments of power that compel conformity to hegemonic ideals of gender that marginalize individuals. Failing to adhere to such standards of “true” transsexuality is the basis for denial of transition related treatment.

In his first chapter, Benjamin lays out elaborate and insightful explorations of the various biological aspects of sex and the potential for sex variance outside of the traditional sex binary. Benjamin deconstructs the traditional sex binary by providing an informative discussion of intersex conditions to illustrate the rich biological diversity in the ways that sex manifests itself in contrast to the traditional sex binary. Despite this

initial attempt at taking a nuanced approach to sex, Benjamin's subsequent chapters reveal conceptions of sex that appear to be deeply rooted in essentialist notions of sex, gender, and sexuality, which in turn informs the scripted narratives used to construct and pathologize transsexuals. As Benjamin puts it, "these persons, in a strictly scientific sense, fool themselves. No actual change of sex is ever possible... If a chromosomal study should be made, however, the true chromosomal sex would be discovered..." (p. 55).

By locating one's "true sex" as chromosomal, Benjamin stands in sharp contrast to his earlier assertion that the "better educated person knows the existence of intersexes, of true and pseudohermaphrodites in whom the physical sex is in doubt" (p. 12), and conflicts with his prior proclamation that there is "no longer an absolute division (dichotomy)" (p. 11). To illustrate the problematic nature of such essentialist ideas, consider an individual with XY chromosomes and Androgen Insensitivity Syndrome. As a result of this intersex condition, the individual develops as a female and is raised and socialized as a woman. Is she not a woman? Is she not female? Should she be marginalized as less than a "true" woman because—as Benjamin asserts—her "true" chromosomal sex is "male"? What are the underlying drives that are influencing such rigid adherence to essentialist notions of sex and gender despite evidence to the contrary?

The answer to this last question can be derived from further analysis of the power laden narratives used by Benjamin and his colleagues to simultaneously pathologize transsexuals, yet lay the necessary foundation and framework from which transition related medical care could be justified and provided within the patriarchal medical establishment via diagnostic formulation and treatment of "abnormality" and "deviance".

It is critical to understand the social, cultural, and institutional contexts in which these diagnostic narratives and treatment protocols were written. *The Transsexual Phenomenon* was published just three years after Betty Freidan's *The Feminist Mystique* (1963) and seven years before homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Given this context, one begins to see the hegemonic forces that influenced the treatment protocols for transsexuals during this era. Indeed, if we examine the list of contributors to Green and Money's anthology, *Transsexualism and Sex Reassignment* (1969),

only 3 of the 35 contributors were women. Of the three women, one was a graduate student, another was a surgical nurse, and the third was a psychologist that addressed transsexual intelligence—not diagnosis or treatment.

As we begin to assess the literature dealing with the “transsexual phenomenon,” we begin to see that these male clinicians were predominantly concerned with transsexual women—with minimal attention given to transsexual men. Richard Green’s, *Sexual Identity Conflict in Children and Adult* (1968), exemplifies the later point. Of the book’s 18 chapters, only four chapters are concerned with female-to-male transsexuals and/or the expression of masculine traits in girls. The remaining chapters of his book are reserved for addressing transsexual women and “feminine boys.”

This is a critical aspect for understanding what dynamics of power brought to bear on developing the diagnostic criteria and treatment protocols. When the clinicians establishing the means and modes of treatment are predominately male identified, it is cause for skepticism for how the diagnostic and treatment protocols might be unduly influenced by hegemonic conceptions of sex, gender, and sexuality. Moreover, given the patriarchal nature of the medical establishment, with few women clinicians at the time, the defining symptoms and traits of the “true” transsexual was constructed vis-à-vis the gaze, desires, and sexual utility to the heterosexual male.

Symptomology and Pathology: A Constructed Figment of Imagination

Compulsory [Heterosexuality].

Chief among these prerequisites for Gender Confirmation Surgery/Sex Reassignment Surgery (GCS/SRS) was compulsory heterosexuality (Benjamin, 1966; Money, 1968; Stoller, 1968). A “true” transsexual woman was required to be sexually attracted to men. As was previously noted, during this era homosexuality was still listed as a pathological condition within the DSM. To be a “true” transsexual, it was unfathomable—for these clinicians—that a transsexual woman’s sexual orientation would differ from these male clinicians’ construction of normative female sexuality (i.e. passive and heterosexual). Gender and sexuality were conflated as one and the same.

The transsexual feels himself to be a woman and is attracted to men (Benjamin, 1966, p. 28)... The transsexual shows a much greater degree of sex and gender role disorientation

and... emotional disturbance... He lives only for the day when his female soul is no longer outraged by his body, when he can function as a female – socially, legally, and sexually. In the meantime, he is often asexual or masturbates on occasions, imagining himself to be a woman. (1966, p. 27)

These passages are not only indicative of compulsory heterosexuality, but demonstrate the lack of clinician consciousness of the dynamics of power in relation to these narratives, clinician interpretations of observation, and regulation of access to treatment. Benjamin sets the standard that “true” transsexual women must be sexually attracted to men. In fact, in subsequent related passages he clarifies that they be sexually attracted to “normal men”—not homosexual men. This limited engagement in sexual activity (i.e. asexual and occasional masturbation) does not appear to warrant further exploration for Benjamin. Such behavior is treated as symptomology of “true” transsexuality based on hegemonic views of female sexuality as passive with low libidinal drives. That is to say, that women—and thus transsexual women—were not seen as sexual beings, but rather are sexual objects that derive their sexual fulfillment in relation to sexual subjectivity to men.

Applying a critical lens, the limited sexual activity could be indicative of a sexual orientation that does not conform to diagnostic protocols. Why would a transsexual disclose details of their sexuality that could preclude them from GCS/SRS? Further, this behavior could be explained by psychosocial challenges in relating to potential partners because of the transsexual woman’s physical anatomy and social stigmatization. More simply, a transsexual’s genitals could present physical and emotional challenges to relating to potential partners, yet Benjamin appears satisfied that the lack of sexual engagement is simply an affirmation of passive “female” sexuality.

Nullification: Sexual Gratification and Objectification.

While compulsory heterosexuality for transsexual women illuminates social nullification of female sexuality, the nature of the early surgical techniques provides additional insight into the power-laden narratives and practices that have informed treatment of transsexual women (Benjamin, 1966; Money, 1968; Stoller, 1968). These practices not only had implications for constructing the defining characteristics of a “true” transsexual, they had consequences that led to the physical nullification and objectification of the bodies of transsexual women.

U.S. based surgeons, during the 1960-80's, appear to have been focused on surgical techniques that constructed a modestly sensate vaginal cavity for transsexual women, but not with creating a sensate clitoris. As such, the transsexual woman's sexual satisfaction became dependent on phallogentric stimulation. The surgical construction of the neo-vagina centered on the sexual gratification of the male partner and the sexual objectification of the transsexual woman.

...the penile skin is utilized to create the labia minora... All these tissues contain sensory nerve ends, which later may help to convey sexual satisfaction, possibly climaxing in orgasm. The creation of the artificial vagina is for many transsexual males the crucial part of the operation. (Benjamin, 1966, P. 112)

While these practices are troubling, they were relatively progressive in relation to many of the techniques performed outside the U.S. (Green & Money, 1969). These crude surgery practices were not concerned with maintaining any sexual sensitivity. Many of these surgeries quite literally nullified the transsexual woman's ability to derive any form of sexual stimulation. These procedures were nothing more than a penectomy. Indeed, Johns Hopkins and other university based gender clinics were called upon in several of these cases to do corrective surgery. However, the reconstructive surgeon's abilities were limited given the lack of sensate tissue after a penectomy.

“Born in the Wrong Body”: Conformity to Scripts and Access to Care.

Money and Primrose presents the cases of 14 Transsexual Women as a glimpse into the various psychological aspects of transsexualism (Green & Primrose, 1969). In assessing these cases, they conclude that there is “a high degree of verbal adherence to feminine stereotypes on the part of the male transsexual... [that] may be in part the result of a conscious, superficial imitation of female behavior” (p. 118). This brief passage offers rich insight into that limited clinician consciousness into the dynamics that assert power and dominance in whom determining “objective truth”, which regulates access to transition related care. In constructing the defining characteristics of “true” transsexuals, these clinicians set a rather high, strict, and heteronormative standard that transsexuals had to meet in order to qualify for hormones or GCS/SRS. With transsexuals seeking out clinical literature to better understand themselves and possible medical interventions, accessible literature like Benjamin's *The Transsexual Phenomenon* (1966) informed the lexicon and constructed scripts. These are scripts that transsexuals are compelled to maintain with high rigidity in order to appease

and convince gatekeepers that they warranted GCS/SRS and related transition procedures. In addition to compulsory heterosexuality, sexual passivity, and gendered ambitions, “born/trapped in the wrong body” and “god made a mistake” are just a couple of the cliché scripts that have been perpetuated by the diagnostic protocols.

Money and Primrose attempt to uncover and infer gendered behavior and mannerisms as inherent to sex. Their narratives elude to these gendered behaviors as natural, inherent, and unconscious to cisgender women, yet acts of impersonation and imitation for transsexual women. Money and Primrose are far from alone in dismissing the transsexual woman’s gender expression. This is a consistent practice throughout all of the historical publications from the 1960s through the 1970s. Throughout these works, transsexual women’s gender expressions are depicted through trivializing terminology including masquerade, imitation, superficial, abnormal, artificial, and deviant. The use of these terms by clinicians, indicative of their positivist views of sex and gender, is dismissive of the experiences of transsexual women as fallacies. This is further substantiated by these clinicians habitual referencing of transsexual women as male/men and with masculine pronouns. These publications betray a constant process of linguistic demarcations, distinguishing the normal, real, and true, from those experiences that are deemed abnormal, artificial, and deviant. Their essentialised ideals of gender precluded these clinicians from seeing socially constructed aspects of gender and sex. Examining these traits as social constructs would have threatened the hegemonic order of gender, sex, and sexuality for which patriarchy is dependent upon. These are but a few of the narratives these clinicians used to pathologize and construct transsexual women as predators out to deceive “normal” (i.e. heterosexual) men. The objectivist fallacy becomes increasingly clear as these heterosexual cisgender male clinicians construct diagnostic narratives of transsexuals—particularly transsexual women—in terms that deny their gender identity.

The Closure of Johns Hopkins Gender Identity Clinic and Repercussions.

By the mid-1970s, the Gender Identity Clinic at Johns Hopkins was in turmoil (Wexler, 2007). Jon Meyer became head of the Department of Psychiatry in 1969 and took over primary responsibility for evaluating candidates for hormones and GCS/SRS. Meyer became concerned that patients seeking surgery

would deviate into other topics such as grief and loss, which prompted him—in collaboration with Donna Reter—to do an “objective” quantitative follow-up study of the long-term benefits of surgery (Meyer & Reter, 1979). In 1979, Meyer and Reter issued their findings and concluded that; “we now have objective evidence that there is no real difference in the transsexual’s adjustment to life in terms of jobs, educational attainment, marital adjustment, and social stability” (Wexler, 2007).

Money refuted these findings by asserting that the value of the surgery should be measured via the qualitative subjectivities of the patients, and not the quantifiable data points measured against normative expectations of success. Meyer’s “objectivist” approach failed to be conscious of the ways in which it is impossible to be a neutral historian, which impaired his conscientiousness of the ways his normative lens informed the study. We find heterosexual cisgender clinicians “objectively” determining the success of surgery based on normative expectations of the transsexual woman to find suitably gendered employment, marry a “normal” man, obtain a gendered education, and become social affirmed in their gender identity. As such, surgical success was measured by a transsexual woman’s ability to conform to the heteronormative middle class expectation of a woman to gain a gendered college education or vocational skill (i.e. nurse, teacher, or secretary), get married to a “normal” male, and become his dotting housewife whom derives her sexual gratification from meeting her husbands sexual desires. After all, as was noted earlier, the surgical procedures of the time removed most sexual sensitivity with the exception of phallic penetration.

On the heels of Meyer’s study, Paul McHugh—who admittedly sought the chair of Johns Hopkins’ Department of Psychiatry to end GCS/SRS—shuttered the clinic in 1979 (Wexler, 2007). Given Johns Hopkins stature within the medical community as the top medical school in the U.S., the handful of gender identity clinics at universities (e.g. UCLA, Northwestern, Minnesota) around the US were compelled to close their doors under pressure from inside and outside their host institutions. Given the skepticism within the medical community at the time, it was difficult for these institutions to justify continuing to provide surgery in the vacuum left by Johns Hopkins closure. As a result, only a handful of surgeons—including Stanley Biber of Trinidad, Colorado and Eugene Schrang of Neenah, Wisconsin—in private practices continued to provide GCS/SRS.

Denial of Care: Medicare, Medicaid, and Insurance Exclusion Clauses.

When Medicaid and Medicare were established in the 1960's, there was limited consciousness of transsexuality or the possible implications for federal policy. Under these circumstances, there was no public outcry demanding that legislation contain specific exclusions for GCS/SRS and related procedures. To the contrary, language not specific to transsexual medical treatments could be viewed as requiring coverage for such care (46 FR 47993). "Specifically, Title XIX states that Medicaid agencies may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §440.230 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition (§440.230 (c))" (Gorton, 2007).

Moreover, case law from the late 1970s held that "transsexualism as a condition cannot be excluded from coverage... under state operated federally funded Medicare programs" (Israel, 1997, p. 217). However, in one such case—*Rush v. Parham/Rush v. Johnson*—the federal district court ruled that the state of Georgia's claim that GCS/SRS "was experimental, cosmetic, unsuitable, or unavailable" (Israel, 1997, p. 217) was not convincing. The appeals court reversed this ruling and sent it back to the lower court to determine whether the state had a policy and procedures for prohibiting experimental procedures and whether the states determination of GCS/SRS as experimental was reasonable (Israel, 1997). In the final decision, the federal district court relied heavily on the DSM, which at that time stated, "since surgical sex reassignment is a recent development, the long term course of the disorder with this treatment is unknown" (Israel, 1997, p. 217). The court found that, based on this professional literature, the state was reasonable in determining that GCS/SRS was experimental and could deny the claim.

In 1981, the Center for Medicare and Medicaid Services codified this exclusion of GCR/SRS by issuing a new regulation (Rule 140.3) within the National Coverage Determinations for Medicare and Medicaid. The rule states that, "Because of the lack of well-controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism, the treatment is considered experimental... Transsexual surgery is not covered" (CMS, 1981).

These events illustrate the power of narratives within professional publications for informing public policy, yet simultaneously once a policy has been established it can be difficult to change. In this case, the

DSM III had direct implications for court decisions, which gave CMS grounds for barring coverage through Medicare and Medicaid. This federal regulation barring coverage has remained unchanged for over 32 years despite the DSM being revised twice and the SoC being revised six times since the rule was issued.

Health insurance industry coverage practices are frequently informed by public policy, particularly Medicare and Medicaid. With CMS prohibiting GCS/SRS, the health insurance industry followed suit. Coverage exclusion clauses for GCS/SRS and related care became standard insurance industry practice within the U.S. (HRC, 2011). As such, the historical professional narratives and practices are the basis for public and private policies that currently deny coverage to transsexuals.

Professionalization: WPATH, the Standards of Care, and the DSM.

With the closure of Johns Hopkins and affiliated university gender identity clinics and increasing opposition and scrutiny to the treatment of transsexuals, the Harry Benjamin International Gender Dysphoria Association—now WPATH—was formed in 1979 as a multidisciplinary professional association to conduct research, promote evidence based standards of treatment, and engage in public policy advocacy. In that same year, the association published the first *Standards of Care* (SoC), which universalized principles, standards, and protocols for the allied professions to grant access to transition related care, particularly hormones and GCS/SRS. Over the past three and a half decades, the SoC have been through seven revisions to reflect the evolving professional understanding of “best practices” for treatment. In fact, the current position of WPATH holds that transition related medical procedures are medically necessary. The SoC also define the scope of practice for each of the allied professions, including clinical social workers. (Coleman, et al, 2011; WPATH, 2008; WPATH, 2011).

Throughout the first six revisions of the SoC, few changes were made to the core standards for accessing hormones and GCS/SRS (WPATH, 2011). The SoC have functioned in tandem with the DSM. At the core of these standards was the role of clinical social workers—as therapists—as the authority in assessing patient diagnostic appropriateness for hormones and GCS/SRS. Prior to receiving the required therapist’s letter approving hormone replacement therapy, a transsexual was required by the SoC to attend weekly therapy for a minimum of 3 months. In the early versions of the SoC, this prerequisite was also met with a

requirement to be successfully undertaking a so-called “Real Life Experience” (RLE)—living full-time as their preferred gender for three months.

Per the SoC, the RLE has historically been the basis used by clinical social workers—as therapists—for assessing suitability for access to hormone therapy and GCS/SRS. The RLE was used to evaluate the individual’s ability to successfully function in society as the preferred gender. This was measured by the individual’s ability to hold a job, attend school, maintain social relationships, and change their legal name. In order to receive GCS/SRS, one had to be on hormones and undergo a minimum of 12 months of the RLE in conjunction with weekly therapy. Access to GCS/SRS required two therapists’ letters of recommendation, with at least one authored by a psychotherapist with a doctorate.

In analyzing the SoC, a variety of power dynamics unfold in relation to whom can or cannot access care based on their ability to bear the costs—financial and social—associated with these protocols. Given the prevalence of exclusion clauses in insurance policies, as well as Medicare and Medicaid, therapy is often not covered for individuals with a Gender Dysphoria/Gender Identity Disorder (GD/GID) diagnosis. Compliance with therapy requirements can cost an individual several hundred dollars each month, which is an insurmountable burden given the rate of extreme poverty within the trans community. By requiring initiation of a RLE prior to receiving hormones, the SoC deny an individual the social capital hormones can provide through the development sex characteristics for the preferred gender. To put it more plainly, a transitioning transsexual woman will increase her likelihood of social acceptance as a woman if hormones have been given to soften and feminize her physical features. Lastly, it speaks volumes to the nature of power and patriarchy that accessing hormones and GCS/SRS is so heavily regulated and monitored—monitored and regulated by clinical social workers, among other therapists. What other medical procedure requires this level of regulation and scrutiny over personal autonomy? Versions one through six of the SoC relocates “expertise” over one’s life away from the client and places it in the hands of therapists, including clinical social workers. Given the power that letters of recommendation have on a transsexual’s ability to access treatment, the SoC reinforces “scripted narratives” within therapy sessions rather than fostering a therapeutic relationships in which the

individual can address the psychosocial vulnerabilities inherent in changing their gender in a patriarchal society.

The seventh version of the WPATH SoC, published in 2011 (Coleman, et al, 2011), began to address many of these issues by discontinuing the requirement of therapy—though it still highly recommends therapy—and letters for accessing treatment. This revision also took the initial steps toward incorporating approaches that center the individual as the expert over their own life by sanctioning informed consent models of treatment that have been used in community clinics. These models center the individual as experts in their own lives by disclosing the risks and consequences associated with procedures and returning autonomy to the individual to decide whether to assume such risks and consequences by undergoing the procedures.

In 2013, with the release of the DSM V, significant progress was made in depathologizing GD/GID (APA, 2013). As a signifier of this progress, the name of the diagnosis was changed from Gender Identity Disorder to Gender Dysphoria. The new diagnostic criteria shifts from a binary cross gender conceptualization of diagnosis to a conceptual framework of gender non-congruence that recognizes the spectrum of potential gender identities or expressions. The diagnosis was further clarified to explicitly remove any possible inference that the diagnosis is a psychosis, a disorder, and that it is not a diagnosis carried by a patient for life. Under the DSM V, the diagnosis is only valid until gender dysphoric distress is eliminated by assuming one's preferred sex and gender.

Despite this progress, segments of the trans community believe the revisions to the DSM failed to go far enough. The trans and intersex communities have been most troubled by two of the selected members of the APA's Sexual and Gender Identity Disorders Work Group – Kenneth Zucker and Ray Blanchard (Blanchard, 2004; Grant, 2006; APA, 2012c). These communities were concerned with the potential bias these two men might bring to the process given their body of scholarship, particularly with Zucker as Chair of the working group. Zucker's work has been primarily concerned with gender variant children, and he advocates for a controversial reparative therapy approach for treating such children. He holds that enforcing strict gender norms in the social play of a gender variant child will eliminate the gender non-congruence in

time. Blanchard is controversial because of his history of pathologization of lesbian identified transsexual women. For Blanchard, these individuals are not “true” transsexuals, but rather men that have inverted their sexual attraction toward women to appoint that they seek to be the objects of their attraction. He coins the name Autogynophilia for this so-called diagnosis. His assertions are based on a presumptive fallacy that cisgender women do not find aspects of themselves sexually attractive and stimulating (Moser, 2009). Once again we encounter compulsory heterosexuality; true womanhood is inextricably linked to a woman’s sexual subjectivity to men.

Discussion

The historical treatment (both medical and social) of transsexuals through time has pushed this community “to the edge.” It is a population that suffers from endemic levels of attempted suicide, extreme poverty, discrimination (i.e. employment, housing, health care), and vulnerability to exploitation and violent crime (NASW, 2008; NASW, 2012; GLMA, 2010; Grant et al, 2010; Levasseur, 2010; Lambda Legal, 2010; & NCTE & Task Force, 2011). The 2010 National Transgender Discrimination Survey (Grant, et al 2010; NCTE & Task Force, 2011) documents a population with a 41% attempted suicide rate and extreme poverty at 4 times higher than the general population. Despite our profession’s *Code of Ethics* and stated commitments to addressing oppressed and undeserved populations in general, and the marginalization of transsexuals and gender non-conforming individuals (NASW, 2008; NASW, 2012) specifically, a disconnection between its stated values, commitments, and actions remain in place. Social work is failing an extremely vulnerable and oppressed community for whom the historical model of treatment—via the SoC—are clearly insufficient.

The stated commitment of expanding public and private research in this area (NASW, 2012), has not resulted in increased focus on research and scholarship about the population. Clinical social workers, moreover, have historically been complicit gatekeepers to transition related care (Lev, 2004; Brown & Rounsley, 2003). Access to transition related medical procedures are predicated on letters of recommendation from clinical social workers, among other therapists. In our role as therapists, clinical social workers have been empowered—through the SoC—with the authority to make subjective judgments over the validity of an client’s gender identity and their capacity to be socially affirmed as their preferred gender. The

measures at the base of these subjective determinations are, however, fraught with heteronormative notions of sex, gender, and sexuality that delimit the autonomy of these clients. Thus, in passively accepting existing standards of treatment without engaging in significant research, examination, or contestation, clinical social workers have historically been, and continue to act as, complicit gatekeepers perpetuating the marginalization, stigmatization, and pathologization of the trans community.

Recommendations

Bridging the False Dichotomy: The Clinical is Political.

The profession of social work is uniquely positioned among the allied professions to address the marginalization of the trans community by bridging the false dichotomy between clinical and macro practice. In 34 states, it remains legal to discriminate on the basis of gender identity and expression (HRC, 2013). Addressing employment discrimination by joining with LGBT advocacy organizations (e.g. NCTE, HRC, and Task Force) in lobbying for the passage of a gender identity and expression inclusive Employment Non-discrimination Act (ENDA) should be a primary priority for social workers given the high levels of unemployment, underemployment, and extreme poverty within the trans community. ENDA would produce the two-fold benefit for addressing poverty and health care access because health coverage in the U.S. is primarily employer based. In the absence of ENDA, social workers should be lobbying to pass similar and expanded protections at the state level that mirror protections for other marginalized populations. Passage of such a measure would stem the wide spread practice of discrimination and provide legal recourse to trans individuals should an employer discriminate, which would, in turn, improve the ability of trans individuals to obtain and retain employment regardless of their trans status.

The profession should join in lobbying and petitioning the Centers for Medicare and Medicaid Services to remove the 32-year-old National Coverage Determination regulation (Rule 140.3) prohibiting reimbursement of GCS/SRS, especially given the outdated nature of the professional standards that informed its development and in light of non-discrimination provisions of the Patient Protection and Affordable Care Act (CSM, 1981; 78 FR 15559, 2013). Further, the social work profession should use the states of California (Barnhart, 2013), Oregon (Savage, 2012), Colorado (DORA, 2013), Vermont (Donegan, 2013), and the

District of Columbia (White, 2013) as models for public policy advocacy for increasing access to health care, including medically necessary transition related service, for the trans community (WPATH, 2008; AMA, 2013; NASW, Lambda Legal, 2012). In the past 12 months, these states have used the PPACA and clarification of state non-discrimination laws to establish regulations barring health insurance exclusion clauses for trans related care and requiring parity of coverage, mandating that if a procedure is covered for other patients for any other diagnosis, the procedure must be covered for transition related care. These regulations do not require specific procedures to be covered, but uses coverage of procedures for other diagnoses in cisgender individuals to set the standard for what should be covered. Coverage in the one instance and not in the other becomes the essence of discrimination, which triggers the non-discrimination requirements of the original legislation. With the health insurance exchanges required in each state under the PPACA, issuing regulations in above fashion has significant potential for increasing access to transition related care—including therapy—for working and middle class trans individuals. However, the advocacy work for the establishment of these regulations is, as usual, being done by organizations within this marginalized population (e.g., Transgender Law Center, & DC Trans Coalition)—rather than by, or with the aid and support of, social work organizations.

While these are by no means the only issues for which a lack of public policy marginalizes the lives of trans clients, employment discrimination and access to health care are simply among the most critical. Additional public policy considerations include: expansion of government and private research to specifically include questions that capture data from trans individuals in a sensitive and trans aware manner, expansion of access and legal protections in the provisioning of critical services (i.e. homeless shelters, welfare programs, correctional facilities, & hospitals), and standardization of requirements for changing name and gender on government issued identifications.

Social Work Education & Professional Development: Towards Trans-affirmative Practice.

Critical to addressing the needs of the trans community is development of curricular resources for schools of social work and professional development courses (Martin, et al, 2009). Such materials need to be integrated into core courses, and not relegated to specialty electives (e.g. LGBT Practice, LGBT Social Policy)

where they simply “preach to the choir.” Trans knowledgeable and affirming providers, including clinical social workers, are few and far between. As a result, trans individuals are regularly turned away by therapists who demur that Gender Dysphoria is not their “specialty.” As the collaborative 2009 study between the Council on Social Work Education and Lambda Legal (Martin, et al, 2009) indicates, social work schools have not been adequately preparing students for the needs of trans clients, particularly within their core curricula. But whether it is in a private clinical practice, state human services agency, or health care facility, social workers are increasingly likely to be confronted with clients that are trans. Social workers should be trained to provide at least basic trans-affirmative care; never should a member of this marginalized population be turned away from services based on the professional’s personal feelings of inadequacy or be offered inadequate care because the professional is untrained and unprepared.

Standards of Care, DSM, and Access to Care

While the NASW’s call for removal of GD/GID from the DSM is the correct course of action for the long-term, a moratorium on this call is necessary (NASW, 2012). The diagnosis is currently the only viable mechanism for justifying transition related care as medically necessary. Eliminating the DSM diagnosis would remove the diagnostic framework for justifying reimbursement from private insurance companies, Medicare, or Medicaid for transition related procedures, just at a time when trans inclusive health coverage seems to be expanding (HRC, 2012), There is no doubt that social work should work towards developing and establishing within the general medical field a trans-affirming diagnostic framework, that contests the hegemonic and pathologizing framework of a “mental disorder.” However, simply removing the diagnosis from the DSM without an immediately viable alternative within the broader medical field leaves the trans community without access to necessary medical services. Continued efforts need to be focused on depathologizing the DSM and SoC while a viable trans-affirming medical framework is developed.

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