Sociology Compass 9/9 (2015), 803–813, 10.1111/soc4.12297

Normative Accountability: How the Medical Model Influences Transgender Identities and Experiences

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Abstract

The medicalization of gender variance is a key force in transgender people's experiences of embodiment, identity, and community. While most directly dictating experiences of diagnosis and medical classification, it is important to acknowledge that the effects of medicalization are widespread across social contexts and institutions. I explore the medical model of transgender identity, with special attention to its current diagnostic classification, in order to highlight how transgender people's interactional experiences of gender are shaped by medical authority. I review literature that highlights the operation of the medical model as a normative accountability structure in its influence across multiple institutions of social life including health and healthcare, transgender community groups, and legal classification.

Introduction

In May 2013, the American Psychiatric Association released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (APA 2013). One notable change in this edition was the revision in terminology for the transgender-related diagnosis. While listed as *Gender Identity Disorder* in the text-revised fourth edition (*DSM-IV-TR*) (2000), the new diagnosis is termed *Gender Dysphoria* in *DSM-5* (2013). Much has been written debating the presence of a transgender diagnosis in the varied versions of *DSM* as well as the benefits and detriments of medical classification, diagnosis, and treatment of gender variance. Transgender scholars, activists, and advocates have had an ambivalent relationship to the medical model of transgender identity from the time it was formally introduced in *DSM-III* (APA 1980). As Burke's (2011) research shows, transgender activists and advocates consider the medical model of transgender identity to be at once empowering and also pathologizing. I will not be exploring these conflicting positions on medicalization further. Rather, I refer readers to Burke's (2011) review of these debates and focus here on an exploration of the medical model that recognizes its influence in both medical and non-medical social locations and institutions while neither supporting nor rejecting its merit.

In what follows, I explore the medical model of transgender identity, with special attention to its current diagnostic classification, in order to highlight how the medical model operates as a normative standard to which transgender people's interactional experiences of gender are held accountable in medical, legal, and social interactions. First, I give an overview of the current medical model of transgender identity. I then offer an abbreviated explanation of West and Zimmerman's (1987) interactional model of doing gender as it applies to transgender identity and experiences. Following these general overviews, I review literature that demonstrates how the medical model serves as an accountability structure for transgender people's interactional experiences of gender in multiple areas of social life including healthcare, community, and legal contexts. I end this article with a discussion of considerations for future research.

The medical model

The early history of the medical model of transgender identity in the United States, from endocrinological and surgical advancements that made medical transition possible to the inadvertent harm done to transgender people by the early university-based gender clinics, has been covered in extensive detail by other researchers in transgender studies and transgender sociology (Denny 1992; Drescher 2009; Rubin 2006; Stryker 2008). For the purposes of this paper, I offer an abbreviated overview of the current state of the medical model.

Transgender identity and experience has been formally claimed and defined by medical authority since the introduction of a psychiatric diagnosis for gender variance in *DSM-III* (1980). In May 2013, the American Psychiatric Association released *DSM-5*, which included a new description and diagnosis for gender variance that discontinued the use of 'disorder' in the diagnostic label (For a detailed account of the events leading up to the change from gender identity disorder to gender dysphoria, see Lev 2013). Listed as *Gender Identity Disorder* in *DSM-IV-TR*, the text-revised edition of *DSM-IV*, the new diagnosis is termed *Gender Dysphoria* in *DSM-5*. However, the change is largely symbolic, and the continued presence of a psychiatric diagnosis for gender-variant people undermines the new terminology. Further, the new diagnosis does little to combat the general understanding of transgender identity as a medical condition, specifically a psychiatric illness, necessitating a variety of medical interventions including psychotherapy, hormone therapy, and surgery (Teich 2012).

The term "gender dysphoria" is not a new concept for the transgender community and has been used for decades in reference to the discomfort transgender people feel in relation to their birth-assigned sex category (e.g., Cromwell 1999; Devor 1996). *DSM-5*, framing transgender people's discomfort as mental illness, defines Gender Dysphoria in the following way:

> *Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. (emphases in original, APA 2013, p. 451)

As the definition above indicates, the diagnosis has shifted to focus on the psychological consequences of transgender identity such as discomfort and distress rather than transgender identity itself being symptomatic of mental illness. However, the language in the description above remains focused on embodiment as the vehicle of discomfort and distress. This focus positions discomfort and distress surrounding the incongruence between assigned sex category and gender identity as resulting from a lack of access to medical interventions rather than the social consequences of gender ideology, transphobia, or cissexism. Both the current and previous definitions of gender variance in the *DSM* position medical intervention as the next logical and necessary step in dealing with Gender Dysphoria. While intervention may indeed be the next step for some transgender people, the *DSM*'s definitions tend to overemphasize the importance of medical intervention for all transgender people.

Medical authority over gender variance by way of continued psychiatric diagnoses has led to the development of a hegemonic medical model for understanding transgender people's experiences of gender over the life course. The medical model of transgender identity should be understood as the American Psychiatric Association's framing of gender variance as "a psychological condition […] that requires medical treatment, including gender affirming surgery or hormone therapy" (Koenig 2011, p. 619). Positioning transgender experience and

identity within the medical model creates the following three-step process of becoming transgender: (i) experiencing discomfort and distress surrounding gender throughout life; (ii) acquiring a psychiatric diagnosis for gender variance; and (iii) accessing gender-affirming medical interventions. While the content of the diagnosis, in terms of language used and descriptions given, has shifted over time to be less damning of transgender people, the form of the diagnosis has continued to sustain this narrowly defined process of transgender identity.

The medical model offers a medically supported avenue for gender-affirming healthcare and does well to legitimize the discomfort that transgender people experience as a result of feeling ill at ease in bodies that may not match their personal identification. However, as I will show later in this paper, the medical model's pervasive influence positions it as an accountability structure for transgender people's experiences of gender in multiple areas of social life including healthcare, community, and legal contexts. To better demonstrate how the medical model operates across social contexts and institutions, I employ doing gender theory (West and Zimmerman 1987) with special focus on social accountability (Hollander 2013; Lucal 1999). Here, I offer an abbreviated explanation of West and Zimmerman's (1987) interactional model of gender as it applies to transgender identity and experience. Following this general overview, I review literature that demonstrates how the medical model serves as an accountability structure for transgender people's interactional experiences of gender in multiple areas of social life including healthcare, community, and legal contexts

The interactional model

The interactional model, based on West and Zimmerman's (1987) theory of doing gender, places the development and meaning of gender in the social rather than individual domain. Doing gender theory positioned gender as an accomplishment of social interaction rather than an essential characteristic of individuals. For West and Zimmerman, individuals' sex and sex category are separate entities with the former determined via "biological criteria," such as sex organs and chromosomes, and the latter through "identificatory displays" or social representations of sex (1987, p. 127). Both of these classifications are based on others' evaluations, be it doctors in the case of sex or interaction partners in the case of sex category. Gender, however, is defined as "the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category" (1987, p. 127). Gender is thus a social accomplishment conceptually separate from, albeit normatively linked to, sex and sex category.

The social accomplishment of gender relies on continued accountability to normative situated standards for gender presentations that are coherent with assigned sex categories: that is, masculinity with perceived maleness and femininity with perceived femaleness. As West and Zimmerman explain it, accountability is the crux of doing gender. While doing gender does not assume purposive individual attempts to meet specific standards, individuals are said to always already be doing gender in social interaction, as "accountability is a feature of social relationships" (p. 137). As Hollander (2013) explains, accountability is ubiquitous and ongoing regardless of individual acknowledgement or investment. To do gender, then, is to "engage in behavior *at the risk of gender assessment*" (West and Zimmerman 1987, p. 136).

Raewyn Connell's (2009) reflection on doing gender theory highlights transgender people's unique experiences of gender and sex category by focusing on embodiment. It is here where the medical model becomes influential in the interactional experiences of transgender people. Connell argues that gender, as a social accomplishment, is embodied in ways that are impossible to ignore. Part of doing gender is signaling embodiments, in addition to practices, that cohere with assigned sex categories. Transgender people who cannot or do not wish to access gender-affirming medical interventions experience what Connell terms *contradictory embodiment*

(Connell 2009, 2012). Connell argues that transgender experiences of doing gender would be better understood through a lens that "centers on recognition and the relationship of embodiment to recognition" (2009, p. 109). For Connell, to do gender is to engage in interaction while being recognized as gendered in particular ways. Embodiment, Connell argues, is central to that recognition.

To better capture transgender people's embodied experiences of gender recognition, Catherine Connell (2010) coined the concept "doing transgender." Connell defines doing transgender as "transpeople's [sic] unique management of situated conduct as they, with others, attempt to make gendered sense of their discordance between sex and sex category" (2010, p. 50). To better understand the interactional model of transgender identity, we must account for the experiences of transgender people who socially signal secondary sex characteristics (e.g., facial hair, breasts, and vocal pitches) that do not align with their gender presentation or sex category. In doing so, we must acknowledge that, against the backdrop of our normative sex/gender system, accountability to the medical model is often required for transgender people to access embodiment and, thus, social recognition that coheres with their gender identity.

The interactional model of gender positions transgender identity as something that individuals do within interactional contexts rather than something that is essential to, and thus diagnosable for, individuals. While the interactional model does well to establish the social constraints on and consequences of gender, scholars working in this area must specifically acknowledge transgender people's subjection to medical authority in the negotiation of their contradictory embodiments. In what follows, I review literature that further demonstrates the influence of the medical model, as an additional accountability structure for transgender people, in transgender people's experiences of doing gender in various contexts of social life.

The medical model and normative accountability across social contexts

In order to demonstrate its pervasive influence, I argue that the medical model of transgender identity operates as a normative accountability structure that influences transgender people's experiences of doing gender in multiple institutions of social life including health and healthcare, transgender community groups, and the legal system. According to the interactional model of gender, as individuals interact in everyday life, they are held accountable to normatively appropriate behaviors and sanctioned when their behaviors do not adhere to normatively masculine and normatively feminine standards. Lucal (1999) writes, "[g]ender is pervasive in our society" and individuals "cannot choose not to participate in it" (p. 791). Put another way, "even if people choose not to meet gender expectations, they can hardly help responding to them" (Hollander 2013, p. 7). For transgender people, whose gender-affirming social interaction, healthcare, and legal documents are distributed according to a medical model, responding to the medical model is a necessary part of daily life.

Medical accountability

Transgender people's accountability to a medical model of identity and experience is perhaps most visible in regard to their access to gender-affirming healthcare. In 2012, the World Professional Association for Transgender Health (WPATH) released the 7th edition of its Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People (Coleman et al. 2012). WPATH is the professional organization for transgender health practitioners, and its Standards of Care are non-binding guidelines for the administration of transgender healthcare, including but not limited to psychotherapeutic counseling, hormone replacement therapy, and gender-affirming surgeries. One marked change of the 7th edition was the removal of the recommendation for diagnosis (then Gender Identity Disorder, now

Gender Dysphoria) before the administration of gender-affirming medical care. The recommendation for diagnosis was rescinded and replaced with an informed consent clause that stated individuals 18 years old and above should have access to care as long as they were aware of the risks. However, as stated above, WPATH's Standards of Care for transgender health are non-binding and thus non-mandated. That is, unless a healthcare practitioner seeks to uphold the latest standards in their treatment of transgender patients, the Standards of Care have very little impact, and practitioners still have the freedom to regulate access to gender-affirming healthcare and, thus, transgender identification at their discretion.

Extensive research has shown that transgender health practitioners often use their discretion to act as gatekeepers in that they hold transgender people accountable to the diagnostic criteria of the medical model, and when they fail to meet these narrow standards, they are denied access to gender-affirming medical care (Bolin 1988; Cromwell 1998; Denny 2006; Drescher et al. 2012; Kessler and McKenna 1978; Namaste 2000; Spade 2003). While the diagnostic criteria of the medical model have shifted to be less rigid, the focus on lifelong identification with the opposite sex and desire to rid oneself of natal sex characteristics remain. These criteria hold transgender people accountable to the trope of transgender people being *born in the wrong body*. Similar to the *born this way* trope of lesbian and gay experience (Bennett 2014; Walters 2014), *born in the wrong body* discourse eclipses any alternative narrative of gender identity as fluid, emergent, processual, or interactional and constituted by social norms and influence. In using the language of bodily incongruence and cross-sex characteristic identification, the American Psychiatric Association reinforces the *born in the wrong body* trope and places undue influence on the gendered trajectories of transgender people. Butler (2006) argues that this influence may operate as a type of peer pressure that encourages transgender people to undergo procedures that position their bodies within the normative gender binary. That is, while the medical model of transgender identity and experience may offer a path forward for those interested in medical interventions, it also operates as a normative set of standards for what it means to be transgender.

Community accountability

Research conducted in the 1990s showed that, at the time, members of transgender community groups engaged in accountability practices that were deeply reliant on the medical model of transgender identity and experience (Gagne and Tewksbury 1998, 1999; Gagne et al. 1997; Schrock 1996; Schrock et al. 2004; Schwalbe and Schrock 1996). These accountability practices required transgender community members to engage in "acts of self-observation and self-reporting" (Schleifer 2006, p. 58) that reaffirmed medical authority. The studies cited above reported that transgender people's understandings of their identities, narratives of self, and relationships to their embodiments were constructed according to a medical model and transgender people were sanctioned, ostracized, or pushed out of community groups when they failed to conform. Accountability to a medical model was most visible in the collective creation of a normative transgender narrative "equally invested in a proper early trace of transgendered [sic] consciousness as much as in a future gendered arrival" (Chen 2010, p. 202). While community narratives that align with a medical model may in fact be accurate accounts of some transgender people's experiences, not all transgender people identify with the medical model or require medical interventions. Thus, reliance on a medical model at the expense of others is argued to be a disservice to transgender community in that it creates "an unspoken hierarchy" (Bornstein 1995, p. 67) that positions transgender people who do not align with a medical model as "not 'trans' enough because of lack of surgeries or hormones" (Mog and Swarr 2008, np).

Transgender studies scholars have complicated the research surrounding accountability to a medical model within transgender communities (Califia 2003; Namaste 2000; Serano 2013; Spade 2003). As Spade (2003) writes, transgender people's relationship to medical discourse and authority is "fraught with difficulty" (p. 29). The medical model does not allow for deviation, and, as discussed above, medical intervention often requires "narratives of struggle around [transgender] identities that mirror the diagnostic criteria" (Spade 2003, p. 29). Thus, as Califia (2003) and Namaste (2000) suggest, accountability within transgender communities surrounding medicalized narratives may be more accurately described as utilitarian. That is, transgender people accumulate and pass on formulae for narratives that are deemed acceptable by medical professionals in order to assist transgender people in navigating medical settings rather than to regulate their personal experiences, identifications, and narratives.

It is worth noting that data on transgender community dynamics have by and large been missing from the sociological literature since the late 1990s. While the research on transgender community accountability may not necessarily represent the dynamics within transgender community groups today, it is important to acknowledge the documented effects of a medical model in non-medical transgender community settings. It is also important to consider the alternative accounts of medical accountability within transgender communities, specifically its utilitarian components as well as its contribution to a 'trans enough' hierarchy. More research is needed to explore the persistence, effects, and motivation of community accountability patterns related to a medical model in the evolving transgender communities of today.

Legal accountability

In addition to social and medical settings, transgender people are also held accountable to the medical model of identity and experience in their gendered interactions within the legal and criminal justice systems. Legal scholars have argued that the medical model of transgender identity also creates the terms of legal gender recognition for transgender people (Keller 1999; Koenig 2011; Lee 2008; Romeo 2005; Spade 2003, 2008). Transgender men and women seeking legal transition—which secures gender marker correction on official state and federal documents—are required to obtain a formal court order declaring their newly assigned sex category. Most states require proof of surgical reconstruction, and anatomical coherence be provided before the state will recognize a transgender person's identity (National Center for Transgender Equality 2013). That is, in order to be legally recognized and affirmed as men and women, transgender people are held accountable to a medical model of identity that requires medical interventions. Not only does this legal requirement limit transgender people's self-determination, but also it determines the legal definition of gender and sex category for all people. As Keller (1999) argues, if our medico-legal systems have the authority to grant gender to individuals, then those same systems have the authority to determine what exactly that gender will look like and how it will operate in society.

In addition to identification distribution, transgender people are also held accountable to a medical model within the criminal justice system as individuals are housed according to their legal and, thus, genitalia-based sex. In order to be housed according to their personal and authentic sex identification, transgender people must be legally classified as such. Extensive research has been conducted on the classification protocol for and treatment of transgender women in criminal and immigrant detention facilities (Anderson 2010; Conrad and Spade 2012; Faithful 2009; Jenness and Fenstermaker 2014; Shah 2010; Stanley and Smith 2011). While the incarceration of transgender women in male prisons and detention centers places transgender women at risk of emotional, physical, and sexual violence from guards as well as inmates, prisons and detention centers have failed to make sufficient progress in policy change that

would address the standards for treatment (Anderson 2010; Lamble 2012; Oparah 2012; Peek 2004). Policies related to the placement and treatment of transgender women prisoners are state and, at times, facility based. Prisons who have made efforts to protect transgender prisoners often place transgender prisoners in solitary confinement as a way to segregate them from other, more dangerous prisoners (Arkles 2009). Solitary confinement, while protecting prisoners from other prisoners, does not protect the prisoners from the violence inflicted by guards and corrections officers (Spade 2010). Further, the detrimental psychological and physical health effects of solitary confinement (Haney 2003) often serve as further punishment that they did not earn (Edney 2004). In the case of criminal and immigrant detention, transgender people's social experiences of gender are held accountable to a narrow definition that is reinforced by a medical model of transgender identity and experience.

In highlighting the medical model's pervasive influence across social institutions and contexts, we are better able to understand transgender people's experiences of gender in everyday life. The research discussed above shows not only that the medical model of transgender identity is at play within psychiatric settings but also that it influences transgender people's experiences in accessing gender-affirming medical interventions, community support, and legal recognition. This body of research is small, and there is much room for additional research that explores the medical model as an accountability structure in transgender people's experiences of gender in everyday life. In the following section, I will address how future and ongoing research on this topic must analyze intersecting categories of social difference, specifically differences related to socioeconomic status, race and ethnicity, and sex category.

Considerations for future research

Highlighting the pervasive influence of the medical model across social institutions and contexts allows for a robust understanding of the ways that medical definition and social interaction work together to structure transgender people's gendered identities, bodies, and experiences. As shown above, when the medical model is positioned as a normative accountability structure in transgender people's experiences of doing gender, we are better able to understand the medical, social, and legal contexts that both empower and constrain transgender people. The medical model serves as an accountability structure that legitimizes gender-affirming medical intervention while simultaneously restricting access to those who conform to a narrow set of criteria, that builds transgender community while at the same instance marginalizing members who do not conform, and that facilitates legal identity affirmation while also providing the basis for policies that place transgender prisoners and detainees at higher risk of violence and emotional distress.

As presented above, existing research within transgender studies and transgender sociology does well to document the influence of the medical model across contexts. However, increases in transgender awareness, education, community mobilization, and identification coupled with *DSM-5*'s reiteration of medical authority over gender variance set the stage for additional in-depth research in this area. Moving forward, research on this topic must answer calls for an intersectional approach to transgender studies (Broad 2002; Vidal-Ortiz 2008; Vries 2012). An intersectional approach not only should account for heterogeneity among transgender people (Hines 2006) but also must highlight how categories of social difference affect transgender people's experiences of accountability to a medical model.

The effect of the medical model on transgender people's interactional experiences of gender must be examined in relation to differences in socioeconomic status. The majority of gender-affirming medical interventions must be paid for out of pocket. Access to health insurance often does not help as insurance policies often have explicit clauses stating that they do not cover any

psychologists, specialists, procedures, or medications related to gender reassignment (Mayer et al. 2008). Holding transgender people accountable to a medical model thus excludes those who do not have the financial or social resources to access the services necessary to receive diagnosis and/or subsequent medical interventions.

The effects of socioeconomic status on an individual's accountability to a medical model extend beyond bodily integrity. Transgender people are disproportionately victims of poverty and homelessness (Grant et al. 2011). Scholars have drawn attention to no- and low-income transgender people's marginalization within public and private social services (Spade 2011). This marginalization is often a result of "contradictory embodiment" (Connell 2012), as is the case when transgender women are excluded from women's shelters due to woman-born-woman and anatomical coherence policies. That is, when transgender people do not or cannot adhere to a medical model of gender variance, their experiences of economic marginalization may be magnified. When social support services are reliant on accountability to a medical model, the experiences of those with access barriers must be taken into account.

The effects of economic barriers to gender-affirming medical interventions disproportionately affect transgender people of color (Gehi and Arkles 2007). The racialized effects of class must not be ignored. The National Transgender Discrimination Survey (Grant et al. 2011) found that Black respondents were unemployed at over twice the rate of White respondents and were significantly less likely to have health insurance than White respondents. The social circumstances of poverty make it nearly impossible to afford the services that are constitutive of a medical model of transgender identity. Accountability to a medical model of transgender identity and experience may create social conditions of additional marginalization for low-income transgender people, disproportionately low-income transgender people of color, within an already marginalized community of transgender people.

In addition to recognizing racialized class barriers to gender-affirming healthcare, future research must continue to examine the connection between the accountability to a medical model and the White, western construction of transgender as an umbrella identity category encompassing global gender variance (Aizura et al. 2014). As Roen (2001) and Vries (2012) have pointed out, the dominant frames used to understand transgender identity—including the medical model—may not be as salient for populations who resist White western medical imperialism. However, as discussed above, one need not be invested in the medical model to be subject to its accountability. Continued research is necessary to better understand how accountability to the medical model—as a White, western conceptualization—impacts transgender experience, identification, and community for transgender people of color and non-western gender-variant people subsumed under the transgender umbrella.

While this review has focused on the medical model of transgender identity as an overarching category, it is important for future research in this area to examine how transgender men and women experience accountability to a medical model differently. Transgender men and women have differing relationships to their gendered body parts and the gender-affirming medical care specific to them and thus differ in the types of gender-affirming surgeries they consider most necessary (Prosser 1998). According to the National Transgender Discrimination Survey Executive Summary (Grant et al. 2011), transgender women are much more interested in genital affirmation surgeries than are transgender men, while transgender men desire chest reconstruction at a much higher rate than do transgender women. This differential focus on specific types of surgical gender affirmation may impact the relative influence of the medical model on transgender people's interactional experiences of gender in everyday life.

It is critical that we continue to examine the widespread influence of the medical model across social institutions. Recent work in transgender studies—such as Stanley and Smith's (2011) collection of essays on trans embodiment within the prison industrial complex, Spade's

(2011) explication of the role of sex segregation in the continued oppression of transgender people, and Talley's (2014) theorization of the role of facial feminization surgery in the identity work of transgender women—is exemplary of what it means to recognize transgender people's accountability to a medical model across social contexts. As the medical authority over transgender phenomena is reaffirmed by the APA, contested within transgender communities, and debated within academic discourse, it is vital that we continue to examine the effects of this tension in the daily lives of transgender people.

Short Biography

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Note

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