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Transcending pathology, transforming the thinkable transperson: young transpeople, the law and gender self-determination

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TRANSCENDING PATHOLOGY, TRANSFORMING THE THINKABLE
TRANSPERSON: YOUNG TRANSPERSON, THE LAW AND GENDER SELF-
DETERMINATION

A Thesis

Presented in

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Requirements for the Degree of

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BY

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ABSTRACT

While contemporary attitudes, laws and policies in the U.S. toward lesbian, gay and bisexual people are increasingly more humane and just, transgender and gender nonconforming people continue to experience widespread structural oppression, discrimination and physical and psychological violence. Through a close analytic reading of fourteen contemporary court decisions involving young transgender and gender nonconforming people, this paper examines the seemingly neutral institutions of law and medicine and exposes how access to institutional resources hinges on a medically authorized diagnosis of Gender Identity Disorder. It explores the harm caused by this pathology, its erasure of socialization, and its normalization of gender conformity. It challenges the dominant societal and institutional knowledge that says transpeople are mentally ill, threatening, deceptive and the locus of the violence we experience. The analysis implies the need for medicine and law to value one's right to self-determine their gender identity and expression, the need for the erasure of pathology as a means to access trans related resources, and the need for a societal and institutionalized shift away from understanding gender nonconformity as inherently harmful. I suggest a critical trans politics embrace a strategy of working with while transforming beyond institutions in its desires to decrease institutionalized harm and increase trans survival.

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This paper is dedicated to trans and gender nonconforming people everywhere.

INTRODUCTION

Since the explosive liberation movements of the 1960s and 70s in the U.S. the rise of neoliberalism over the last forty years has led to a trend of nonprofitization of social movements. Direct results of neoliberalist policies like the destruction of economic safety nets (ie. welfare and public housing) coupled with the astronomical increase in the criminalization of poor communities and racialized communities, have forced social movements to adopt models of volunteer-based and/or nonprofit organizations to fill the gaps in social services created by government abandonment (Spade 2011). Additionally, the most visible lesbian, gay, bisexual (and sometimes transgender) movements for social and political change have strayed from their radical roots, now focusing on law reform and singular, neoliberal issues like the right to serve as openly gay or lesbian in the military or the right to marry someone of the same legal sex. While these agitations might seem well directed, many scholars, activists and others have pointed to the fact that these dominant goals are backed mostly by wealthy elites who value inclusion and recognition within the current social order, rather than critical evaluation of how just and equitable said social order is. Moreover, they do not challenge underlying roots of inequality, but rather, are solely based on liberal individual rights. Lisa Duggan (2003) and Michael Warner (2000) have defined homonormativity as a term that helps us understand the ways in which conservative and assimilationist gays, lesbians (and sometimes trans* people) contribute to the privatization of mass culture. Meanwhile, many transgender and gender nonconforming people—particularly those who are poor, and/or racialized—are facing different struggles (ie. homelessness, lack of adequate healthcare, poverty,

transphobia, criminalization and shortened life spans). Dean Spade summarizes the Leftist critique of homonormative politics:

For those who know that the US military is a primary force of systematic rape, colonization, land and resource theft, genocide, and other racist and gender-based violence, the notion that a lesbian and gay political stance should focus on military inclusion rather than demilitarization is a grave, divisive mistake. For those who have long articulated opposition to state incentivization and reward for heteropatriarchial sexuality and family structures and punishment for others, the idea that lesbian and gay people should seek marriage recognition rather than aim to abolish marriage and achieve more just methods of distribution is similarly problematic. The history of these controversies and the political choices made during their development relates to the rise of neoliberalism in the wake of the social movements of the 1960s and 1970s [...] (Spade 2011)

Spade goes on to describe how the LGB politics of recognition and inclusion has created a significant political rift between people whose race, class, immigration, and gender expressions and privileges (read: white, middle class, documented, non-trans*) give them the capacity to benefit from such inclusion and recognition, and those who will remain targets of systems of violence and social control despite formal prohibitions of exclusion based on sexual orientation (Spade 2011). In part, this is because the grounds for inclusion require assimilation and acceptance of standard norms, thus (re)producing marginalization of those who are outside of these lines of demarcation. Often, trans* and GNC young people exist outside of those lines. The seemingly pedestrian and liberatory connotations of “equality”—one of the buzz words of the politics of recognition and inclusion—nourishes the myth of an “equal playing field” for all. We need to demythologize this politics. If not, we risk the further distortion and erasure of queer and trans* lived experiences. This project is situated amidst this political divide and aims to centralize the lives of those young, trans*/GNC people who are invisibilized, and thus, simultaneously marginalized and excluded because their lives do not fit within this

prescriptive framework of homogeneity with regard to heteronormative middle-class white frameworks. Additionally, this system based on rights does not intervene into structural oppression, which would alleviate oppression for a greater number of people. It instead relies on the granting of rights and privileges to individuals based on one's location in a particular category defined by the state as a protected category.

Numerous scholars, activists and writers have documented how lesbian, gay, bisexual, queer, transgender, and intersex youth are simultaneously invisible and disproportionately represented in the legal context (Arriola, 1998; Fedders, 2006; Feinstein, 2001; Irvine, 2010; Majd et al, 2009; Marksamer, 2008; Wardenski, 2005; Ware, 2011; Valentine, 2008; Valentino, 2011). Given the fact that most research, media attention, and powerful organizations focus on white middle class youth, many juvenile legal professionals assume that LGB and GNC youth come from middle class, white families. Because of this, juvenile legal jurisdictions detaining large numbers of racialized youth do not serve LGB and GNC youth (Irvine 2010). Currently, there are no federal or state agencies that require the collection of data on sexual orientation (Irvine, 2010). However, studies suggest LGB and GNC youth represent about 13-15 percent of the total detained population in the juvenile legal system (Irvine, 2010; Majd et al, 2009). Many of these young people experience harassment, violence, and discriminatory charges while involved with the juvenile legal system and are not obtaining necessary services because they are often invisible—many choose to not disclose their LGB and/or GNC desires and/or identities. They might also be abused by close family members or peers, so “coming out” poses an additional risk to their already unsafe circumstances (Majd et al, 2009; Wardenski, 2005; Valentino, 2011). In comparison to their heterosexual and/or

gender conforming youth counterparts, LGB and GNC youth are twice as likely to be held in secure detention and/or isolation for truancy, warrants, probation violations, running away, and/or prostitution (Irvine, 2010). My preliminary research on this topic reveals an incongruence: while LGBTQI youth—particularly those whose gender expressions do not align with heteronormative expectations—are disproportionately represented in the legal system, there is minimal research documenting this reality. Within the research that does seek to document this reality, there is a lack of an analysis of how particular categories such as race, gender, class and/or nationality can structure punishment.

While there is a lot of analysis of medical and legal discourse as it produces gendered subjects, this paper will contribute to this trajectory of scholarship by (1) centralizing cases involving young people, (2) focusing on gender nonconformity (regardless of self-identification) and (3) making visible how a seemingly neutral institution, law, in fact works to naturalize and normalize gender conformity. Generally, medical gatekeepers regulate and police gender non-conformity along strictly gendered lines so that gender (and sexual) self-determination is very limited for trans*/GNC youth in this country. Further, gender nonconformity limits one's believability, casts one as "always already" deceptive, and feeds into derogatory queer archetypes such as "the deceptive tranny," always out to "trick" people into thinking they are of the opposite sex (Mogul et al, 2011). But gender is not a flat plane. Many scholars have shown that gender is and always has been heavily racialized in this country (Davis, 2003; Mogul et al 2011; Roberts, 1994; Somerville 2000; Spade 2006).

In *Queering the Color Line: Race and the Invention of the Homosexual Body*, author Siobhan B. Somerville links medical and sexological literature and the invention of race in the late-nineteenth and early-twentieth-century in the U.S., showing how ideologies of gender were shaped by dominant constructions of race, and how scientific assertions about racial difference were often articulated through gender. Somerville summarizes,

Methodologies and iconographies of comparative anatomy attempted to locate discrete physiological markers of difference by which to classify and separate races. Sexologists drew on these techniques to try to position the “homosexual” body as anatomically distinguishable from the “normal” body. Likewise, medical discourses on sexuality appear to have been steeped in pervasive cultural anxieties about “mixed” bodies, particularly the mulatto, whose symbolic position as a mixture of black and white bodies was literalized in scientific accounts. Sexologists and others writing about homosexuality borrowed the model of racially mixed body as a way to make sense of the “invert,” an individual who appeared to be neither completely masculine nor completely feminine. Finally, racial and sexual discourses converged in psychological models that understood “unnatural” desire as perversion: in these cases interracial and same-sex sexuality became analogous within later conceptions of sexual object choice. (Somerville 2000, 37)

Somerville also comments on the power of sexology as a field and its attempt to “[...] wrest authority for diagnosing and defining sexual “abnormalities” away from juridical discourse and to place it firmly within the purview of medical science” (Somerville 2000, 18). Today, medical science informs how the law understands so-called “sexual abnormalities,” which includes gender identity and expression along with sexual orientation, sexual desire, etc. Contemporary medical gatekeepers impose often impossible standards on trans*/GNC people (ie. the requirement of multiple and costly surgeries, most of which the majority of trans people never seek; the requirement of matching identity documents, while there are conflicting laws around this from state-to-state) that define what it means to be a woman or a man. Because the courts often defer to

medical “science” in this regard, my project will borrow from Dean Spade and others by arguing further for the demedicalization of gender nonconformity as a strategy of trans liberation. The last section of this paper will be devoted to the implications of my findings for trans liberation in this regard.

Another goal of this project is to imagine different ways to understand liberation beyond legal reformatory methods and goals. In Dean Spade’s new book, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of the Law* (2011), he critiques law as an independent and neutral institution, and argues for demedicalization. Spade writes,

Some political projects that focus on how the law treats particular groups fall into the realm of reform, where it is assumed that if said group is written into a false sense of “protection,” then all systems that ensure their marginalization and oppression are no longer relevant. As is the case with the fight for hate crimes laws, the outcome (particular groups being “protected” by the law) only reinforces “[...] the logics of harmful systems by justifying them, contributing to their illusion of fairness and equality, and by reinforcing the targeting of certain perceived “drains” or “internal enemies,” carving the group into “the deserving” and “the undeserving” and then addressing only the issues of the favored sector” (Spade 2011, 124).

This project does not intend to focus on reformatory measures as a result of the research. It instead aims to highlight the discursive dividing mechanisms of a system that claims to be gender neutral. In so doing, in the conclusion I will offer some directions for movement building around trans* liberation.

I am primarily interested in what kind of legal and medical subjects trans*/GNC youth are produced as through legal and medical discourse, and what kind of shape those subjecthoods take. For example, after the well-known case of Brandon Teena, did the way the court talk about Brandon dehumanize or humanize Brandon? My thesis explores fourteen contemporary court decisions throughout the United States that involve

trans*/GNC young people. Through an analysis of those decisions, I will address the following questions: Drawing on Foucault’s theory of “competing discourses” (Foucault 1980) how are dominant identities naturalized? How is difference mediated and organized among competing discourses through a pervasive ideology of heteropatriarchy? How do these institutions rhetorically humanize or dehumanize these subjects? What linguistic and other discursive patterns exist within the court’s scrutiny of these youth? Are these young people “unthinkable” as human subjects? (Butler 2009). And in the context of this particular analysis, what are alternative ways to define liberation outside of a politics of recognition and inclusion?

Background Rationale: A Contribution to a Critical Trans* Politics

The U.S. has a historical legacy of gendered policing. In their recent book, *Queer (In)Justice: The Criminalization of LGBT People in the United States*, authors Mogul, Ritchie, and Whitlock trace gendered policing to colonization itself:

From the first point of contact with European colonizers—long before modern lesbian, gay, bisexual, transgender, or queer identities were formed and vilified—Indigenous peoples, enslaved Africans, and immigrants, particularly immigrants of color, were systematically policed and punished based on actual or projected “deviant” sexualities and gender expressions, as an integral part of colonization, genocide, and enslavement. (Mogul, Ritchie, and Whitlock 2011)

While there is an increasing interest among scholars and activists to focus on the disproportionate rate at which gender nonconforming and racialized people are targeted by the legal system, we must contextualize this work within the historical legacy of gendered and raced policing, rather than understanding it as merely a contemporary phenomenon. Additionally, I see my project as an attempt to respond to the following:

Criminologist Beth E. Richie argues that in order to bring queers into the public debate about crime, policing, prosecution, and punishment in a meaningful way, it is critical to “take as a starting point the need to interrogate the ways that gender, sexuality, race, and class collide with harsh penal policy and aggressive law enforcement”. (Spade 2006)

While more and more attention and scholarship is being devoted to the ways in which the prison industrial complex affects trans* and GNC people, the mainstream rhetoric in the U.S. around us currently revolves around the ethical issues that arise when considering administering hormone blockers and hormone replacement therapy (HRT) to minors. These concerns, like the LGB fight for marriage equality, and the right to serve in the military as openly gay are largely issues grounded in white homonormativity and fit within a politics of inclusion. This politics values recognition and inclusion of marginalized people within the current social order. For example, the HRC (Human Rights Campaign) works to create incentive among its supporters to value gay people’s inclusion within the institution of marriage, rather than considering how the myopic focus on that institution enables the erasure of attention to a wide variety of other inequities (ie. poverty, lack of resources, education and homelessness). There is no visible critical thinking around how that single-issue fight ignores the continued marginalization of trans* and GNC youth, many of whom are engaging in street economies and facing a host of social and economic problems. Moreover, because assimilation is predicated on hetero-, and homonormativity—and thus, gender conformity—it in no way addresses the lived realities of those whose identities, behaviors, and desires fall outside of those dominant and overlapping categories. My intent is to contribute to a radical agitation for awareness of and action around institution- and state-sponsored violence towards

trans*/GNC youth in the juvenile legal system, and the overlapping education and medical institutions.

On institutional and interpersonal levels, trans*/GNC youth can face the compounded powers of ageism, homophobia/transphobia, racism, and poverty. This project will enter at this discursive intersection. My goal is to contribute to the scholarship and activism that is focused on revealing how institutions naturalize and normalize dominant gendered behavior, desire, and identity. While this topic is becoming more popular, there is scant concrete research around trans* and GNC youth in the legal system. To be clear, I have no interest in merely calling attention to how these particular categorizations of people are oppressed. By focusing on the plight of individuals, we risk homogenization, and we also risk falling into the realm of reformatory measures. Rather, focusing on how knowledge production works in the legal context, we come to understand that the law is, in fact, not neutral as it claims to be. The focus is on the rhetorical strategies of the legal, medical, and educational institutions that, in turn, (re)create this oppression. Because this project is situated within a long history of radical queer and trans* politics, it is a contribution to the ongoing struggles for self-determination, liberation, and justice.

Theoretical Frameworks

Learning from lawyer and activist Dean Spade (and numerous others) I define a critical trans* politics as a politics grounded in critiques of capitalism, hetero- and homo-normativity, punitive responses to all instances of violence, a valuing of sexual and gender self-determination, racial justice, and liberation from interlocking systems of

oppression. The critical trans* politics I refer to is also grounded in liberation from, rather than assimilation into dominant expectations of racialized, gendered, and classed norms. As an aside, I am not interested in berating the choices of individuals (ie. to get married, to join the military, to fit within the gender binary). Rather, I am interested in how institutions mechanically limit the range of individual choice. Additionally, I use the term ‘queer’ to denote behaviors, identities, and desires that cannot be neatly categorized under the dominant norms of hetero- and homonormativity and whiteness. I also use the term ‘queer’ as reflective of a political standpoint that is aligned with a critical trans* politics, and also embraces Cathy J. Cohen’s (1997) call for queer politics to “[...] focus on and make central not only the socially constructed nature of sexuality and sexual categories, but also the varying degrees and multiple sites of power distributed within all categories of sexuality, including the normative category of homosexuality” (Cohen 1997, 438-9). As Cohen and others have pointed out, queer politics often positions queer identities, behaviors, and desires as simplistically opposed to non-queer identities, behaviors, and desires. Instead, Cohen calls for an intersectional analysis that recognizes “[...] how numerous systems of oppression interact to regulate and police the lives of most people” (Cohen 1997, 441). Shifting the exclusive focus on identities to how identities are invested with varying degrees of normative power, we can understand the roles that race, class, and gender play in defining people’s differing relations to dominant and normalizing power.

Another note on language: In this project, I use the term ‘queer’ to identify those people whose behaviors, identities, and/or desires fall outside of gendered, raced, and classed norms. I will also use ‘transgender’ or ‘trans*’ or ‘trans’ or ‘trans*/GNC’ when

referring to people whose behaviors, identities and/or desires fall outside of the heteronormative gender binary, regardless of self-identification. More often, I will use the joint term, ‘trans*/GNC.’ Because not all gender nonconforming people self-identify as transgender or transsexual, and indeed many gender nonconforming people are not necessarily transgender or transsexual, I have chosen to use the term ‘gender nonconforming’ when referring to all people whose identities, desires, and behaviors fall outside of traditional gender norms in the U.S. context. The asterisk at the end of ‘trans*’ denotes that there are multiple endings—transsexual, transexual, transgender, transfeminine, transmasculine, transwoman, transman, transperson—to trans. The asterisk is a placeholder for whatever ending the respective person chooses. The asterisk, as some have critiqued, is not another “umbrella term,” flattening the diversity of trans expression and self-identification, but is in fact intended to do the opposite. It functions as a placeholder for multiple endings and in the context of a long paper, helps the writer avoid repeatedly writing out those various multiple endings. I acknowledge that ‘trans*’ with an asterisk probably originated in the academy and not necessarily from those “on the ground.” I do not think the origin of language is always so black-and-white and suspect that ‘trans*’ originated from a variety of people in a variety of settings. I am a graduate student writing for the academy *and* I am also an “on the ground” transperson, for example. The two are not mutually exclusive. This paper attempts to intervene the insularity of the Ivory Tower by bringing in transpeople’s lived experiences and exposing, for example, the great disconnects between the legal mandate towards pathology and actual transpeople’s lived experiences. I welcome critique of the usage of

trans* and entertain the possibility of multiple truths around which language to use in which context.

My research and analysis will also be grounded in an anti-prison politics, which I understand as positioned alongside a critical trans* politics. Angela Davis, Michel Foucault, Dean Spade and Julia Sudbury will inform the anti-prison critique at the heart of this project. Along with a political grounding in a critical trans* politics and an anti-prison politics, this research will also be grounded in the theory of intersectionality (Crenshaw, 1991; Hill Collins, 1998; hooks, 1984), Black Feminism, and Foucault's theories on power and knowledge. Because intersectionality is imbued with different meanings by different people, Crenshaw clarified her original definition in a recent keynote address. She defined intersectionality as "a framework to identify different modes of power and how they come together in different contexts" (Crenshaw 2012). This project will embrace that definition. While the popular critique of intersectionality is that people are more complex than the clinical intersection of points—that is, personhood is more multidimensional than intersectionality allows—I maintain that the theory of intersectionality is still useful because it can help us understand how interlocking systems of oppression operate simultaneously on multi-scalar levels. Because the people I am focusing on in this study—trans*/GNC youth—categorically reside at the intersections of age, gender, as well as class and race, this theory is useful for this project.

Additionally, Gramsci's concept of hegemony (1999) enables me to critically explore how dialectical relations of power, communication, and organization are articulated in ways that reproduce social hierarchies of difference within the legal system.

Gramsci understood hegemony as the distinctive mode of rule in the modern state, which he described as emerging in the second half of the nineteenth century. He writes,

[i]n the period after 1870, with the colonial expansion of Europe...the internal and international organizational relations of the State become more complex and intricate and the fortieightist formula of the 'permanent revolution' is elaborated and superseded in political science by the formula of 'civil hegemony'. For the first time, the state can be regarded as "integral" as "political society plus civil society, that is hegemony armoured with coercion. (Gramsci 1999)

A period thus began where the state needed the consensus of the citizen and also had to create that consensus for it to function. For Gramsci, coercion is not the essence of state power. Hegemony *is* power. And it may be protected by coercion. Hegemony's dependence on coercion will be explored within my project as it pertains to gendered norms.

Second, I understand Black Feminism to be a reaction to the centralization of middle-class whiteness pervasive in much of early feminism in the U.S. Groundbreaking articles like "The Combahee River Collective Statement" (1978) called attention to the ways in which racism, sexism, and class oppression are inextricably bound together. Because the legal field is not a vacuum and is also inextricably bound with other realms of knowledge production and social control, Black Feminism is useful for this project as it helps us to understand that those interlocking systems of oppression are also potent within the legal field.

Third, my analysis borrows from the tradition of feminist poststructuralism in order to theorize gender and subjectivity in ways that satisfy a mind not interested in dominant objective truths because of their oppressive effects on more marginalized groups. Some key elements of the theoretical perspective of feminist poststructuralism are weaved throughout the paper, including an understanding of knowledge as socially

produced and inherently unstable, an emphasis on the importance of language and discourse and a decentering of the individual subject (Weedon 1987). Close analytic reading is discussed as one way of working that is consistent with feminist poststructuralist theory.

Lastly, because knowledge production and social control are at the heart of this project, Michel Foucault's theories on knowledge and power, as well as social control will be central to the theoretical grounding of this work. As he details in *The History of Sexuality, Vol. 1* competing institutions, structures, and relations create and maintain ideology, discourse, and actions. This theoretical foundation enables us to see how institutions that claim to be neutral, such as law, medicine, and education in fact naturalize gender conformity, independently and collaboratively.

Medicalization is the process by which human behavior comes to be defined and treated as medical condition, and thus become the subject of medical study, diagnosis, prevention, and/or treatment. Medicalization can be driven by new evidence or hypotheses about conditions, by changing social attitudes or economic considerations, or by the development of new medications or treatments. From a sociological perspective, medicalization is studied in terms of the role and power of professionals, patients, and institutions, and also for its implications for people whose livelihoods may depend on the dominant concepts of health and illness. Medicalization may also be termed 'pathologization,' which is a concept devised by sociologists to explain how medical knowledge is applied to behaviors which are not self-evidently medical or biological. The term 'medicalization' emerged in sociological literature in the 1970s in the works of Irving Zola, Peter Conrad and Thomas Szasz. These sociologists viewed medicalization

as a form of social control in which medical authority expanded into domains of everyday existence, and they rejected medicalization in the name of liberation. These sociologists did not believe medicalization to be a new phenomenon, arguing that medical authorities had always been concerned with social behavior and traditionally functioned as agents of social control (Foucault 1965; Szasz 1970).

Because this project will look at how law, medicine, and education understand gender nonconformity in often conflicting ways and in ways that invisibilize and marginalize the lived experiences of trans* and GNC people, Foucault's theories on competing discourses is central to my analysis. Discourse, as defined by Foucault, refers to, "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern" (Foucault 1980). Foucault's work is always in the context of history, in the sense of what he termed the 'archaeology' or 'genealogy' of knowledge production. That is, he looked at the continuities and discontinuities between 'epistemes' (taken by Foucault to mean the knowledge systems which primarily informed the thinking during certain periods of history: a different one dominating each epistemological age) and the social context in which certain knowledges and practices emerged as permissible and desirable or changed. For Foucault, knowledge is inextricably bound to power, so much that he uses the linked term 'power/knowledge.'

Foucault's conceptual analysis of a major shift in western cultural practices, from 'sovereign power' to 'disciplinary power' as described in *Discipline and Punish: The*

Birth of the Prison (1979) demonstrates this method of genealogy. He traces the transition from top-down forms of social control in the form of physical coercion meted out by the sovereign to a more diffuse and insidious form of social surveillance and process of 'normalisation.' The latter, he writes, is represented best by Bentham's Panopticon, a nineteenth century prison system in which prison cells were arranged around a central watchtower from which the supervisor could watch prisoners. Because the prisoners could not be certain when they were being watched, over time, they began to police their own behavior. The Panopticon has become the metaphor for the processes whereby disciplinary 'technologies,' together with the emergence of a normative social science, 'police' both the mind and body of the modern individual (Foucault 1979). Power, for Foucault, is understood as, "a dynamic of control and lack of control between discourses and subjects, constituted by discourses, who are their agents. Power is exercised within discourses in the ways in which they constitute and govern individual subjects" (Foucault 1980). Foucault is interested in how some discourses shape and create meaning systems that gain the status and currency of "truth," and also dominate how we define and organize both ourselves and our social world. This domination prevails at the expense of the marginalization and subjugation of alternative discourses. Foucault believes alternative discourses are sites where hegemonic practices can be contested, challenged, and resisted. In particular, Foucault looks at the social construction of madness, punishment, and sexuality. For him, there is no static or definitive structuring of either social or personal identity or practices (as there is in a socially determined view in which the subject is completely socialized) (Foucault 1979). Rather, both the formation of identities and practices are related to, or are a function of, historically specific

discourses. An understanding of how these and other discursive constructions are formed may open the way for dissent and transformation.

Foucault developed the concept of the ‘discursive field’ as part of his attempt to understand the relationship between language, social institutions, subjectivity, and power. Discursive fields, such as the law or the family, contain a number of competing and contradictory discourses with varying degrees of power to give meaning to and organize social institutions and processes. They also offer a range of modes of subjectivity. It follows then, that if relations of power are dispersed and fragmented throughout the social realm, then so must be resistance to those relations of power (Foucault 1979). In “Orders of Discourse” (1970) he argues that the ‘will to truth’ is the major system of exclusion that forges discourse and which tends to exert pressure and constraint on other discourses. Thus, there are both discourses that constrain the production of knowledge, dissent, and difference, and some that enable new or alternative knowledges, dissents, and differences. The questions that arise within this framework that are useful for this project regard how some discourses maintain their authority, how some voices get heard while others are silenced, and subsequently who is empowered and disempowered.

Foucault also discusses disciplinary mode of power versus the population-management mode of power. Population-level interventions rely on categorization to sort the population rather than targeting individuals based on particular behaviors or traits (Foucault 1978). This concept of population-management will be central to this project because often, trans people struggle with gender categorization in the purportedly neutral administration of programs, policies, and institutions like homeless shelters, prisons, jails, foster care, juvenile punishment, public benefits, immigration documentation, health

insurance, Social Security, driver licensing, and public bathrooms (Spade 2011). The dual nature of caretaker or surveillance state (or as Foucault calls it, “apparatuses of security”) will also be considered in my analysis. In one of his lectures, Foucault warned of the ways that power, “[...] when mobilized to cultivate the life of the population, always includes a process of identifying “threats” and “drains” who must be killed through abandonment, massacre, or other means in order to protect that population” (Spade 2011). Foucault also called for society to criticize the workings of institutions that appear to be both neutral and independent, so that we can “unmask” the political violence they enact in order to fight against them. Otherwise, he warned, we risk the reconstitution of that very violence (Foucault 1971). This project aims to respond to that risk.

Since not all court decisions are published, I will only use those court decisions that have been. Using the legal database, Westlaw my initial search yielded about fifty cases. Given the scope of this project, I narrowed my analysis to the fourteen cases wherein the trans*/GNC person was central to the issue for the court and where institutionalized harm was most visible in the language of the decisions. I conducted a close analytic reading of those cases, focusing on categorization of young trans*/GNC bodies and people, allegedly neutral language, tensions between legal, medical, and educational discourses, and surgical and other requirements such as the diagnosis of Gender Identity Disorder (GID). I will use a feminist discursive analysis and will also develop an inductive process. Legal scholarship and respective laws will also contextualize my analysis.

ANALYSIS

I. Courts Frame Trans*/GNC People as Inherently Deceptive and Deviant

“These menacing young queers do not actually have to do anything harmful or violent to warrant intensified police scrutiny, harassment, and other measures intended to keep youthful intruders at bay. The fact that they exist, moving into and through public spaces, is reason enough to fear and contain them.”

-Mogul, Ritchie, and Whitlock, *Queer (In)Justice*

While young trans*/GNC people face multiple and overlapping medical and legal obstacles to getting what they need in order to survive, this is one leg of a broader historical legacy of queer oppression in the U.S. This legacy continues to thrive partly because of the production of queer archetypes, which are ascribed to those queer people who do not fit within the white, heteronormative, gender binary regime. The dominant queer archetypes rely on formational descriptors, which characterize us as inherently deceptive and deviant, and ultimately trump our humanity.

Understanding these archetypes and how they figure prominently in the courts’ understandings and treatments of young trans*/GNC people links contemporary knowledge production around gender nonconformity with a long historical legacy of queer oppression, broadly conceived, reminds us of the power of cultural production around this particular category of marginalized people, and ultimately reveals how the law’s acceptance of queer archetypes leads to greater harm against trans*/GNC people. In their 2010 book, *Queer (In)Justice: The Criminalization of LGBT People in the United States*, authors and attorneys Mogul, Ritchie, and Whitlock link the policing of gender in the U.S. to the colonization of North America. They describe the historical legacy of gendered policing here:

[f]rom the first point of contact with European colonizers—long before modern lesbian, gay, bisexual, transgender, or queer identities were formed and vilified—Indigenous peoples, enslaved Africans, and immigrants, particularly immigrants of color, were systematically policed and punished based on actual or projected “deviant” sexualities and gender expressions, as an integral part of colonization, genocide, and enslavement (Mogul, Ritchie, and Whitlock 2010, 1)

Mogul, Ritchie, and Whitlock go on:

“[a]s queer identities substituted for individual perverse acts, the process of criminalizing sexual and gender nonconformity was facilitated through the construction of ever-shifting and evolving archetypal narratives. Rooted in historical representations of Indigenous peoples, people of color, and poor people as intrinsically deviant, fueled and deployed by mass media and cultural institutions, these narratives now permeate virtually every aspect of the criminal legal system” (Mogul, Ritchie, and Whitlock 2010, 19)

The archetypes they name, “gleeful gay killers,” “lethal lesbians,” “disease spreaders” and “deceptive gender deviants” are based upon early pathologizing, medical, and scientific assessments of homosexuality from the late nineteenth century to mid-twentieth centuries (Mogul, Ritchie, and Whitlock 2010, 43). Four common themes unite the archetypes. First, they highlight that sexual and gender transgressors were (and still are) cast as intrinsically mentally unstable. The second theme focuses on the danger, deception, and dishonesty allegedly embedded in sexual and gender nonconformity. The third theme asserts that queer people are perpetually engaged in nefarious efforts to lure and recruit innocent heterosexuals. And the final theme asserts that violence is an inherent part of queer erotic desire, sexual expression, tragic despair, and antisocial disposition (Mogul, Ritchie, and Whitlock 2010, 43-4). In the cases considered, various institutions focus microscopically on sexual or gender nonconformity as the root of the case at hand, even when it is irrelevant to the central question for the court. As will be discussed in the following sections, particularly in the child custody cases, the courts focus too heavily on gender conformity as a potential threat to parental responsibility and

care. In fact, there exists no empirical evidence to support the dominant assumption that a trans*/GNC parent would not be as good a parent, or that a parent's support of their trans*/GNC child is inherently harmful to the child.

Pathology in the late nineteenth century to mid-twentieth centuries referenced above is now articulated through queer archetypes rooted in deception. In the case of *People v. Doktozezk* the trans*/GNC person was pegged with deceiving a man into believing she was “a real woman” as part of a negotiation for sex. In this story, the John picked up the woman, believing her to be born birth assigned female. The man learns that the woman was not born birth assigned female, to which he responded with verbal and physical assault. The John defended himself by saying that the woman deceived him into believing she was “a real woman.” In the case of *People v. Doktozezk*, the John won. The judges summarize the arguments put forth:

The prosecution's theory was that since appellant suspected Dominique was a man before the oral copulation, he had to “beat her up to protect [his] own manhood.” The prosecutor argued that appellant stripped the victim of her dignity because he regarded her as “just some transsexual.” The defense theory was that Dominique was “a liar,” and that she was beaten by someone else after she left the motel room. Even defense counsel conceded, however, that “[i]t's pretty obvious whoever beat him up did not like homosexuals.” The jury not only found that appellant was the person who administered the assault, it also demonstrated by its verdict its agreement with the argument of both counsel that the crimes were motivated because of the victim's sexual orientation. Support for the jury's conclusion is found in evidence proving that appellant and his co-conspirator called Dominique “faggot” and spent much of their time in her company trying to prove, angrily and violently, that she was a man. This evidence reasonably justifies the jury's findings. Therefore, it is irrelevant to our review that the circumstances might arguably have been reconciled with a contrary finding (*People v. Doktozezk* 2003, 3).

Both the prosecution's and the defense's theories originate in the construction of Dominique as a deceptive sexual and gender deviant, and the jury agrees with both arguments in that the violence was provoked by Dominique's sexual orientation, rather

than say, the perpetrator's homo- and/or transphobia. Even when the victim lands a legal win, as was true in this case, the prevailing logic still relies on the construction of Dominique as a sexual/gender deviant. And while we see this victim blaming occur across identity categories, Dominique's nonconforming gender expression is a particularly salient factor in that construction.

In perhaps the most well known case involving a trans*/GNC young person, *Brandon v. County of Richardson*, young transmasculine Brandon went directly to the police to report that he had been raped and had his life threatened by two acquaintances who he clearly identified to the police early on. The police officers should have followed procedure and arrested the two men, but instead one of the officers questioned Brandon profusely and inappropriately about his gender identity and expression. Again, we see the construction of the queer criminal as rooted in one's sexual or gender nonconformity, even when the trans*/GNC person is obviously the victim. The court describes Officer Laux's questioning of Brandon just hours after he had been beaten and raped twice: "Laux further asked questions regarding Brandon's gender identity crisis such as, "Do you run around once in a while with a sock in your pants to make you look like a boy?" (*Brandon v. County of Richardson* 2001, 22-30). At one point during the interview, the following exchange took place:

Q. Why do you run around with girls instead of, ah, guys being you are a girl yourself?

A. Why do I what?

Q. Why do you run around with girls instead of guys beings you're a girl yourself? Why do you make girls think you're a guy?

A. I haven't the slightest idea.

Q. You haven't the slightest idea? You go around kissing other girls?.... [T]he girls that don't know about you, thinks [sic] you are a guy. Do you kiss them?

A. What does this have to do with what happened last night?

Q. Because I'm trying to get some answers so I know exactly what's going on.

Now, do you want to answer that question for me or not?
A. I don't see why I have to.
Q. Huh?
A. I don't see why I have to.
Olberding: You, you don't have to answer. It's, this is all voluntary information.
Laux: The only thing is if it goes to court, that answer, that question is going to come up in court and I'm going to want an answer for it before it goes to court. See what I'm saying? I'm trying to have the answer there so we can try to avoid that question if it's not the answer I want to hear.
Brandon: 'Cause I have a sexual identity crisis.
Q. Your what?
A. I have a sexual identity crisis.
Q. You want to explain that?
A. I don't know if I can even talk about it...." (*Brandon v. County of Richardson* 2001, 22-3)

Victim blaming of trans* and nontrans women occurs regularly and is well documented. In the case of this transman, it goes a few steps further, where the officer treats Brandon like a deceptive puzzle to be figured out, trying to understand Brandon's gender nonconformity by asking entirely irrelevant and offensive questions. According to Mogul, Ritchie, and Whitlock this series of questions trace back to the queer killer archetype, which "[...] embodies the assumption that sexual- and gender-nonconforming people do so because they are queer" (Mogul, Ritchie, and Whitlock 2010, 31). While Brandon did not kill anyone, this same logic still dominates even when he is so obviously the victim. The power of this archetype is that it can be applied fluidly to any situation involving a sexual- and/or gender nonconforming person, regardless of their actions or role in the conflict.

It is important to write and speak about the queer archetypes that Mogul, Ritchie, and Whitlock have identified in their groundbreaking book, which links the criminalization of LGBT people in the U.S. with historical legacies of colonialism, racism, and nation-state building, because of the wide-reaching saliency those archetypes

have over how LGBT people are treated in courtrooms, in police stations, in schools, in medical offices, on the streets and in our homes. As Mogul, Ritchie, and Whitlock point out, “[t]he image of the sexually degraded predator continues to resurface with a regularity that would be banal were it not for the devastation wrought on the LGBT lives it touches. Queers are cast as a perpetual threat not only to children and innocent adults, but to the normalcy, promising futures, and rigidly gendered, raced, and classed social order that those innocent lives represent” (Mogul, Ritchie, and Whitlock 2010, 34). LGBT people interested in a trans*/queer politics of liberation must work to break these archetypes down, revealing their Straw Man logic. There is no statistical or clinical based research that links sexual/gender nonconformity with criminality, violence, or deception. Rather, that link fits neatly into the fabric of the dominating myths about what it means to be a credulous and dignified human being. As trans*/GNC people, we need to identify the flaws in the dominating myths that dehumanize us, not to fit in to those neatly prescribed societal norms that we have been cut out of, but to reclaim our humanity and to possibly prevent further injustice and harm.

II. Courts Defer to Pathology: Gender Nonconformity Not Protected Unless Diagnosed With Gender Identity Disorder (GID)

In this second of five sections I trace the emergence of the medical category of transsexual as heavily pathologized from the beginning of documented psychology in the western world to contemporary medical and legal understandings of trans*/GNC people. I bring in Dean Spade’s idea of worthy/unworthy trans* subjects in relation to the ways the courts privilege some people over others and I discuss some contemporary cases

which deal most explicitly with GID diagnosis and reveal how GID fits within the individual rights-based framework and thus fails to legally protect and uphold the inherent dignity and humanity of transpeople. I look at some of the impossible and arbitrary requirements of GID diagnosis and how courts defer to those standards. I argue instead for an institutional embrace of gender self-determination rather than a deference to pathology as a means to accessing legal protection, medical therapies and technologies, and generally achieving a position within who is understood to be a thinkable human.

The construction of the transsexual person was developed by doctors in the late 1800s as a new field of medicine emerged—sexology. The first documented sexologist who took a special interest in the sexual impulses of gender variant individuals was probably Krafft-Ebbing (1840-1902), professor of psychiatry at Vienna. His *Psychopathia Sexualis* was published from 1877 to after his death. Through the work of the early sexologists such as Krafft-Ebbing, transsexuality became a recognized phenomenon available for study, discussion and treatment (Foucault 1978). I will discuss in future sections the historical context of the criminalization of trans*/GNC people, which spawned from this historical legacy of pathology.

It was not until the 1940s that gender variant people were formally pathologized, marked by the invention of Gender Identity Disorder (GID). While I argue that gender nonconformity is not a mental illness, GID has helped many trans*/GNC people get what they need from institutions. However, this individual rights-based framework—based on a medically authorized individual diagnosis of GID—does little for the survival of most transpeople. While some of the people involved in the legal cases in this study won their case, they had to prove themselves “truly” transgender to the courts by adhering to linear

and palatable gender narratives (which then enabled a medical diagnosis), being able and wanting to access hormonal and surgical therapies, and by subscribing to heteronormative expectations for gendered behavior and presentation. Not every trans*/GNC person is able and/or desires these performative actions. Moreover, regardless of desire, no one should have to.

Spade's overall argument in *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law* is that the individual rights-based framework of gay and lesbian politics is not a viable alternative to trans* survival. Instead, we need to focus on the "distribution of life changes"—administrative regimes that value some lives over others. Spade helps us to focus our efforts on social transformation, not on the window-dressing of claims for state inclusion or protection. He also shows how the lesbian and gay rights struggle for antidiscrimination laws, hate crimes statutes, and inclusion through institutions such as marriage and the military excludes a large number of GLBT people. From a staunchly Foucauldian stance Spade argues that the production of "perfect plaintiffs" for these single-issue fights is not only exclusionary, but also feeds the very system that produces these inequities by maintaining the existing distribution of power (Spade 2011).

The courts' reliance on GID diagnosis fits within this individual rights-based framework, which serves the following problematic functions: (1) it enables the court to understand the trans*/GNC person as an intelligible legal and human subject via pathology; (2) it creates two categories for these intelligible subjects: those deemed worthy of medical therapies and technologies and legal services and protections, and those deemed unworthy of medical therapies and technologies and legal services and

protections; and (3) it nourishes the history and proliferation of institutionalized violence towards trans*/GNC young people, while functioning on a guise of “equal protection” for only those individuals who through a variety of means are funneled into the “worthy” category.

Of the fourteen federal and state cases considered in this study, all of the courts’ deliberations rely on the diagnosis (or lack thereof) of GID for the trans*/GNC young persons involved. While this diagnosis certainly helps some individuals get what they need from the medical industry, schools, and the law, the courts’ embrace of GID fits within the individual rights-based framework, and thus fails to truly contribute to trans* survival.

Within the medical community, there is some debate around whether or not GID should remain in the Diagnostic Statistics Manual (DSM). As well, there is debate among gay and lesbian communities, and even some queer and transgender communities. Indeed, GID diagnosis provides leverage for some trans*/GNC people when it comes to legal protections, and access to various forms of therapy such as counseling, hormone replacement therapy (HRT) and surgeries. The GID diagnosis has certainly helped many trans*/GNC people access medical therapies and technologies, obtain legal name changes on various identification documents and legally secure marital relationships. While GID diagnosis can ensure protections and access for some people, its logic divides us in its production of two distinctly different camps: those who are “worthy” and those who are “unworthy” of protections and access (Spade 2011). Those diagnosed with GID are deemed as worthy of protections and access because they have a mental illness. Those who do not pass this test are therefore deemed unworthy of protections and access. Their

feelings and self-determinations about their gender are often written off as sexual fetish, a phase, simply a “preference,” or some other mental illness. Spade and others have also written about the ways we, as trans*/GNC people attempting to gain passage by medical and legal gatekeepers, often have to perform a linear and palatable gender narrative in order for our gender nonconformity to be taken seriously enough to warrant therapies, name changes, gender marker changes, etc. This institutional need for trans*/GNC people to perform a gender narrative that fits within the dominant heteronormative paradigm must be resisted and transformed. As trans*/GNC people, we must agitate for the total demedicalization of our bodies, our minds and our humanity. My analysis recognizes that GID has contributed to trans* survival for individual people; however, I argue for a no-compromise solution to our systematic pathologization.

I now move to the cases where institutions are most explicitly relying on GID diagnosis and/or surgery and hormones as antidotes to this “disorder.” In the case of *Doe v. Bell* (2003), the New York Supreme Court held that transsexual foster youth are protected by state law, prohibiting discrimination on the basis of disability in housing. The judges in this case considered the inclusion of GID as a disability for protection. Without the diagnosis of GID, the young trans* person, referred to as Jean Doe throughout the decision, would have lost this case and would have been forced to wear traditionally masculine clothing, and experience further isolation and abuse because of her gender expression. The judges in this case concluded that “[b]ecause of her GID, and the psychological treatment she has been receiving for her condition” (*Doe v. Bell* 2003, 12) it was *medically necessary* for Jean to wear traditionally feminine clothing. The judges recognize Jean Doe as fitting within an identity category of protection because of

her gender “disability.” More specifically, the judges considered whether Jean Doe is disabled under the State Human Rights Law. The judges write, “Under the State Human Rights Law, the term “disability” is broadly defined. Disability “means (a) a physical, mental or medical impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques” N.Y. Exec. Law § 292(21). Doe argues that, under this broad definition, she is a person with a disability, namely G.I.D. The Court agrees” (*Doe v. Bell* 2003, 6).

While this case can be framed as a legal “win,” the logic by which it does so still feeds the pathologizing and othering of trans*/GNC people generally, and feeds the worthy/unworthy model of doling out medical, social, and legal services and protections. Had Doe not claimed disability, chances are she would have lost the case and been forced to wear traditional male clothing, which would have quite obviously caused her great distress. The disability claim allowed Doe to express her gender freely. A braiding of the individual rights-based framework and the diagnosis of GID led to Doe’s legal success; however, no one should have to fit within the confines of a mental illness/disability and fight tooth-and-nail just to secure basic human rights like being able to dress in a way they feel comfortable with, and to be housed in a space that is accommodating of one’s preferred gender expression. However, Dean Spade helps us to entertain both the idea that transpeople should not have to subscribe to pathology in order to get basic needs met and the idea that a radical disability framework can, if done carefully, be employed effectively for transpeople. He writes, “we must strike a balance between wanting to avoid over-reliance on medical evidence while contending with the fact that many trans

people's lives are entangled with medical establishments, and for those people, it would be beneficial to prove that sex reassignment related treatments are "medically necessary" and should be covered by Medicaid and private health insurance" (Spade 2003, 35).

The second case also deals directly with GID and the individual rights-based framework; however, in contrast to Doe, this gender nonconforming person was not considered worthy of protection because they did not meet the arbitrary requirements of a GID diagnosis. In *Smith v. Smith* Christine's mother sought dissolution of a prior ruling that granted custody of Christine to her father on grounds that her mother was helping her access transgender support groups and to generally live her life as a girl. The court's rationale was that because Christine did not meet enough requirements of GID, her mother's support of her being trans* was harmful. The judges describe the previous court's ruling: "[t]he court also found that the harm likely to be caused by the change of environment was greatly outweighed by the advantages of changing the children's environment" (*Smith v. Smith* 2007, 7), referring to transferring custody from the mother to the father, who was not supportive of Christine's expressed gender self-identification. Here, the court defaults to GID to assess whether or not Christine's mother's support of her child's gender identity is harmful or not. Only until the child can meet enough requirements of GID to be considered mentally ill enough, can her mother's support be validated under the eyes of the law. There is something fundamentally wrong with that rationale. For young trans*/GNC people and those caring for them, pathology is often a medical and legal requirement for therapeutic treatment. If they do not meet the requirements of the GID pathology and are accessing therapeutic treatment such as support groups, they could be, for example, taken away from their parents and put into

state custody. This twisted logic once again naturalizes and normalizes gender conformity and places trans*/GNC people under extreme scrutiny.

In this case, “[s]ix medical professionals were called on to assess Christine’s gender nonconformity. Dr. Pleak “recommended that the child be permitted to explore the true nature of his gender, including the ability to wear girl’s clothing [...] The court discounted Dr. Pleak’s testimony *because he did not sufficiently rely on the DSM-IV standards* (emphasis mine)” (*Smith v. Smith* 2007, 6). Even when this medical professional made a reasonable recommendation—that Christine be allowed to, *at least*, explore her gender expression—the judge’s unwarranted judgment on Dr. Pleak’s testimony outweighed any possibility of Christine’s ability to self-determine her gender expression. The medical professional in this case made a reasonable recommendation: that Christine be allowed to explore her gender. Yet, the judges did not buy that recommendation because it lacked a GID diagnosis origin. As Foucault reminds us, the law often speaks of itself as a neutral arbiter; however, because trans*/GNC people—especially young trans*/GNC people—do not fit within a neat legal or medical categories, medical professionals such as Dr. Pleak must diagnose an individual with GID in order for their recommendations around gender exploration and free expression to have any teeth. Ultimately, the incongruence between how law and medicine understand gender nonconformity, and the inconsistent and arbitrary reliance (or lack thereof) on GID results in a decrease in trans* survival.

Like Dr. Pleak, Christine’s mother (the appellant) was also supportive of Christine’s gender expression. The judges write, “[...a]ppellant apparently came to the conclusion that the boy suffered from GID without consulting medical professionals, was

taking the boy to GID support group meetings before obtaining any medical diagnosis, and was entertaining the idea of hormone treatment or surgery for the child” (*Smith v. Smith*, 2007, 10). The courts in this study consistently rely on the diagnosis of GID in order to understand whether or not Christine is *truly* transgender, as dictated by medical professionals and the DSM, rather than simply asking Christine how she feels, and how she would like to express her gender. Crenshaw’s theory of intersectionality applies here, where Christine faces three compounded modes of power: ageism, transphobia, and perhaps more deeply, misogyny.

The grounding premise of GID is that the gender nonconforming behavior is representative of disorder or confusion with one’s very identity, which produces gender conformity as both “natural” and “normal.” Cases such as *Doe v. Yunits* (2000) dangerously reproduce this naturalization and normalization. Pat Doe, the gender nonconforming person, was referred to a therapist who diagnosed her with GID. The therapist, Havens, determined that it was “medically and clinically necessary” (*Doe v. Yunits* 2000, 2) for Pat to wear traditionally female clothing. The judges continue, “[i]n addition, plaintiff’s ability to express herself and her gender identity through dress is important to her health and well-being, as attested to by her treating therapist. Therefore, plaintiff’s expression is not *merely* a personal preference but a necessary symbol of her very identity” (emphasis mine) (*Doe v. Yunits* 2000, 5). The freedom to express one’s gender as one sees fit is not enough in the realms of law, medicine, and also in this case, schools.

In order for the person to deserve protection and for their human rights not to be coerced or violated gender nonconformity must prove to be as a defining feature of one’s

core identity as a human person and as a medically defined problem. What this logic denies is the very processes and structures of socialization, and of the role that institutions like law, medicine, and schools play in the construction of gender conformity as the default “natural” state. Defining gender nonconformity as a disorder arbitrarily naturalizes gender conformity. Pat is also understood as “biologically male but, as a result of the gender identity disorder, has a female gender identity and prefers to be referred to as a female. Phrased simply in non-medical terminology, Doe has the soul of a female in the body of a male” (*Doe v. Yunits* 2000, 1). Here, the court attempts to both uphold the medical standard of GID and complement it with the western notion of “the soul.” Again, the law often claims to be neutral; however, it is evident here that the law can arbitrarily choose societal truths/myths that fit its logic for any particular case.

Doe v. Yunits also deals with the intersection of gender nonconformity and disability. The court considered that the state of Massachusetts, in contrast with the federal government, chose in Article CXIV to protect all persons who meet the definition of “qualified handicapped individuals” (*Doe v. Yunits* 2000, 7). The judges comment,

[t]here is wisdom to such an approach. It recognizes that, as our knowledge of genetics, biology, psychiatry, and neurology develops, individuals who were not previously believed to be physically or mentally impaired may indeed turn out to be so, and may warrant protection from handicap discrimination. It also recognizes that this may mean that persons who were previously thought to be eccentric or iconoclastic (or worse) and who were vilified by many people in our society may turn out to have physical or mental impairments that grant them protection from discrimination. Stated differently, the traits that made them misunderstood and despised may make them persons enjoying special protection under our law (*Doe v. Yunits* 2000, 7).

Under this logic, the gender nonconforming legal (and social) subject can either *and only* be “eccentric or iconoclastic (or worse)” or “physically or mentally impaired,” and thus,

deserving of legal protections. What this logic erases is the broad range of gender nonconformity that *most people* exhibit at some point or another during their lifetimes. It also negates gender self-determination and freedom of gender and sexual expression, and instead funnels gender nonconforming people into one of two strict categories: outcast or disabled. Both categories strip trans*/GNC people of our inherent dignity. Moreover, both categories function to naturalize and normalize gender conformity.

To varying degrees, the court decisions in thirteen of the fourteen cases studied included considerations around surgery, hormone replacement therapy (HRT), counseling, as well as deterrence of gender nonconforming behavior as antidotes to GID. However, only one case focused more extensively on surgery as a central issue. In *Brian L., also known as Mariah L. v. Administration for Children's Services*, a twenty-year-old transgender young person in foster care, Mariah's law guardian moved for order directing Administration for Children's Services (ACS) to pay for her to have "sex reassignment surgery" (*Brian L., aka Mariah L. v. Administration for Children's Services* 2006, 2). The court held that "[...] while the record contains evidence that the operation is the generally recognized successful treatment for gender identity disorder, the record is incomplete, and, therefore, this issue is not yet ripe for determination" (*Brian L., aka Mariah L. v. Administration for Children's Services* 2006, 2-3). The court deferred to a psychologist, Rachlin, who stated that "[...] the surgery was necessary for petitioner's emotional well being [...] without it her emotional and behavioral problems, e.g., anxiety, borderline personality disorder, would "deteriorat[e]," thereby "hinder[ing] further relationship, adjustment, personal and professional growth" (*Mariah L. v. Administration for Children's Services*, 2006, 7-8). Even though Mariah lost this case

(meaning that ACS was not required to pay for her surgery), as with the case of *Doe v. Bell*, the diagnosis of GID enabled both Jean and Mariah to pass through the medical and legal gatekeepers and thus to be considered “truly” transgender and worthy of legal protection and access.

This is a precarious issue. As a transgender person myself, who is in community with many other trans*/GNC people, I can attest that surgeries are not “necessary” for all trans*/GNC people. In fact, many of us are satisfied with the bodies we were born into. This is one of the dominant myths about us: that we were born “trapped in the wrong body.” While many people do desire surgeries, producing this particular knowledge that understands surgery as a *necessary* remedy to the disordered gender nonconforming medical subject naturalizes gender conformity and reproduces trans*/GNC people as inherently disordered, othered, incomplete, or otherwise less whole than our gender conforming counterparts. Furthermore, it feeds another dominant myth regarding all human beings: that each individual is either gender conforming or gender nonconforming. In reality, everyone is up against gendered expectations and double standards, and many people who might otherwise describe themselves, or be described as, cisgender or nontrans, certainly exhibit gender nonconforming behavior in some context at some point in their lives, or in many contexts, and at many points of their lives. A fruitful topic for further study could be the relationship and transformative possibilities between a radical disability framework and trans politics.

Surgery and hormone requirements also create impossible legal and medical standards for trans*/GNC people. Here we can see the courts’ overt lack of knowledge around trans*-related surgeries. Often, individuals are legally mandated to seek and

successfully endure multiple surgeries, some of which literally cannot be done in tandem. Moreover, many of these surgeries cost thousands of dollars. According to the most updated version of the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, which is a publication of the World Professional Association of Transgender Health (WPATH), “hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008)” (Coleman et al 2011, 1). While these standards of care have evolved over time and are now currently looser than in years past, as we will see in the next case, courts will still often require trans*/GNC to obtain multiple, costly, and often conflicting surgeries in order to simply be legally comprehensible, and in order to maintain things like custody of children.

Some of these necessary—or unnecessary, depending on the state and judge’s arbitrary discretion—sex reassignment surgeries include "complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation [...] including breast prostheses if necessary, genital reconstruction (by various techniques which must be appropriate to each patient [...])[...] and certain facial plastic reconstruction." In addition, other non-surgical procedures are also considered medically necessary treatments by WPATH, including facial electrolysis and hormone therapy (Coleman et al 2011, 2).

Of the trans masculine population, for example, less than 1% ever seek genital surgery. Genital surgery for trans masculine people can exceed \$50,000. The most common sought after procedure is a bilateral mastectomy with chest reconstruction. This procedure can cost anywhere between \$5,000-\$9,000, which includes the cost of the

actual procedure, anesthesia, hospital stay, and other surgical fees. Travel expenses are not included and surgeons who perform this type of procedure are scattered throughout the world. There is also an elective “sculpting” procedure, where the surgeon conducts liposuction around the abdomen/hip area to produce a more masculine contouring. This procedure can cost between \$8,000 and \$30,000. Of the trans feminine population, genital reconstruction (orchiectomy, penectomy and vaginoplasty) is sought after more frequently than the trans masculine population. This procedure can cost between \$7,000 and \$24,000 (Surgery encyclopedia 2014). The price ranges vary widely due to factors such as specific type of procedure, the need for additional surgeries, location and surgeon’s individual pricing, and surgical fees. I include the prices here to show not only how expensive these procedures can be, but also to contribute to my argument that most trans*/GNC people cannot afford most of these procedures, and many never seek them at all.

Additionally, whenever a court considers a transperson’s genitalia, the judges are almost exclusively concerned with whether or not they have a penis, regardless of the person’s birth assigned sex or self-determined gender. This fact is not only evidence of institutional violence, which Foucault stated the need for challenging in an interview in 1971 (Foucault 1971). It is also evidence of the fact that the courts are not interested in how the person self-identifies, but are simply phallic-obsessed. They are only interested in where the penis is, where it might have gone, (and when), or when it might appear in the future. This clear obsession with the penis centralizes it as the primary node of realizing—that is, *making real*—one’s gender identity. This obsession with the phallus is

rooted in the historical legacy of sexism and misogyny. So, while transphobia might look and sound like a different beast, sexism is deeply integral to transphobia.

Sterling Simmons' marriage case succinctly illustrates this obsession with the phallus as well as the court's impossible and impractical surgery standards. In the case of *In re Marriage of Simmons v. Simmons* transgender Sterling Simmons' wife sought marriage dissolution and custody of their child. The fact that Sterling was assigned female at birth complicated the custody decision. And so, whether Sterling ever legally had custody of the child he raised from birth, hinged on the judge's decision to produce Sterling as "truly male." In that discussion, it was noted that "[.a]ll of the physicians testified that there were other surgeries which had to be done on petitioner before he could be considered completely sexually reassigned, which would include a vaginectomy, reduction mammoplasty, metoidioplasty, scrotoplasty, urethroplasty, and phalloplasty" (*In re Marriage of Simmons v. Simmons* 2005, 3). Even though Sterling had been taking testosterone for many years and had "[.u]nderwent a total abdominal hysterectomy and a bilateral salpingo oophorectomy, which removed his uterus, fallopian tubes and ovaries" (*In re Marriage of Simmons v. Simmons* 2005, 2), the court required Sterling to obtain all of the additional surgeries stated above. Not only are the costs of those surgeries astronomical (estimated at around \$200,000 total), some of them *cannot physically be done in tandem with others*. For example, Sterling could get a metoidioplasty followed by a phalloplasty, but could not get these operations done in the reverse order. Had he sought a phalloplasty before this case, he would not have been able to then obtain a metoidioplasty, for example. Moreover, the surgical requirements revolve almost exclusively around the phallus. The most sought after procedure by trans masculine

people, chest reconstruction surgery, is not even listed here. Only the reduction mammoplasty is stated, which is typically sought after by female identified people who, for example, might be suffering from breast cancer. Typically, if a trans masculine person seeks chest surgery, it is a complete masculinization of the chest, not simply a breast reduction. Multiple physicians collectively advised this court to require Sterling to obtain surgeries that are extremely expensive and not reflective of the types of surgeries trans masculine people seek out. The terrifying reality is that these potently misinformed medical professionals have the highest authority over our bodies both in the operating room and in the courthouse.

So, not only is the court entirely misinformed about the fact that most trans*/GNC people never seek and/or cannot afford such surgeries, they are also entirely misinformed on the actual surgical procedures that people do seek. Because Sterling had not obtained all of those surgeries—and indeed he is an exception to most transpeople, having obtained so many surgeries—the court did not consider him to be truly male. As a consequence, his marriage of nearly twenty years became null. In one knock of a gavel, twenty years of marriage were erased. It was as if it never existed. It was as if he never existed. As an additional consequence, Sterling could not be legally considered his child’s parent. Because of arbitrary surgical requirements, Sterling was stripped of all custodial rights of the child he helped raise, and thus fell outside of the pale of law entirely. He was now a legal stranger to the young person who knew him as ‘Dad’ his entire life. Had the court considered that Sterling had parented his child from birth, and had his ability to self-determine his gender as male been given equal legal and medical

weight, Sterling might have been able to keep custody of the child—his child—he loved and raised from birth.

The law's embrace of GID reinforces the medical field's naturalization and normalization of gender conformity, which can have devastating effects for trans*/GNC people. Not only are we funneled into one of two categories: unworthy or worthy of accessing medical and legal technologies, therapies and other resources, but we are required to obtain surgeries the majority of us never seek, and must recite a linear gender narrative premised on heteronormative gendered norms. We can see Gramsci's theory on hegemony and its coercive effects here. In order for a critical trans* politics to interrupt this institutional reliance on GID, it must first reject the individual rights-based framework, reliant on a singular identity category and instead propagate for the right to self-determine one's own gendered expression and identity. Fortunately, medical language around gender expression and identity is beginning to move away from pathology; however, it still has a long way to go until everyone has the right to freely determine their gender. The conclusion of this paper will discuss some of those progressive changes and will specifically explore the new diagnosis, Gender Dysphoria and its potential ramifications for transpeople.

III. Medicine Produces Gender Nonconformity as a Problem Inherent to the Individual, Law Follows Suit

As discussed in the previous section, GID diagnosis creates two categories of trans*/GNC people: the worthy of both being categorized as “truly” transgender and of access to obtaining medical therapies and technologies, name changes, and other

institutionally backed services; and the unworthy (Spade 2011). As I will discuss in more detail later in this section, unless the trans*/GNC person's gender narrative adheres to a heteronormative and linear model, medical professionals grant little credence to their voiced proclamation of their gender identity and expression. The GID diagnosis thus silences one's right to self-advocate beyond the limits of a heteronormative linear model of gendered behavior and identification, and ultimately, blocks our freedom to determine for ourselves whether or not to pursue medical therapies, technologies, and other services related to our gender expressions and identities.

In this section I will build off of the last section by expanding on how medical and legal institutions employ one of sexism's well-worn tools, victim blaming as a mechanism of social control and gatekeeping towards young trans*/GNC people. I will look at the internationally accepted standard of care for trans*/GNC people, The Harry Benjamin Standards of Care to understand how trans*/GNC people are required to subscribe to a linear and heteronormative gender narrative. I will follow that contextualizing with examples from cases where the above themes are most salient. I end this section with the stated need for trans*/GNC people and our allies to not only bring awareness of the harmful effects of our pathologization, but to fight for a total rejection of pathology.

Along with the western notion of the individual self and the individual self as one, static core identity goes the notion that gender nonconformity is an illness, a lack, a problem, or some other negative "thing" inherent to the individual self. This centering of the individual self—particularly as being a passive recipient of a disorder—perpetuates the normalization and naturalization of gender conformity and also fits in with the U.S.

specific sexist legacy of “victim blaming.” Victim blaming locates the origin of violence in either the interpersonal dynamic of the people involved or in the behavior/dress of the person who experienced violence, rather than larger structural factors such as differences in how girls and boys are socialized to interact with one another, sexism, misogyny and hegemonic masculinity. The pathology around trans*/GNC people mimics this victim blaming logic by refusing to consider gendered socialization as well as the responsibility of institutions in the production of both gender nonconformity and gender conformity. This results in an arbitrary normalization of gender conformity, and further harm against trans*/GNC people.

The medical community in the U.S.—comprised of institutions and the individuals that keep them afloat—upholds this dominant knowledge and often demands a linear and heteronormative gender narrative from individuals in order to obtain protection and access to medical therapies, technologies, and services. The Harry Benjamin Standards of Care was the longtime leading guide for medical professionals in the western world working with trans*/GNC people. According to the guide, which was first published in 1979, one must attest to lifelong, strong feelings of feeling like the opposite sex in order for the medical professional to allow the patient to access things like a prescription for hormones or a letter affirming the person’s gender identity (which is then given to agencies like the Department of Motor Vehicles in order to change the gender marker on Driver’s Licenses and state identification cards)¹. In Section VIII.

Treatment of Adolescents of Part 2, A Brief Reference Guide to Standards of Care the

¹ Since the court decisions looked at in this paper were published, WPATH published an updated version of the Standards of Care in 2011, which includes softer requirements around the new condition, Gender Dysphoria. The previous publication, cited here, is from 2001.

provider is instructed as follows: “[...] in order to provide puberty delaying hormones to a person less than age 18, the following criteria must be met: [...] a. throughout childhood they have demonstrated an intense pattern of cross-gender identity and aversion to expected gender role behaviors” (*Coleman et al* 2001, 1). Such feelings can often be evidenced using a simplistic framework for understanding sex and gender, where say, the birth assigned girl prefers playing with trucks and action figures and prefers pants over dresses, while the birth assigned boy prefers playing with dolls and tea sets and prefers dresses over pants.

The simple reality is that *most people's*—not just GNC people—gender narrative is colored more by shades of grey than abstract correlations between childhood toy and clothing preferences and gender expression and/or identity. People's desires, behaviors, and self-identifications evolve over the course of one's life. While some people do experience direct links between toy and clothing preferences and their gender identity/expression, many do not. The bottom line is that no one should be required by institutions like law and medicine to conform to linear gender narratives—or *any* prescribed gender narrative, for that matter. Moreover, there is the assumption that gender conforming people do not have aversions to “expected gender role behaviors.” Why such behaviors are expected is not explored in this document, thus normalizing heteronormativity. There is merely an arbitrary standard of heteronormative gender role behaviors that trans*/GNC people are pushed up against.

In section XII. Requirements for Genital Reconstructive and Breast Surgery of Part Two, two surgery requirements are especially restrictive to one's autonomy and self-determination: “12 months of continuous hormonal therapy for those without a medical

contraindication [...] 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and should not be used to fulfill this criterion” (Coleman *et al* 2001, 2). Acquiring hormones for a consecutive 12 months—or at all—is a social and economic barrier for many trans*/GNC people. Many of us do not have health insurance, which will sometimes cover some or all of the costs of the actual hormone and other materials like syringes, needles, Sharps box (a container for disposing of needles and syringes), alcohol swabs, bandages, etc. For those whose insurance does not cover this or for those without insurance, the cost can go well beyond one’s budget. This scenario often forces us into obtaining hormones from friends or through street economies, which can be very inconsistent and/or unsanitary. Moreover, even when we do have access and resources to obtain hormone prescriptions, many of us do not want to remain on hormones for longer than a year, or our prescriptions may fluctuate depending on our desire and/or financial ability to obtain those prescriptions. Even further, some people cannot take hormones because it would conflict with other health conditions (ie. high blood pressure, pre-existing risk of developing particular cancers). Hormones are powerful, and unless you are well read on the topic and ask for a lower dose to begin with, your medical provider will likely start you out on a high dose. This can be a shock to the mind, body, and psyche. Many of us begin taking hormones then realize we might not want to grow facial hair or breasts, for example. This is not necessarily because we have “ambivalence about proceeding.” In fact, many *non-trans* people do not like how their secondary sex characteristics have manifested throughout their lives and seek out hormones or surgeries as a result. Non-trans women who seek breast reductions or enlargements do not suffer

the same scrutiny from medical professionals for such desire, for example. Non-trans people seeking similar hormone treatments and surgeries are not shackled to such a tight narrative about their gendered life experience in order to obtain what they need. While medical institutions attempt to restrict transpeople's desires and funnel them into a constrictive narrative, we resist by taking the power back into our own hands, by building community with each other and sharing stories and strategies to navigate systems that aim to flatten our robust lives. I will address some of those strategies in the conclusion of this paper.

As discussed previously, the requirement of the linear gender narrative is premised on a heteronormative model of human behavior where behaviors, preferences, and desires are saturated in the presumption of heterosexuality. This narrative tells us that boys who like sports and rough-housing also prefer girls as sexual and/or romantic partners, and girls who like to wear dresses and play "house" prefer boys as sexual and/or romantic partners. Such heteronormative myths masquerading as objective truths about human behavior are not grounded in any actual research. Moreover, such simplistic assumptions do the majority of people's life experience an injustice. While some progressive medical institutions no longer rely on these standards of care (such as Chicago's Howard Brown Health Center), many still do. And while the most recent version of the DSM takes a more progressive approach towards gender nonconformity, there is no guarantee medical professionals will heed the advice of these newer models of care.

The most recent version of the Diagnostics and Statistics Manual (DSM), the DSM-V was published in 2013, after all of the fourteen cases considered in this study

were published. While the DSM is rarely explicitly cited in the published court decisions, it is in fact the leading manual for diagnosing patients. The DSM-V replaced Gender Identity Disorder with Gender Dysphoria, a milder degree of pathology, but pathology nonetheless. Both GID and Gender Dysphoria latch on to this framing of gender nonconformity around the individual self. Both ‘disorder’ and ‘dysphoria’ center the individual as the cause or the carrier, and do not take into account the role of socialization and institutions in the production of both gender nonconformity *and* gender conformity. Victim blaming proliferates throughout our society, most visibly in how individual people and institutions handle sexual violence towards women and girls. Victim blaming is a mechanism of social control, steeped in misogyny, patriarchy and trans*phobia.

Medical professionals working with trans*/GNC people in this country historically rely on the DSM and Harry Benjamin Standards of Care in order to properly diagnose and treat us. Being gender nonconforming in this country denotes having a problem, a lack, or a disorder inherent to the individual self. For example, in the case of *In the Matter of the WELFARE OF S.M.T.* the young person’s gender nonconformity is mentioned just once in the last paragraph of the decision: “Appellant claims that these findings fail to address his unique circumstances; appellant is transgender and wears women’s clothes. He has mental health issues, academic deficiencies, and sexual identity issues” (*In the Matter of the WELFARE OF S.M.T.* 2008, 4). The court simply lumps all of these “issues” into one conglomerate, while centering the onus on S.M.T. himself. The point here is that the judges unthinkingly categorize gender nonconformity as an inherently negative “issue,” rather than acknowledging the hostile society that disallows, stigmatizes and punishes gender nonconforming people. Rarely do medical professionals

identify the very institutions within which they work as the producers of gender nonconformity *and* conformity. This blind reliance on institutionalized truths makes it very difficult to intervene this cyclical nature of knowledge production.

In the custody case of *Smith v. Smith* the court called on experts to discuss the parameters of GID. The court writes, “The trial court concluded from these experts that GID is a real condition that affects between 1 out of 30,000 and 1 out of 100,000 people. The court accepted the Diagnostic and Statistical Manual of Mental Disorders, 4th (“DSM-IV”) standard for diagnosing GID:

{¶ 19} 1. Repeatedly stating a desire to be or insisting that the child is the other sex.

{¶ 20} 2. A preference for cross-dressing or wearing attire typical of the opposite sex.

{¶ 21} 3. Strong and persistent preferences for and admiration of cross-sex roles in play or fantasies.

{¶ 22} 4. Strong or intensive desire to participate in the stereotypical games and activities of the other sex.

{¶ 23} 5. Strong preference for playmates of the other sex.

{¶ 24} The court concluded that a person needed to display at least four of the indicators to be properly diagnosed with GID. (*American Psychiatric Association* 2000, 4)

All standards of GID listed here center the individual as the cause or recipient of this “condition that affects” them. There is no discussion of mandatory socialization into socially-constructed gender roles, nor is there any scrutiny applied to the DSM itself. Moreover, there is no reason stated for a person needing to display at least four of the indicators in order to be properly diagnosed with GID. The court merely accepts the standards then proceeds to discuss various prescribed methods of treating GID.

The police who interviewed Brandon in the well-known 1993 case of Brandon Teena also framed Brandon as the passive recipient of GID. The court describes Brandon in the introduction: “Brandon had been sexually abused as a child, and in her [sic] late

teens, developed gender identity disorder, a condition in which one develops a strong dislike for one's own gender and assumes the characteristics, both behaviorally and emotionally, of the other gender” (*Brandon v. County of Richardson* 1997, 19).

Throughout the 44 pages of this court decision, the judges do not consider socialization around gender roles, the pathology grounding GID, or how institutions like medicine could have produced what the court perceives to be a disorder inherent to Brandon himself. About halfway through the decision, the judges include testimony from Mario Scalora, a licensed clinical psychologist and assistant professor of psychology at the University of Nebraska at Lincoln. In regards to his credentials, the judges only include Scalora has been licensed as a clinical psychologist since 1989 and that he had worked with 300 to 400 victims of sexual abuse. The judges write, “Scalora testified that Brandon was the victim of childhood sexual abuse, which had a substantial and negative effect on how Brandon perceived her [sic] own sexuality. Scalora testified that Brandon subsequently developed gender identity disorder, which may have been related to her [sic] childhood sexual abuse. He further testified that Brandon was “very negatively impacted” by the rapes Lotter and Nissen committed upon her [sic].” (*Brandon v. County of Richardson* 1997, 28). Dr. Scalora leaps from the fact that Brandon suffered childhood sexual abuse to a development of GID, omitting any substantial empirical evidence defending the causal connection between the two. This leap from child sexual abuse to gender nonconformity occurs throughout many of the cases in this study, without any research-based claims to back it up. This needs to be challenged. The tragedy of Brandon Teena’s early death of course lies in the fact that he was attacked, raped, then eventually murdered partially due to the police officers’ refusal to arrest and detain the perpetrators

he clearly identified and named directly after the rapes. But the tragedy also lies in the fact that the legal and medical institutions dealing with this case produce Brandon as an inherently tragic figure, specifically because of his gender nonconformity. Raped or not raped, Brandon is framed as inherently other, inherently doomed.

Medicine and law are responsible for harmful knowledge production around trans*/GNC young people and must be held accountable. Bringing cases like these to light and examining the institutionalized rhetoric that (re)produces that harm increases potential to crush such harmful myths and to replace them with a truer, more nuanced, and more dignified account of our actual lived experiences. But we need to do more than just raise awareness. The DSM's replacement of GID with Gender Dysphoria is a step in the right direction, but we need to agitate for a full rejection of pathology of gender nonconforming people, behavior, identities, and desires in order for this kind of arbitrary and institutionalized harm to end.

IV. Hands Tied and Lips Sealed: How Courts Trap Gender Nonconforming People in a Preference/Pathology Catch-22

"It is in the knowledge of the genuine conditions of our lives that we must draw our strength to live and our reasons for acting."
-Simone de Beauvoir

One of the ways the legal system ensnares young trans*/GNC people within its confines is by denying them the right of sharing their perspective on their lived experience. Foucault's 'will to truth,' discussed in the introduction explains how seemingly neutral institutions actually silence voices of dissent. Medical institutions define us within discourses of pathology that produce us as mentally ill and/or confused.

Because we do not fit within the neat legal categories of male and female the legal field defers to those medical productions in order to understand us as thinkable subjects, rather than granting credence to our perceptions of our lived experiences. In this section I explore how these discourses of pathology trap trans*/GNC people in what I name a Preference/Pathology catch-22. I argue that through employing this Preference/Pathology catch-22, the interlocking institutions of law and medicine both dehumanize us and systematically prevent us from getting what we need in order to survive.

During the Civil Rights Era in the U.S. the Supreme Court developed what is called “suspect classification” to describe any classification of groups meeting a series of criteria suggesting they are likely the subject of discrimination. Suspect classification comes out of the fifth amendment and the equal protection clause of the fourteenth amendment, which was further clarified by SCOTUS (the Supreme Court of the United States) in the case of *Korematsu v. United States*, 323 U.S. 214 (1944). These classes received—and continue to receive—closer scrutiny by courts when an Equal Protection claim alleging unconstitutional discrimination is asserted against a law, regulation, or other government action (*Korematsu v. United States* 1944). The Supreme Court established the judicial precedent for suspect classifications in the case of *Korematsu v. United States*, 323 U.S. 214 (1944). The Court upheld the "relocation" of Japanese Americans living on the west coast during World War II, yet Justice Hugo L. Black, in his majority opinion, stated that all legal restrictions which curtail the civil rights of a single group are immediately suspect. Though it is now widely recognized that no compelling justification existed for the relocation order and that racial prejudice rather than national security led to the forced removal of Japanese Americans, *Korematsu* did

signal the Court's willingness to apply the Equal Protection Clause to suspect classifications. The Supreme Court recognizes race, national origin, religion and alienage as suspect classes. It therefore, in theory, analyzes any government action, discrimination in employment, education, etc. that discriminates against these classes under strict scrutiny (*Korematsu v. United States* 1944).

Currently, the legal system still exhibits ambivalence around how to handle cases involving gender nonconformity, mostly due to the fact that we do not fit within the neat categories of male and female; however, trans*/GNC people appear to be falling more and more under a suspect classification. In April of 2014 the Office of Civil Rights (OCR) issued a guidance: "Title IX's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and OCR accepts such complaints for investigation." (OCR 2014, 4). The problem with this is that one of the criteria for being recognized as such requires that being transgender must be proven to be an immutable characteristic, a requirement reminiscent of how the courts began to handle race-based discrimination in the Civil Rights era in the U.S. In order for it to be proven as an immutable characteristic, we must successfully jump through the hoops of the GID and be diagnosed as mentally ill. Trans*/GNC people should not have to bow down to pathology in order to meet basic needs, to maintain custody of our children, to be treated as human. This is one institutional mechanism of social control, aimed at maintaining both gender conformity and the gender binary. I will now expand on the harm caused by the court's refusal to take the trans*/GNC person's account of their own experience at face value, lay out the

Preference/Pathology catch-22 and explain why a shift toward a valuing of self determination would greatly impact the lives of trans*/GNC people in legal settings.

A requirement of the institutional reliance on GID is the erasure of self-determination and the trans*/GNC person's lived experience and perspective on their own life experience. Not only does law rely on GID, it requires a medically certified diagnosis. Simply stating that one has GID is not enough. The courts understand this kind of self-proclamation as a mere preference, which has almost no legal weight. Key qualifying phrases such as "*believes to be* a man/woman," "*insists on wearing/being* referred to as..." (*Doe v. Bell* 2003) tears the authenticity of gender identity and expression away from the self and replaces it with a mandate to prove pathology. Medicine's and law's interlocking decision to understand gender nonconforming identities and expressions as either mental illness, and therefore protected, or merely a preference, and therefore not protected, erases all possibility of being protected on the grounds of self-determination. That is, because trans*/GNC expression and identity is framed in this soft realm of preference, our actual deep and authentic understandings of ourselves and our right to self-determine our gender identity and expression get funneled into one of two categories: preference or pathology. The preference frame robs the trans*/GNC person of their agency and ability and freedom to self-determine their gender expression, and ultimately functions to dehumanize us altogether. In order to be considered within a protected category, "transness" needs to be proved an immutable characteristic, authorized by medical authorities. If it is not immutable, and therefore changeable, then one is not protected because one could just theoretically change their gender for whatever reason. So, herein lies the problem. One can self-determine their

gender (rather than attempting to get into the “worthy” category under a GID diagnosis), but only under the pretense of enduring mistreatment and abuse while also being mandated to be different. If immutability cannot be proven, the gender nonconforming identity then usually becomes categorized into its default position, preference. Preference carries virtually no legal weight, so most trans*/GNC people face a legal and medical catch-22. Legitimacy in the legal context is only granted to those with a certifiable mental illness. Without it, we can fall outside of the pale of law entirely.

Not only does this Preference/Pathology catch-22 leave many trans*/GNC people with their hands tied, it also requires a hand over our mouths by deliberately omitting the trans*/GNC person’s account of their lived experience. Because medical professionals and lawmakers rarely look to the very people their work might impact, their decision-making can often be drastically misinformed. In the majority of the cases considered in this study, few trans*/GNC people are asked how they understand or define their gender identity or expression in their own language and on their own terms. And in the cases where they are asked, their testimony is then poured through the sieve of the GID requirements, where only the qualifying statements are then considered. Institutions like law, medicine, and schools not only compete, but work collaboratively to uphold the dominance of pathology around trans*/GNC people. While all fourteen cases carry some element of denying the trans*/GNC person’s voice, I now turn to discussion of the five cases where the Preference/Pathology catch-22 and subsequent erasure of the trans*/GNC person’s lived experience is most great and clear.

In the case of *Doe v. Bell* the question for the court is whether Jean Doe’s gender nonconformity can be categorized as a protected disability. If it does, she would be

allowed to wear traditionally feminine clothing in the all-boys foster care facility in which she lived at the time. If it does not, she would be required to wear traditionally masculine clothing, despite the extremely harmful effects. By looking at the language the judges use to initially describe Jean we can see that her gender identity has already been delegitimized by the judges. They write that Jean Doe “[...] experiences an intense need to wear women’s clothing and act as a woman” (*Doe v. Bell* 2003, 2). This language constructs Jean as a caricature of a *real* woman, a dehumanized remnant of something that should have or could have been a *real* woman or a *real* man. If Jean were able to both speak for herself and have the judges consider that testimony legitimate we would likely glean a more authentic and truer understanding of her gender identity. Rather, the courts use preference to produce her dehumanization by offering a hollow construction of the other, the non, the fake, the imposter. If the legal system valued gender self-determination, Jean and others like her might be treated more humanely, and might experience greater legal protection. Instead, the law constructs preference of gender expression as something that is not considered integral to the person, and therefore minor and trivial, and not worthy of protecting. Ultimately, no one should have to fit within a special classification in order for the courts to help stop mistreatment, discrimination and abuse. Law and medicine like to refer to themselves as neutral institutions; however, we can see the real danger of allowing institutions to interpret gender nonconformity, especially when it pertains to young people whose voices are already silenced by ageist social structures. From the dawn of modern psychology, medicine has functioned to rip the gender nonconforming person from her humanity and replace it with a myth-informed, mentally ill caricature, the effects of which we still witness and endure.

In the child custody case of *Smith v. Smith* the court was to decide whether the trans*/GNC young person's mother was to be denied custody due to her support of her child's gender identity. This court bolsters the preference/pathology dichotomy here most vividly in order to justify the denial of custody. Referring to an interview with twelve-year-old Christine, the judges noted, [...] the child expressed a desire to wear girl's clothes and to have "girl stuff," (*Smith v. Smith* 2007, 6) although he did not specify what "girl stuff" meant. The judges continue,

The court found that the boy enjoyed stereotypical male activities such as wrestling with his brother, shooting his BB gun, and playing video games. The boy did not talk about participating in any stereotypical female activities except for wearing girl's clothes. The court also found that the child's friends were all boys, and that he appeared to be attracted to one particular girl who was not attracted to him. The boy did not report being attracted to any boys except as general friends. He was not able to name any female heroes or idols. The court did not notice the boy exhibit any female mannerisms during the in camera interview. (*Smith v. Smith* 2007, 6)

The court's arguments here bolster their decision to affirm the prior court's ruling, which granted custody to the father instead of the mother. There are a variety of mechanisms at play here: the deference to heteronormatively gendered interests, the requirement of having friends of the same birth assigned sex, the conflation of homosexuality with gender nonconformity, the arbitrary requirement of having "female heroes or idols," and the observation of the child's lack of vaguely described "female mannerisms" during the interview. Not only are gender conforming young people never asked to meet any of these requirements, nowhere in this court's observation does the reader gain insight into how the child *actually felt* about their gender, nor is there any rationale given for why these particular observations were noted. Again, the law here is anything but neutral as it claims to be. There is some loose reliance on the requirements of GID at play here;

however, they are not cited or explained. The court simply relies on dominant heteronormativity without any explanation in order to normalize gender conformity, curb gender nonconformity and police the mother's gender-affirming behavior of her child. The trial court, which is the court that considered this case before the appellate court documented in this study, eventually determined that Christine

“[...] needed to be in an environment where he could be treated like a boy and allowed to develop as a boy, so that he could make a more informed decision about his gender at a later point in life. The court interviewed the boy in camera, and did not sense anything particularly feminine about him. The court found that the boy had little interest in being a girl other than in his desire to wear girl's clothing. The court observed that the child acted like a girl only when he was around his mother, and seemed to have no trouble behaving like a typical boy when he was with his father. The court concluded that Appellant may be forcing her son to become a girl. The court decided that by making Appellee the residential parent, the child would be permitted to find out if he was only acting like a girl to please his mother, or if he really was a transgender child. Thus, the trial court conducted the analysis that it was required to do and relied on substantial rebuttal evidence to overcome the presumption of retaining the current residential parent” (*Smith v. Smith* 2007, 12)

Again, nowhere in this court's observation and conclusive notes on Christine's gender identity and expression does the reader understand how Christine feels or thinks about herself or himself, nor are there any psychological findings presented that back up this either/or framing of Christine as either trying to please their mother or being “truly transgender.” The need for the court to determine if she/he “really was a transgender child” requires only determining if she meets enough requirements of GID. Here we see both Foucault's ‘will to truth’ theory as well the Preference/Pathology catch-22 clearly in action where the court's logic relies almost exclusively on pathology, deliberately excluding Christine's own understanding of herself or himself, and also excluding the possibility that the father might be forcing Christine's gender against her will.

In the case of *Doe v. Yunits* the judges literally use the phrase “merely a personal preference” (*Doe v. Yunits* 2000, 5) to describe the gendered behavior of Pat Doe, a fifteen-year-old high school student. The court refers to her as “transgendered” and referred to as she/her throughout the decision, and is also referred to as “a biological male” with a “female identity” (*Doe v. Yunits* 2000, 1). In the opening paragraph of the decision the judges write, “Doe is biologically male but, as a result of the gender identity disorder, has a female identity and prefers to be referred to as a female. Phrased simply in non-medical terminology, Doe has the soul of a female in the body of a male” (*Doe v. Yunits* 2000, 1). The court notes that in a medical context Doe is mentally ill, but in laymen’s terms her physical body just simply doesn’t reflect her soul. Neither explanation of her gender came from her own testimony, nor is there any explanation why an abstraction such as “the soul” has any legal weight. Not only does the inconsistency between pronoun use and Pat’s self-identification reveal that the court does not acknowledge Pat’s gender self-determination as valid in and of itself, the use of the adjective “transgendered” over the noun “transgender” produces a passive social, medical, and legal subject whose gender is something that happens *to* them, rather than a reflection of how they feel or understand themselves to be. Moreover, the court’s and the school’s emphasis on Pat’s clothing choice as being reflective of her “very identity” over “merely a personal preference” (*Doe v. Yunits* 2000, 5) feeds the Preference/Pathology paradigm, thus restricting her legal freedom. Pat must either adhere to GID requirements in order for her gender nonconformity to be taken seriously, or have it dismissed as mere preference and gain no legal protection.

Amendment 1 of the U.S. Constitution protects people's right to freedom of expression; however, the Preference/Pathology dichotomy marginalizes those material, non-conforming, gendered expressions that fail to fit within its confines. Included in their discussion of the case, the judges flex their ageism while stating, "[...] in the case at bar, defendants contend that junior high school students are too young to understand plaintiff's expression of her female gender identity through dress and that "not every defiant act by a high school student is constitutionally protected speech"" (*Doe v. Yunits* 20005). We can read between the lines here and rightly infer that "not every defiant act" is a direct nod to the gender nonconforming behavior at hand. Amazingly, the threat of gender nonconformity to this school district's administration is apparently so great, it cannot be protected by the U.S. Constitution. Moreover, because the gender nonconforming people in this study are all young people, they face the compounded powers of ageism and trans*/homophobia, which is blindingly evident here. The omission of Doe's perspective on her own lived experience is a compounded product of ageism and pathology's role in the production of gender conformity as natural and normal.

The next case includes some glaring pathology around a young person referred to as M.F. in the court's writings. M.F. was adopted from an orphanage in China when he was just thirteen months old. By fifth grade M.F. had been marked as "emotionally disturbed," including reactive attachment disorder, attention deficit hyperactivity disorder, gender identity disorder, and major depressive disorder" (*Dept. of Education, State of Hawaii v. M.F., by and through her Parents R.F. and W.F.* 2011, 6). M.F. actually prefers to be referred to as D so I will refer to him in that way throughout this discussion.

Here, because D apparently was dealing with other mental health related issues, it was conceivably easier to lasso his gender nonconformity in with pathology. There was almost no discussion around whether to include gender nonconformity along with the other “multiple conditions.” The fact that the law can make such sweeping correlations with little to no protest or discussion tells us once again that the law is not neutral as it claims to be, and in fact makes arbitrary statements and correlations with no repercussions. A year after D verbalized his gender identity, the court writes,

Despite M.F.'s enjoyable 2008 summer at Variety School, she began to develop a "gender identity issue" during her fifth grade year, although her father testified at the administrative hearing that she was doing fine academically. Tr. 211-12. At some point, she began dressing and acting like a male, and she stated she wanted to be a boy. AR 338. She changed her identity to "D." Variety School teachers and professionals accommodated M.F.'s preferences, and many reports refer to M.F. in the male gender and by M.F.'s taken name of "D." See, e.g., AR 6 ("Although ... the Student is biologically a girl, she insists on being referred to as 'he', he dresses and has the outward appearance of a boy. He has rejected the name [M.] and insists on the name of '[D.]' "). (*Dept. of Education, State of Hawaii v. M.F., by and through her Parents R.F. and W.F.* 2011, 10)

As is true for the majority of the cases considered in this paper, the court does not include any testimony from D. It is also important to note the “although” between the description of D “develop[ing] a “gender young trans*/GNC person was doing well in school; however, the court frames it paradoxically, as if the two are inherently mutually exclusive. Again, the courts arbitrarily produce an unfounded correlation.

In contemporary U.S. society gender nonconformity is overwhelmingly understood as psychological condition of suffering, of being or performing “less than” those whose gender conforms with societal expectations. Unless people with power in institutions such as law, medicine, and schools are willing to listen to the trans*/GNC person’s account of our own lived experience and be taken seriously and legitimate in and of itself, this destructive, discursive construction of pathology will continue to harm trans*/GNC people. Courts will maintain their authority in continuing to make sweeping, unfounded transphobic and ageist statements that have serious, material effects on young trans*/GNC people. A move towards a valuing of gender self-determination in the legal

and medical communities and the institutions that carry out their work would greatly relieve trans*/GNC young people from being funneled into one of the narrow arms of the Preference/Pathology catch-22. Gender self-determination allows all people the freedom to determine their gendered behavior, desires, and identities without having to succumb to unfounded, arbitrary requirements created for the purposes of heteronormative social control.

V. We Will Hurt You: Courts Frame Gender Nonconformity as Locus of Violence

While there is no grounding empirical research to this claim, the dominant narrative in contemporary U.S. society around trans*/GNC people is that we are inherently a threat to ourselves, others and society. While trans*/GNC people are blamed for the violence of others who are made uncomfortable by our power, it is in fact the hostile nature of our heteronormative, patriarchal gender binary regime that produces violence against us. The courts employ this narrative of harm to (re)produce the idea that transpeople are inherently threatening and also the cause of the violence we experience. This is one institutional strategy to strengthen the patriarchal gender regime and to normalize gender conformity. Here, Crenshaw's theory of intersectionality helps us understand how sexism and transphobia intertwine to further cast trans*/GNC people outside of the realms of humanity.

In this section I highlight that there is no empirical research that proves gender nonconformity is harmful, and link this to the gendered, historical legacy of sexism, "victim blaming" that unfairly puts the onus on the person who actually experiences violence. I then discuss six cases where the courts subscribe to the narrative of harm to point to the blinding irony of the fact that trans*/GNC people are the ones who are

disproportionately harmed by others and society (not the other way around) and I also discuss the link between the narrative of harm and the hypersexualization and dehumanization of trans*/GNC people. The narrative of harm is one mechanism of social control whereby institutions such as law place an undue burden on trans*/GNC people to change who we are simply because our mere existence disrupts the dominant heteronormative, patriarchal gender binary regime. While all fourteen cases considered in this study frame gender nonconformity as inherently threatening, I will focus here on the six cases where this theme is most vivid in the published court decision. The first five cases deal with the institutions governing child custody and social services, and the sixth case deals with schools.

In the case of *Doe v. Bell* the social services agency subscribed to a narrative of harm, which the judges accepted without empirical evidence. The New York City's Administration for Children's and Commissioner William Bell ("ACS") argued that Doe's decision to wear girl's clothing provoked the sexual harassment and violence she experienced at the hands of boys who also lived in the facility. ACS was more concerned with the wellbeing and safety of the (presumably gender conforming) boys than with that of Doe's who was so obviously the more vulnerable person. As in domestic violence situations where the woman experiences violence at the hands of a man, the onus is almost always placed on superfluous factors such as what kind of clothing the woman was wearing, whether or not she had been drinking and how her behavior could have provoked hostility in the man. The man's alcoholic or drug intake and his violent behavior is almost never focused on as severely. Doe, like many other female identified people, is interpolated through this logic as a hypersexual being and as the cause of her

own vulnerability in a hostile situation. This ludicrous logic functions here as well, in ACS's explanation of its dress policy:

ACS asserts that its dress policy is necessary to protect the safety of residents and staff. According to Dr. Antoine [the facility's director], it was necessary to restrict the kind of dress worn by Jean Doe because a male in feminine clothing creates a "sexual dynamic ... that can lead to unsafe and emotionally harmful sexual behavior." Further, at the facility, "there are many boys who are not emotionally mature and who feel confused or threatened by the presence of a transgendered boy among them and are prone to act out when Jean is nearby. (*Doe v. Bell* 2003, 15)

ACS claims the policy exists in the name of safety; however, the real harm done by this policy is the denial of Jean's need/desire to wear clothing consistent with her gender identity. The deeper harm is that this logic ultimately excuses violence experienced by trans*/GNC people. The boy residents are "let off the hook," so to speak, as their violent "reactions" are justified by an unquestioned male desire. Similar to the kind of "slut shaming" girls and women (and feminine men) face when harassed or attacked—or simply for just wearing clothing that exposes more skin than other clothing—here Jean is hyper-sexualized because of her alignment with an outwardly feminine gender expression. Moreover, trans femininity in particular is framed as the very nexus for potential physical and/or sexual assault. ACS's policy centralizes the trans*/GNC person's appearance as the reason for any potential attack against that person, when it should be creating policies that keep everyone safe, not just those whose gender expressions conform to social norms. This (trans)misogynist policy frames Jean as an inherent threat to herself, and the other children living alongside her, when there is no factual research to support such a claim. Furthermore, as outlined in the introduction of this project, there is ample evidence around violence against people who are gender nonconforming. Not only do transpeople—specifically those of us who are poor or

working class, and/or are racialized—face discrimination and hatred at the hands of individual people, but also endure systemic violence such as police profiling and criminalization. The courts do not question this violence, they simply say that trans*/GNC people should just stop being themselves in order to avoid it. Moreover, of all institutions, one would think a foster care facility would defend the most vulnerable of its occupants, not dehumanize and sexualize them. These policies must be questioned and changed to protect the most vulnerable.

In another case, the clothing of a young trans feminine person was seen as a potential disruption, placing the blame on clothing choices rather than on an environment that is rigidly gendered and that would force someone into not being themselves so that no one would be “disrupted.” Rather, the court should look at the hostile environment that makes such “disruptions” a potential problem. The court’s hyper focus on Pat’s clothing choices in *Doe v. Yunits* detracts from any exploration of the hostile environment, which she endured daily: “skirts and dresses, wigs, high-heeled shoes, and padded bras with tight shirts” (*Doe v. Yunits* 2000, 2). In September of 2000 Pat was warned by her school’s administration that if she continued to wear these items she would be expelled because they were “disruptive to the educational process, specifically padded bras, skirts or dresses, or wigs” (*Doe v. Yunits* 2000, 2). Presumably, the non-trans girls at the school regularly wore some or all of these items and so it is Pat’s gender nonconformity, not the clothing items themselves, that cause such “disruption.” Once again, the threat of harm is unjustly and arbitrarily traced back to the trans*/GNC person.

We can even see the narrative of harm evident in the nuances of language. In the case of *Shrader v. Spain* the courts, through language, produce gender nonconformity as inherently harmful, rather than looking at the broader environment. The judges write:

”[e]xpert testimony established that Nicholas *suffers* from gender identity disorder (emphasis mine)” (*Shrader v. Spain* 1998, 2). The same linguistic framing is used by the court in *In Brian L., also known as Mariah L. v. Administration for Children’s Services*:

Remand to Family Court of proceeding seeking to compel city Social Services Commissioner to pay for sex reassignment surgery for 20-year-old child in foster care who *suffered* from gender identity disorder was required to allow Commissioner to provide court with clear statement of its reasons for denial of requested surgery, which was generally recognized as successful treatment for foster child's *disorder* (*emphasis mine*). (*Brian L., aka Mariah L. v. Administration for Children’s Services* 2006, 2)

The operative word in both cases is ‘suffers.’ While it is true that many of us do indeed suffer a great deal because of our gender nonconformity, it is not because we have a mental illness that causes us to suffer. We suffer because we live in a world whose institutions and societal norms systematically dehumanize us; build myths that define us as grotesque, alien, and ill; and deny us the right to self-determine our gender expressions and identities. Institutional policies (re)produce this narrative of harm around trans*/GNC people by normalizing and naturalizing gender conformity.

In order to get what we need from institutions (ie. changing our name or gender marker on identification documents, obtaining hormones and surgeries, accessing bathrooms, etc.), we must weave ourselves into this narrative of harm, identifying ourselves first and foremost as mentally ill and a threat to ourselves and those around us, in order for our institutional needs to be legitimized and satisfied. Nobody should have to identify themselves as a monster in order to satisfy basic needs, such as housing and education, but unfortunately we trans* people must do this again and again in various institutional settings. Spade’s essay on disability rights and trans politics adds nuance to

this complicated web, where he explores how conceding to disability can be both dangerous and effective (Spade 2003).

Even in cases where the trans*/GNC person “wins” that “win” is couched in a discourse of gender nonconformity as inherently harmful. In the custody case, *In re Custody of T.J.* the “father” of minor, T.J. is a trans woman and the court was to decide whether or not this is enough of a threat to T.J.’s wellbeing in order to transfer custody to his mother. The court writes:

[Respondent] has decided to maintain his male identity. T.J. has exhibited no atypical manifestations which would lead the Court to conclude that his father's gender dysphoria has affected him in any way. While he may be repressing or denying the existence of this condition in his father, these defense mechanisms do not appear, at this time, to be adversely affecting his life. Rather, the evidence supports the finding that the acrimonious relationship which exists between the parents, as pertains to decisions concerning T.J.'s welfare, has been a more harmful influence than the transsexual issue. There is nothing in any of the evidence submitted to suggest that T.J. has any gender identity confusion. In addition, there is no evidence which would lead the Court to believe that providing primary parenting responsibilities to a gender dysphoric father would cause future problems for T.J. (*In re Custody of T.J.* 1988, 5)

While it seems that the court made a decision that is in the best interest of T.J., gender nonconformity is still framed as a threat to the child. It is only because T.J. does not “mimic transsexual behavior” and presumably because the father “decided to maintain his male identity” rather than, say, identifying as transgender, that the GNC father is able to maintain custody of T.J. While it may be a legal win for these individuals, the belief that gender nonconformity is a threat of harm to children (and to everybody) is reproduced by the interlocking medical and legal discourses in this case.

The narrative of harm bolsters the court’s logic in all six of these cases, relying on unfounded medical requirements of trans*/GNC people ceding our right to self-determine

our gender identities and expressions to a pathology that constructs us as inherently harmful. In fact (as Foucault wrote about in the 1970s) the actual harmful agents are the institutions of law and medicine that claim to be neutral, but are in fact responsible for supporting and justifying oppressive policies that restrict trans*/GNC people from getting what they need in order to survive.

CONCLUSION

Working With and Transforming Beyond the Institution: Implications for Trans* Movement Building

I chose this topic because I wanted to house my academic, class and race privilege in a way that actively contributes to the strength and empowerment of one of my own communities, the trans community. I noticed a gaping disconnect between the legal- and medical-based injustices young trans*/GNC people face and the amount of research around those injustices. I wanted to bring to light how young trans*/GNC people are systematically stripped of their human dignity in legal and medical contexts and wanted to arrive at some tangible conclusions as to ways transpeople can resist, fight back, work the system and do whatever it takes to get what we need from these institutions in order to survive. I was dissatisfied with the ways that some of the activist communities I was a part of rejected the idea of working with powerful institutions purely on principle and I was also dissatisfied with the mainstream gay movement's ready acceptance of working with those powerful institutions. This last section will outline some main implications of my thesis for trans* movement building in the U.S. context, with emphasis on working with institutions while also transforming the movement beyond a reliance on those very institutions. The key implications of my project include the need for medicine and law to

value gender self-determination rather than arbitrary gate-keeping, the need for the erasure of pathology as a means to access trans related resources, and the need for a societal shift away from understanding gender nonconformity as inherently harmful, deceptive and deviant. Each of these needs, if met, would re-shape the oppressive discourses and structures that make it harder for transpeople to live our lives with dignity and freedom, and in ways we ourselves desire.

Since the publication of the court decisions considered in this project, several important legal and medical advances that directly affect transgender people have occurred. In order to contextualize my conclusions, I will briefly discuss three main advances: the replacing of GID with Gender Dysphoria in the DSM-V, the removal of surgical requirements in order to change one's gender with the Social Security Administration and the protection of transgender students under the federal civil rights law, Title IX. These three progressive moves represent a massive cultural shift in how U.S. society negotiates the existence of trans*/GNC people, and generally bodes propitiously for the lives of transpeople currently and in future generations to come. However, the reliance on pathology as well as an unquestioning of the gender binary still bolsters each advancement to varying degrees. Given the scope of this project, a deeper analysis around how the gender binary is still maintained within these recent advancements will be explored in a future paper. I will now lay out the basics of these three changes and conclude with implications for trans* movement building.

The first shift occurred in May of 2013 when the Diagnostic and Statistics Manual for Mental Disorders, the DSM-V included the removal of Gender Identity Disorder and replaced it with Gender Dysphoria. According to the American Psychiatric Association

(APA) Gender Dysphoria is characterized by “a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 2013, 1). This definition differs from that of GID in that it is far more general and vague, rather than the detailed requirements of GID that included things like “strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex” or “strong preference for playmates of the other sex” or even that “the disturbance is not concurrent with a physical intersex condition” (APA 2000, 581). The new definition of Gender Dysphoria also does not include much language around genitalia as GID did. The American Psychiatric Association explains that the “DSM-5 aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender. It replaces the diagnostic name “gender identity disorder” with “gender dysphoria,” as well as makes other important clarifications in the criteria. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition” (APA 2013, 1). While this change in language, particularly the statement that gender nonconformity is not in itself a mental disorder represents a gargantuan shift away from pathology—and that should not be underrated—it still centralizes the gender variant individual as the cause of such “distress” many trans*/GNC people feel related to their gendered experience. The truth is that the very idea of gender nonconformity in the U.S. is a direct product of colonization.

As Mogul, Ritchie and Whitlock describe in *Queer (In)justice*, colonizers imposed strict gender binary standards as a mechanism for social control over the native population (and of their fellow Europeans). (Mogual, Ritchie and Whitlock 2011). As transpeople, our dysphoria does not exist in a vacuum where we simplistically and individually wrestle with our “desire to be treated as the other gender” (APA 2000). Rather, our dysphoria is a historical product of colonization and the current societal remnants of the weapon that is the gender binary. This “distress” or “dysphoria” is in fact a harm created by a society with a heteronormative gender binary system. This “condition” that “causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 2013) is a product of the historical legacy of the oppressive gender binary regime. I do not in any way intend to downplay the immense cultural shift towards understanding, appreciation and empowerment of transpeople that I see this change representing, but it must be understood that this current incarnation of pathology still centers the gender variant individual as the problem and moreover, maintains the need for a diagnosis in order to, for example, get insurance coverage for gender related medical treatments and procedures.

Transpeople and allies must continue to agitate for the complete removal of pathology around gender nonconformity in not only manuals such as the DSM, but in insurance policies that require this type of diagnosis in order to provide coverage for gender affirming treatments and procedures. The people with power in these institutions need to be in conversation with other relevant institutions so that the integrity of such policy changes can be preserved.

Only a month later, in June of 2013 the Social Security Administration (SSA) announced a new policy for updating Social Security records to reflect a person's gender identity. Under the new policy, a person can change their gender on their Social Security records by submitting either government-issued documentation reflecting a change (such as a new state I.D. or Driver's License, a U.S. passport, a birth certificate or court order) or a certification from a physician confirming that they have had "appropriate clinical treatment for gender transition" (SSA 2013, 1). This policy replaces SSA's old policy, which required documentation of sex reassignment surgery in order to change one's gender marker. One's gender does not appear on the actual Social Security card and it also does not affect one's Social Security benefits. The SSA claims it uses aggregated data about gender only for statistical and research purposes (SSA 2013, 1).

This is a huge victory for the trans*/GNC community and specifically for transgender people who wish to change their gender marker in the SSA record. It means that the SSA no longer sees a need to police transgender people's right to gender self-determination (within the gender binary). People no longer have to seek out astronomically expensive surgeries in order to obtain the gender marker that they most identify with. That policy change alone alleviates current effects of the historical legacy of the oppression of gender nonconforming people as well as financial barriers to changing one's gender marker that represents their self-determined gender identification. In theory, it erases the reliance on pathology, but the facts are more complicated.

The SSA's removal of surgical requirements does not directly address pathology around gender nonconformity, but indirectly affirms it. In order to obtain a new passport, birth certificate or court order that shows or recognizes the correct gender most states

require some kind of “safe passage” letter described above, which must come from a medical professional. Moreover, some states require the person to have undergone surgeries in order to change their gender marker. So while this new policy represents a forceful leap towards gender self-determination, it still affirms the dominant knowledge that understands gender nonconforming people as mentally ill and in need of medical and/or psychiatric control. While the SSA is the face of the federal government and ultimate holder of personal records, it does not exist in a vacuum. Conflicting state laws and statutes prohibit the full integrity of this policy. In order for the SSA to wholly recognize gender self-determination its policy would not require any supplemental gate-keeping documents, but rather the person’s intent to change their gender marker would be sufficient. There are ways; however, that we as transpeople can avoid the omnipotent reach of pathology while also playing its game in order to get what we need. I will discuss this after I outline the last major shift towards a more just world for gender nonconforming people.

On April 29th of 2014 The Office for Civil Rights (OCR) in the U.S. Department of Education issued official guidance, which makes clear that transgender students are protected from discrimination under Title IX. Title IX is a federal civil rights law that prohibits discrimination on the basis of sex in federally funded education programs and activities. Specifically, the guidance states that “Title IX’s sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and OCR accepts such complaints for investigation.” (OCR 2014, 5). Thus, gender nonconforming students are now a protected class of persons.

The guidance builds on previous federal settlements and court cases, including a case in a California school district where a transgender boy was excluded from school restrooms and field trip accommodations. After some preliminary research it was difficult to find any primary source documentation, which spoke to OCR’s rationale or intent behind this official guidance; however, it is reasonable to assume that the increase in cases involving trans-specific discrimination and the subsequent media coverage have been and are shifting the ways in which powerful agencies such as the OCR choose to either restrict or allow gender nonconformity in various settings.

While it is unclear in the language of the document whether or not the student must meet standards of Gender Dysphoria² it seems as though its reach extends beyond the confines of pathology to include anyone who, as it states, fails to “conform to stereotypical notions of masculinity or femininity” (APA 2013, 1). The inclusion of transgender students will undoubtedly lead to greater protection of gender nonconforming students—at least on paper—but we cannot know how this change in law will be enforced in each individual school and district. Transpeople and allies would strengthen the trans* movement by pushing for greater clarification on this expansion (this is not to say that people are not already doing so). Even when powerful institutions amend laws in progressive ways we must remain vigilant in holding those institutions accountable. Lastly, as Spade spells out in his recent book, *Normal Life* we cannot rely on legal reform to lead the movement (Spade 2011). However, we need not cut off our nose to spite our

² For a person to be diagnosed with Gender Dysphoria, there must be a “marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 2013, 1).

face. We need to be realistic and work with institutions when necessary, even if that means temporarily using the master's tools to get what we need from them.

While all three policy changes rest on a logic that to varying degrees defers to pathology, those of us invested in gender self-determination can use these advances as legal and cultural benchmarks while interfacing with powerful institutions, groups, and individuals. They can provide leverage for our more transformational work. While I agree with Audre Lorde's statement, "For the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change" (Lorde 1984, 2) I believe we must prioritize trans*/GNC people's current life circumstances and obstacles over allegiance to a principle or ideology. "Genuine change" may not begin to occur for several decades, if at all. In the meantime, living, breathing trans*/GNC people are struggling to meet basic life needs and if it means temporarily using the master's tools to alleviate some of that suffering then I think we should at least try to do that. This leads to the next section, where I introduce several on-the-ground projects and movements that are both engaging with dominant and mainstream institutions while also doing transformational work around gender self-determination.

Trans* movement building need not reinvent the wheel, but rather can benefit greatly from examining the structure, vision and work of existing organizations, people and projects that are addressing institutional harm in transformative ways. I will introduce the work of the Chicago Metropolitan Battered Women's Network (MBWN) Court Watch program, the Transformative Justice Law Project of Illinois' (TJLP) Name Change Mobilization Project and the Howard Brown Health Center's (HBHC) THInC

program to highlight some of the radical work already being done around gendered institutional harm. Each of these organizations, projects and programs address one or all of the key implications of my project: the need for institutions to listen to trans*/GNC people's needs as voiced by themselves, the need for the erasure of pathology as a means to access trans related resources, the need for institutions to support gender self-determination and the need for a societal shift away from understanding gender nonconformity as inherently harmful, deceptive and deviant.

While the Chicago Metropolitan Battered Women's Network (CMBWN) does not do specific work around trans*/GNC issues and people its Court Watch Project intervenes the court's victim blaming as it relates to violence against women, and sexism broadly conceived. Like those who have experienced gender-based violence, trans*/GNC people are seen as the origin for our "condition," and are similarly not listened to or taken seriously while explaining our experience and our needs. The movement for gender self-determination could benefit from adapting a version of the CMBWN's Court Watch Project for trans*/GNC people not only in domestic violence cases, but all kinds of cases. The Court Watch Project exists to "promote accountability, transparency and adherence with the Illinois Domestic Violence Act" (CMBWN 2014) by recruiting volunteers to attend and observe both civil and criminal domestic violence court proceedings. Volunteers observe things like whether or not the affected person was listened to or taken seriously, if the judges, attorneys or bailiffs make any sexist or derogatory comments, etc. These observations are not only given to the judges on a regular basis, but are entered into a database to be analyzed and compiled for presentation of an annual Court Watch Report. This community oversight of the courts has the best interest of those affected by

domestic violence in mind and is an excellent model of a community holding an institution—especially one that claims to be neutral—accountable (CMBWN 2014). This project intervenes in the institutional violence of victim blaming and sexism by providing feedback, criticism and observation to the courts, with annual reports. The movement for gender self-determination could adapt a similar project for trans*/GNC people, which could expose and work to decrease discrimination on the basis of gender identity or expression. Moreover, similar types of reports could be created so that there is an increase in research around how trans*/GNC people are treated under the law.

The second project addresses institutional harm specifically targeted at trans*/GNC people by providing “free, zealous, life-affirming, and gender-affirming holistic criminal legal services” (TJLP 2014). The Transformative Justice Law Project of Illinois works on a case-by-case basis, taking referrals from organizations or individual people (TJLP 2014). The project, which is comprised entirely of volunteer attorneys and non-attorneys also coordinates the Name Change Mobilization where trained attorneys and volunteers assist trans*/GNC people in filing petitions to legally change their names and/or gender marker on official pieces of identification, and provide follow-up support by accompanying the petitioner to their court hearing and helping them navigate the name change and/or gender marker change processes at places like the DMV, the Social Security Office, the Center for Vital Records and Statistics, etc. As a former name change petitioner and current volunteer I can attest to the life-changing work TJLP is doing. For example, because many trans*/GNC people face employment discrimination purely based on our physical appearance, having a legal name and gender marker that might not reflect that appearance can compound workplace discrimination. The same set of

problems can occur in school settings, during interactions with the police or even in places like bars where people must show IDs to get in. Having a name and gender marker on official identification documents that reflects how one sees themselves can greatly reduce the levels of transphobic discrimination and violence that many trans*/GNC people face daily. We volunteers and attorneys are on the twelfth floor of the Daley Center every last Friday of the month for six hours, ready to assist our queer and trans*/GNC family, while also being a visibly queer and trans*/GNC presence in a conservative setting. Over the few years that this project has been up and running, the project attorneys have built relationships with the judges and clerks, which have greatly benefited the trans*/GNC people the project supports. Attorneys have also set meetings with judges to intervene some arbitrary choices made by some judges, such as electing to require a birth certificate at one's name change hearing (a requirement which is not in the statute). TJLP sees "advocacy within the criminal legal system as a harm reduction approach to support and empowerment" (TJLP 2014) and is a huge national contributor to the movement for gender self-determination. TJLP enacts a radical and transformative strategy to working within the confines of a dominant institution while also transforming it.

The last example of on-the-ground work around gender self-determination comes in the form of Chicago's Howard Brown Health Center's THInC program, which was created for clients of the health center who wish to access hormones. The Howard Brown Health Center is the leading LGBT health center in the Midwest region of the U.S. and offers a range of services to that population. THInC stands for Trans Hormones – Informed Consent and is a "comprehensive 3-step program designed to assist you in

accessing hormones in an efficient, supportive and validating manner” (HBHC 2010). The THInC brochure states, “While other local clinicians and medical providers may follow standards of care that require clients to demonstrate “lived experience,” or get a letter from a therapist before accessing hormones, Howard Brown has chosen to empower its clients to make choices for themselves about *their* lives and *their* transitions. As a result, our hormone process is based on the concept of “informed consent.”” (HBHC 2010). This means that the person would meet with a “hormone advocate,” who is also a licensed therapist to determine if that person has the cognitive ability to make an independent decision and also has the information needed to make an informed decision. As someone who went through the THInC program to access testosterone I felt affirmed and respected during each step of the program. I simply met with a medical provider to begin comprehensive blood work and discussed why I would like to begin taking testosterone and also brought up potential health concerns, then met with the hormone advocate for about half an hour, during which time we discussed the effects of testosterone and I briefly explained my desire to begin taking it. The last appointment was again with the medical provider where he discussed the results of my blood work and determined that it was safe for me to take testosterone. I was given the prescription that day then returned a few days later to learn how to properly inject the hormone. Howard Brown’s THInC program should serve as a model for other health centers around the country. It places the power in the hands of the trans*/GNC person rather than the medical gatekeeper, it rejects the notion that the person needs to have lived as the opposite gender for an arbitrary amount of time in order to access hormones, and it respects the trans*/GNC person as an autonomous being with the ability and power to

make decisions about their life. The movement for gender self-determination should agitate for more health centers embracing this type of gender affirming programming. The field of nursing, for example, is moving in the direction of community-based healthcare partly because of the disconnect between traditional models of care and the lived realities of actual people (Bellack 1998). More medical institutions need to latch on to this progression by embracing more patient and community led models of care.

Lastly, the movement for gender self-determination need not be as insular as it is, but rather can benefit from creating alliances across difference so that gendered institutional harm, broadly understood, can be addressed and alleviated from many angles. For example, transpeople could build relationships with those who are working on decriminalizing sex work or those who are working on creating more survivor-centered domestic violence laws. As Cathy J. Cohen envisions in her groundbreaking article, “Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?” a new politics that centralizes “one’s relation to power, and not some homogenized identity” (Cohen 1997, 438) as a more privileged factor in determining one’s political comrades. She envisions the nonnormative and marginal positions of various groups of people as “the basis for progressive transformative coalition work” (Cohen 1997, 438). So, for example, the white transman who loses custody of his child because one judge decides his gender transition is not legitimate enough for him to be seen as a legal male (and therefore his marriage null) and the black nontrans woman who goes to prison for shooting an attacker in self defense have been duped by the same institutional logic that marginalizes them because of their nonnormative positions.

Law prefers strict, definable categories. Because trans*/GNC people do not fit within one of those categories, the heteronormative gender binary, the law is often confused by our very existence and so it defers to pathology, the dominant source of knowledge production around trans*/GNC people. The institution of law needs to expand its understanding of what it means to be a human being so that all persons are protected from discrimination, not only those who fit within the accepted contours of what it means to be a man or woman in contemporary U.S. society. We need to reject the dominating individual rights-based framework as not just some people, but all people should be able to get what they need in order to survive. The movement for gender self-determination must work within a critical trans* politics by holding institutions accountable. We can do that by agitating for policy changes on a local level (ie. Howard Brown Health Center) as well as on a national and global level (ie. Social Security, the U.S. Constitution, WPATH policies). Ultimately, in order to increase trans survival, transpeople need to be the decision makers leading the movement, allying ourselves with those who are marginalized under the same flawed logic, and working with dominant institutions to demythologize harmful dominant wisdom about us, while empowering and strengthening ourselves and the communities to which we belong.

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