

MEDICAL TRANSGRESSIONS IN AMERICA'S PRISONS: DEFENDING TRANSGENDER PRISONERS' ACCESS TO TRANSITION-RELATED CARE

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INTRODUCTION

With Chelsea Manning's case making headlines¹ and the hit television show *Orange Is the New Black* highlighting the struggles of a trans woman in prison,² the public is slowly becoming aware of the complex issues facing transgender prisoners. Although it is difficult to determine the precise size of this population,³ a 2009 study by Brown and McDuffie estimates that approximately 750 prisoners in the United States identify as transgender.⁴ This is a relatively small portion of the U.S. prison population,⁵ but it represents a sizable

1 See, e.g., Bill Mears, *Chelsea Manning Sues to Get Transgender Medical Treatment*, CNN (Sept. 24, 2014, 1:55 PM), <http://www.cnn.com/2014/09/23/justice/chelsea-manning-lawsuit> [<http://perma.cc/98MX-N6TY>]; Matt Sledge, *Chelsea Manning Sues Pentagon for Hormone Therapy: 'I Do Not Believe I Will Be Able to Survive.'* HUFFINGTON POST (Sept. 23, 2014, 4:53 PM), http://www.huffingtonpost.com/2014/09/23/chelsea-manning-lawsuit_n_5870360.html [<http://perma.cc/2P68-N3AX>]; Sandhya Somashekhar, *Chelsea Manning Files Suit Over Military's Decision Not to Provide Hormone Treatment*, WASH. POST (Sept. 23, 2014), <http://www.washingtonpost.com/news/checkpoint/wp/2014/09/23/chelsea-manning-files-suit-over-militarys-decision-not-to-provide-hormone-treatment> [<http://perma.cc/H27C-Z2L2>].

2 See, e.g., Jamilah King, *The Women's Prison Issues to Watch for in 'Orange is the New Black.'* COLOR LINES (June 4, 2014, 7:00 AM), http://colorlines.com/archives/2014/06/the_womens_prison_issues_to_watch_for_in_orange_is_the_new_black.html [<http://perma.cc/C2GS-W4NM>]; Gael F. Cooper, *Manning's Gender-Swap Request Echoes Prison Plot on 'Orange is the New Black.'* TODAY (Aug. 22, 2013, 12:14 PM), <http://www.today.com/popculture/manning-s-gender-swap-request-echoes-prison-plot-orange-new-6C10972388> [<http://perma.cc/EJZ6-C39Y>]; EJ Dickson, *"She's A Survivor,"* SALON (July 25, 2013, 12:15 PM), http://www.salon.com/2013/07/25/laverne_cox_on_her_orange_is_the_new_black_character_shes_a_survivor [<http://perma.cc/45UZ-DDF7>].

3 This is largely due to the lack of data provided by the Department of Corrections or the Bureau of Prisons, and the difficulty researchers face in collecting this data themselves due to, among other things, difficulty in gaining access to these individuals and hesitance from many prisoners in wanting to self-identify with the risk of negative repercussions for them while they're incarcerated.

4 Valerie Jenness & Sarah Fenstermaker, *Agnes Goes to Prison: Gender Authenticity, Transgender Inmates in Prisons for Men, and Pursuit of "The Real Deal,"* 28 GENDER & SOC'Y 1, 10 (2014).

5 Approximately 0.05% of the prison population, according to data from the United States Bureau of Justice Statistics in the same year. See BUREAU OF JUSTICE STATISTICS, *Correctional Populations in the United*

portion of America's transgender population. Nearly one in six transgender Americans—and almost half of the African American transgender population—has been incarcerated in a state or federal prison.⁶ Although the issues and concerns of this population have gained more attention in legal scholarship, academia, public policy, and social discourse in recent years, many issues are still largely unresolved for transgender inmates, including their access to medical care.

Transgender individuals have struggled to gain access to comprehensive medical care for decades, and this difficulty is only exaggerated by the confining and often life-threatening conditions of prison.⁷ Prison officials routinely prevent transgender prisoners from receiving access to transition-related health care such as hormone therapy or sex-reassignment surgery.⁸ Given the history of incarceration in the United States, this issue largely affects those who are multiply-marginalized,⁹ not only by their gender identity but often also based on their race and socioeconomic status.¹⁰ The dominant legal argument used to secure medical treatment for transgender prisoners is rooted in the Eighth Amendment's language regarding "cruel and unusual punishments."¹¹ Specifically, legal advocates have argued that gender dysphoria—the state of distress brought on by a disconnect between one's gender identity and biological sex—constitutes a "serious

States, 2010, <http://www.bjs.gov/content/pub/pdf/cpus10.pdf> [<http://perma.cc/W3WR-3BNS>] (last visited Jan. 30, 2015) (providing statistics from 2000-2010).

6 LAMBDA LEGAL, *TRANSGENDER PRISONERS IN CRISIS*, http://www.lambdalegal.org/sites/default/files/publications/downloads/transgender_prisoners_in_crisis.pdf [<http://perma.cc/EZ2R-58SB>] (last visited Jan. 30, 2015).

7 *Id.*

8 *Id.*

9 I use "multiply-marginalized" here to define those whose identity is at the intersection of two or more groups that have historically been socially disadvantaged, excluded, or relegated to a position of marginal importance, influence, or power. *See generally* MULTIPLE MINORITY IDENTITIES: APPLICATIONS FOR PRACTICE, RESEARCH, AND TRAINING (Reginald Nettles & Rochelle Balter eds., 2012) (discussing multiple stigmatized and marginalized identities through a holistic lens and suggesting strategies for assisting multiply-marginalized populations).

10 *Id.*; *see also* Darren Rosenblum, "Trapped" in *Sing Sing: Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 507 (2000) ("Transgendered prisoners' lives reflect the nature of multiply-oppressed identities in which the particularized nature of the oppression commingles with other oppressions to constitute a graver form of victimization.").

11 U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.").

medical need”¹² and therefore cannot be deliberately ignored by prison staff. Although gender dysphoria has been found to be a serious medical need in some cases, there is no unanimous agreement among courts on this issue, and the United States Supreme Court has not addressed the question.

While the progress some courts have displayed in finding that gender dysphoria constitutes a serious medical need is encouraging, there is a serious flaw in the analysis that many of these courts apply. Specifically, in the vast majority of cases in which a court has found gender dysphoria to constitute a serious medical need, the plaintiff has resorted to extreme and incredibly dangerous actions of self-remedy—attempted suicide and/or genital self-mutilation.¹³ There is simply no reason that a prisoner should have to reach this level of physical and psychological trauma before a court will categorize his or her¹⁴ condition as serious enough to warrant treatment. While the case law around this issue certainly does not state that gender dysphoria only meets the standard of “serious medical need” upon the attempt of these acts of self-harm, the case history strongly suggests that these incidents play a critical role in the courts’ findings.¹⁵ In fact, few cases that are brought on Eighth Amendment grounds lack mention of attempted suicide or genital mutilation.¹⁶ This pattern poses a great harm to the transgender prison population and minimizes—if not fully disregards—the serious nature of gender dysphoria in and of itself. Furthermore, framing this argument within the context of medical need necessarily pathologizes the transgender community by describing non-conforming gender identity as an illness, and creates a difficult tension between securing access to treatment and advocating for the acceptance of transgender individuals and their gender identity.

Part I of this Note will provide a background on gender dysphoria and will introduce the concept of prison as a uniquely and problematically gendered space. Part II will

12 See *Estelle v. Gamble*, 429 U.S. 97, 97 (1976) (establishing the standard of what constitutes a violation of the Eighth Amendment in cases of medical need).

13 *Infra* Part III.

14 It is worth noting that even the language we use to discuss this issue reinforces the gender binary, as English traditionally has no third-person, singular, gender-neutral pronoun. Although gender-neutral pronouns such as “xe,” “ze,” and “hir” have been gaining popularity, the male- and female- specific pronouns “he” and “she” are still the dominant pronouns used and expected in conversation, informal, and formal writing.

15 *Infra* Part III; see, e.g., *Kosilek v. Spencer*, No. 21-2194, 2014 WL 7139560 (1st Cir. Dec. 16, 2014); *De’Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003).

16 *Infra* Part III.

introduce the standard of “serious medical need” that is used in Eighth Amendment jurisprudence, with particular focus on how courts have applied this standard to mental health concerns, a category that includes gender dysphoria. Part III will introduce the central argument that, while increasingly more courts have found gender dysphoria or gender identity disorder to be a serious medical need, they have done so predominantly—and thus problematically—in cases in which the plaintiff has taken extreme measures to remedy his or her lack of treatment. This arguably establishes a pattern whereby attempted suicide and self-surgery become metrics for evaluating the severity of gender dysphoria, and implies that gender dysphoria is not deserving of treatment until it has reached these catastrophic levels. Part IV will address the tension between using medical rhetoric to secure necessary rights for prisoners and avoiding the pathologization of the transgender community that is inherent in the Eighth Amendment argument. Part V will conclude by providing alternative legal arguments as well as broader policy suggestions that may be used alongside the traditional Eighth Amendment argument to secure medical care for transgender inmates.

I. Background on Gender Dysphoria and the Gendered Dynamic of Prison

The stigma and marginalization associated with transgender identity is compounded by the oppression of incarceration. Understanding these two factors in tandem allows for a more holistic analysis of the unique issues facing transgender prisoners, particularly as they seek medical care. Sub-part A will provide background on transgender identity and gender dysphoria, and define many relevant terms that will be used throughout this Note. Sub-part B will address the uniquely and problematically gendered nature of prison and the ways in which it disadvantages gender non-conforming prisoners.

A. Background on Gender Dysphoria and Transgender Identity

Gender dysphoria¹⁷ is a term, often used in a medical context, to describe the severe

¹⁷ This paper uses the term “gender dysphoria” as opposed to “gender identity disorder” or “gender non-conformity.” The term “gender dysphoria” has been adopted by the DSM-5, in which it has replaced the manual’s use of “gender identity disorder.” WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 208 (2011), http://www.wpath.org/uploaded_files/140/files/IJT%20SOC%20V7.pdf [<http://perma.cc/X245-37E5>]. Nonetheless, many court opinions cited use the term “gender identity disorder,” and so to the extent that passages are cited the two terms may be thought of synonymously. “Gender non-conformity” is markedly distinct from “gender dysphoria” as it refers to “the extent to which a person’s gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex” without referencing the “discomfort or distress” that is central to the definition of “gender dysphoria.” *Id.* at 5. As such, “only *some* gender non-

distress caused by a discrepancy between the sex a person was assigned at birth (and its accompanying gender role expectations) and a person's gender identity.¹⁸ This implies a marked difference that many scholars and medical professionals have noted between sex, a biological categorization, and gender, a social construct. Conflating gender and sex improperly creates ubiquitous categories of male and female that purport to present all gender possibilities by promoting the gender binary of male and female as the “irreducible essence of gender.”¹⁹ Systems that operate solely within this limiting binary fail to cover the full spectrum of gender identity and thus serve to marginalize and oppress those who do not fit neatly within the biological and gendered categories of male or female.²⁰

The current *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-5”) describes the condition of gender dysphoria as being characterized by “the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender,” noting that “many are distressed if the desired physical interventions by

conforming people experience gender dysphoria.” *Id.* See also AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTIC MANUAL OF MENTAL DISORDERS (DSM-5) (2013); AM. PSYCHIATRIC ASS’N, GENDER DYSPHORIA FACT SHEET (2013), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf> [<http://perma.cc/9UZN-7W3R>] (“[G]ender 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.”).

18 WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *supra* note 17. “Gender identity” refers to an individual’s own psychological and personal identification as a man, woman, or other gender (e.g., agender). When a person’s gender identity corresponds with the sex assigned to them at birth, that person is described as being “cisgender.” When a person’s gender identity or expression is different from those typically associated with their sex assigned at birth, that person may be described as being “transgender.” See, e.g., *Sexual Orientation and Gender Identity Definitions*, HUMAN RIGHTS CAMPAIGN (“HRC”), <http://www.hrc.org/resources/entry/sexual-orientation-and-gender-identity-terminology-and-definitions> [<http://perma.cc/3SKS-N9TN>] (last visited Mar. 9, 2015); *Definition of Terms*, GENDER EQUITY RESOURCE CTR., http://geneq.berkeley.edu/lgbt_resources_definiton_of_terms [<http://perma.cc/K7QH-FR6C>] (last visited Mar. 9, 2015).

19 Rosenblum, *supra* note 10, at 504. For the distinction between gender and sex, see Jenness and Fenstermaker, *supra* note 4, at 8; WORLD HEALTH ORG., *What Do We Mean by “Sex” and “Gender”?*, <http://apps.who.int/gender/whatisgender/en/index.html> [<http://perma.cc/7H6H-P6LM>] (last visited July 22, 2015) (noting that “‘sex’ refers to the biological and physiological characteristics that define men and women,” while “‘gender’ refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women”); see also AM. PSYCHOL. ASS’N, DEFINITION OF TERMS: SEX, GENDER, GENDER IDENTITY, SEXUAL ORIENTATION (2011), <http://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf> [<http://perma.cc/2CTT-FBW8>]; see generally Candace West & Don H. Zimmerman, *Doing Gender*, 1 GENDER & SOC’Y 125 (1987) (discussing the ways in which individuals perform gender based on societal constructs, and differentiating gender from sex and sex category).

20 Rosenblum, *supra* note 10, at 504.

means of hormones and/or surgery are not available.”²¹ Gender dysphoria is associated with clinically significant distress, must last for at least six months, and be manifested in at least two of the following ways:

- 1) a marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics);
- 2) a strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);
- 3) a strong desire for the primary and/or secondary sex characteristics of the other gender;
- 4) a strong desire to be of the other gender (or some alternative gender different from one’s assigned gender);
- 5) a strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender);
- 6) a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).²²

While official sources like the DSM-5 have attempted to use their particular rhetoric to

21 AM. PSYCHIATRIC ASS’N, *supra* note 17. In explaining why the term “gender identity disorder” has been recently replaced with “gender dysphoria,” the APA’s Gender Dysphoria Fact Sheet states that:

[p]ersons experiencing gender dysphoria need a diagnostic term that protects their access to care and won’t be used against them in social, occupational, or legal areas. . . . Replacing “disorder” with “dysphoria” . . . is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is “disordered.”

GENDER DYSPHORIA FACT SHEET, *supra* note 17. Furthermore, while the DSM-5 hopes to clarify that those experiencing gender dysphoria are not “ill,” it also refused to “remove the condition as a psychiatric diagnosis [as that] would jeopardize access to care.” GENDER DYSPHORIA FACT SHEET, *supra* note 17. *See also* Jennifer Sumner & Valerie Jenness, *Gender Integration in Sex-Segregated U.S. Prisons: The Paradox of Transgender Correctional Policy*, in *HANDBOOK OF LGBT COMMUNITIES, CRIME, AND JUSTICE* 229, 237 (Dana Peterson & Vanessa R. Panfil eds., 2014).

22 AM. PSYCHIATRIC ASS’N, *supra* note 17; *see also* Silpa Maruri, Note, *Hormone Therapy for Inmates: A Metonym for Transgender Rights*, 20 CORNELL J.L. & PUB. POL’Y 807, 812 (2011); *see also* Bradley A. Sultan, Note, *Transsexual Prisoners: How Much Treatment is Enough?*, 37 NEW ENG. L. REC. 1195, 1200 (2003).

mitigate the stigma associated with gender dysphoria and its perception as an illness, gender dysphoria still very clearly receives the status of a psychiatric condition by its inclusion in the DSM-5 and has been recognized in the medical community as a legitimate mental health condition, with potential physical manifestations.²³

The recommended treatment process for people experiencing gender dysphoria often comes in three parts. First, individuals must participate in regular psychiatric counseling or psychotherapy.²⁴ This phase allows the transgender individual to discuss his or her gender-related distress with a medical professional who can assist the patient through the treatment process and assess the degree of severity of the individual's gender dysphoria.

In the second phase, the individual must live openly as the gender with which he or she identifies for at least one or two years.²⁵ This often involves dressing as the gender with which one identifies and may also involve beginning hormonal treatment, cosmetic surgery (e.g., breast augmentation, facial cosmetic surgery), and other procedures such as electrolysis.

Finally, once the individual is confident that he or she is ready to make the full, physical transformation and has spent time both examining his or her gender and experiencing life as the desired gender, the individual may seek sex-reassignment surgery.²⁶ Not all transgender individuals desire this procedure. For those who do, the process involves vaginoplasty for transgender females (the process of removing the spongiform erectile tissue from the penis and using the remaining skin to create a vestibule area and a labia minora, which are then inverted to create a vagina) and phalloplasty for transgender males (the surgical creation of a penis involving lengthening of the urethra and clitoral enlargement or skin grafting from another part of the body).²⁷ Transgender individuals who have not completed this third phase are considered "pre-operative," although this term is a misnomer given that many "pre-operative" individuals have undergone several surgical procedures, with the exception of vaginoplasty or phalloplasty.²⁸

23 Sultan, *supra* note 22, at 1200.

24 See, e.g., Rosenblum, *supra* note 10, at 509–10; 1 RTs. OF PRISONERS § 4:36 (4th ed. 2014).

25 Rosenblum, *supra* note 10, at 509–10.

26 Rosenblum, *supra* note 10, at 509–10.

27 Rosenblum, *supra* note 10, at 509–10.

28 Rosenblum, *supra* note 10, at 510.

This treatment procedure is similar to that established by the World Professional Association for Transgender Health (“WPATH”), the preeminent authority on treatment of those suffering with gender dysphoria.²⁹ WPATH’s suggestions follow those described above and include: changes in gender expression and role (which may involve living full- or part-time in the gender role consistent with one’s gender identity), psychotherapy, hormone therapy, and surgery.³⁰ For its part, the National Commission on Correctional Health Care (“NCCHC”) recommends that treatment should follow accepted standards outlined by professionals in the field, such as WPATH, and references treatment options such as hormone therapy, surgery, and treatment for genital self-harm or surgery complications as necessary. NCCHC also expressly states that blanket policies (such as those that ban treatment entirely or provide it only to the degree it was received prior to incarceration) are inappropriate and treatment must be decided on a case-by-base basis. Individualized treatment policies such as these contemplate the complexity of gender dysphoria as well as its specificity in that it describes a particular and severe distress with one’s gender identity.

Transgender,³¹ in contrast to gender dysphoria, is a broad term that describes any person

29 WPATH provides one of the most well-recognized and relied upon set of standards for transgender treatment. As noted by the American Psychiatric Association’s Task Force on the Treatment of Gender Identity Disorder, no professional organization of mental health care providers—including the APA—has its own recommendations for the treatment of gender dysphoria, and instead mental health professionals typically follow WPATH’s guidelines. *See* AM. PSYCHIATRIC ASS’N, REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER (2011).

30 WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *supra* note 17.

31 In discussing how the term “transgender” functions along and against the existing gender binary, it is worth noting that much of the legal scholarship and case law regarding transgender individuals focuses on transgender women, leaving transgender men largely out of the discussion or, at best, merely implying their issues within a larger discussion about transgender identity. Darren Rosenblum, a Professor of Law at Pace University, has commented on this issue, and his careful analysis is worth reproducing in full:

Although transgendered men comprise about half of the transgender population, case law generally addresses the concerns of transgendered women. There is a concomitant skewing of scholarship toward this group. Reasons for the lack of emphasis on transgendered men include the fact that most gender clinics were directed at transgender women rather than men; that phalloplasty is a relatively recent and expensive procedure compared with vaginoplasty; and perhaps most importantly, that there is a male bias in the perspective of researchers. Also, social pressures prevent women from self expression of gender and sexual identity.

Rosenblum, *supra* note 10, at 512–13. Although Rosenblum posits his argument within the context of the

whose gender identity or gender expression³² differs from the gender roles typically associated with the sex he or she was assigned at birth.³³ Not all transgender people experience gender dysphoria.³⁴ The broad category of transgender encompasses both pre- and post-operative transgender individuals, genderqueer individuals, cross-dressers, the androgynous, and other gender non-conforming people.³⁵ Because gender identity is fluid and exists on a spectrum, the broad nature of transgender identity is key to providing individuals a way to identify that does not narrow their own gender identity or expression.

traditional gender binary and thus alludes to some problematic gender conceptions in his discussion (e.g., that social pressures prevent women from gender expression and that this thought can be directly applied to transgender men who may or may not identify with the social pressures placed on cis-, and potentially also trans-, women), he is correct in noting that there are many forces which inform the way we frame and focus the discussion of transgender individuals. For the purposes of this Note, any reference to transgender individuals will speak equally to transgender men and transgender women alike unless otherwise stated, and the pronouns used are intended to reflect this unless directed at a particular transgender individual. Nonetheless, it is important to note this gap in the scholarship and legal precedent, and to be aware of how this gap itself is founded in normative views of the gender binary. Even this Note's attention to the courts' emphasis on genital self-mutilation (also described as "self-castration") impliedly assumes that the victim is a transgender woman, as transgender men cannot alter their genitals to make them resemble a penis or testicles, while a transgender woman in great distress may attempt to cut off her penis to make her genitals more similar to a vagina. This implicit bias in the legal discourse can be seen as disadvantaging transgender men further, by not only failing to discuss their unique issues, but in fact making it harder for them to bring strong claims if self-surgery is emphasized as such a critical factor.

32 See WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, *supra* note 17. "Gender expression" refers to the ways in which individuals manifest and present their gender identity (e.g., through mannerisms, hair and clothing choices, appearance, speech, behavior, etc.). Through gender expression, individuals signal the gender that they identify with and wish to be understood as. Gender expression, like gender identity, may comport with or be different from the typical gender assumptions associated with the sex one is assigned at birth. See, e.g., AM. PSYCHOL. ASS'N, THE GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH LESBIAN, GAY, AND BISEXUAL CLIENTS, *Definition of Terms: Sex, Gender, Gender Identity, Sexual Orientation*, <http://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf> [<http://perma.cc/UV35-Y4P9>]; *Gender Expression*, GILL FOUND., <http://gillfoundation.org/grants/gender-expression-toolkit/gender-expression> [<http://perma.cc/8A5M-CRP6>] (last visited Mar. 9, 2015).

33 *Glaad Media Reference Guide – Transgender Issues*, GLAAD, <http://www.glaad.org/reference/transgender> [<http://perma.cc/S9EX-WVF4>] (last visited Jan. 29, 2015).

34 See Sultan, *supra* note 22, at 1201.

35 See, e.g., NAT'L CTR. FOR TRANSGENDER EQUALITY, TRANSGENDER TERMINOLOGY, http://www.courts.ca.gov/documents/Transgender_Terminology.pdf [<http://perma.cc/9CYB-Y9MV>]. Genderqueer is a term used by some individuals who "identify as neither entirely male nor entirely female." Cross-dressing is defined as dressing in clothing that is "traditionally or stereotypically worn by members of the opposite sex"; cross-dressers often, however, "have no intent to live full-time" as the other sex. Androgyny refers to those who are intermediate between the traditional genders of male and female or who reject gender roles entirely.

Medical definitions, however, often do narrow the broad understandings of transgender with simplistic and limited definitions.³⁶ Similarly, many courts address transgender identity and gender dysphoria/gender identity disorder without recognizing the differences between these terms. As discussed in more detail in Part III, courts may feel that those who are diagnosed with gender dysphoria but do not manifest it through attempted suicide or self-castration simply fall somewhere along the spectrum of transgender and do not meet the standard of “seriousness” articulated in Eighth Amendment jurisprudence. While this kind of analysis at least recognizes that transgender identity occurs along a spectrum, it misunderstands the severe physical and psychological distress that is inherent to gender dysphoria.

In order to conduct an analysis of transgender prisoners and their right to medical care, it is crucial to understand the distinction between the medical terminology used and its application to particular expressions of gender identity. In general, courts have used much simpler definitions to describe transgender identity and gender dysphoria than recognized definitions such as those contained within the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* promulgated by the World Professional Association for Transgender Health.³⁷ The courts’ definitions are not entirely incorrect; rather they fail to grasp the complexities of gender identity and its various representations among individuals. The specific context of prison as a space built around the gender binary adds to this complexity for those who strive to realize their gender identity and expression while they are incarcerated.

B. Context of Prison as a Uniquely and Problematically Gendered Space

Raewyn Connell—an Australian sociologist and author of the seminal 1995 work *Masculinities*—advanced a theory of “the implications of ‘contradictory embodiment’ . . . as understood through an empirical examination of transsexuality in all its complexity.”³⁸ Connell advocated for a focus on the practical implications of achieving and expressing gender in specific contexts, arguing that “[t]he contradiction has to be handled, and it has

36 Sumner & Jenness, *supra* note 21, at 236.

37 See WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *supra* note 17 (defining gender nonconformity and gender dysphoria and examining the often ignored complexities inherent in these identities).

38 Jenness & Fenstermaker, *supra* note 4, at 6–7 (referencing Raewyn Connell, *Transsexual Women and Feminist Thought: Toward New Understanding and New Politics*, 37 SIGNS: J. WOMEN IN CULTURE & TECH. 857 (2012)).

to be handled at the level of the body, since it arises in the process of embodiment.”³⁹ For transgender inmates, the process of embodiment occurs in the uniquely and problematically gendered context of prison. The difficulties that many transgender individuals face in society—such as expressing their gender identity in a predominantly gender binary space and combatting harassment and discrimination—are exacerbated by the context of prison, which not only privileges the normative gender binary, but in fact is largely founded in it.

One of the most basic principles of the prison system is that all inmates can be categorized as either male or female based on their biological sex. This assumption underscores virtually every aspect of the system’s structure.⁴⁰ The prison context largely assumes that sex and gender are both binary and synonymous. Even where prison policies speak to presentation of self, there is a presumption that the male/female sex segregation inherent in the system simultaneously constitutes gender segregation.⁴¹

Although some may argue that American prisons are “at once sex-segregated and multi-gendered,”⁴² in fact prison as a contextual environment rarely recognizes the multi-gendered nature of those within its confines. Prisoners are typically separated based on their sex assigned at birth, and many other factors central to the prison context—the presence of guards, strip searches, medical care, and interactions between prisoners—are addressed in terms of sex and the gender binary. Sex segregation and discrimination are rampant, and indeed central to the prison context, leading advocates and scholars to describe prison as “arguably the most sex segregated of institutions.”⁴³

Transgender prisoners disrupt prison’s central assumption of the gender binary, and in doing so find themselves in serious risk as they attempt to navigate a system that was not designed for them and, on the whole, is not adapting to accommodate them. As such, they are forced to operate within the unique and often predatory prison environment, which is defined by the deprivation of both freedom and markers of individuality often used outside

39 Connell, *supra* note 38, at 868.

40 Jenness & Fenstermaker, *supra* note 4, at 13.

41 Sumner & Jenness, *supra* note 21, at 253.

42 Sumner & Jenness, *supra* note 21, at 229.

43 Jenness & Fenstermaker, *supra* note 4, at 5, 10–11 (“[David Valentine] describes confinement institutions as ‘the most sexist (as well as racist) environment in the country, bar none’ and explains that within this institutional environment ‘the prison subculture fuses sexual and social roles and assigns all prisoners accordingly.’”).

of prison.⁴⁴ Operating in this environment strips many transgender prisoners of their ability to define their own gender expression and places them in a dangerous limbo that augments and compounds many of the difficulties that transgender individuals face in everyday life.

These difficulties can be defined, in part, as category problems. Category problems are those that arise when a transgender individual enters and navigates a space defined within the constricting framework of the gender binary.⁴⁵ Transgender prisoners are forced to fight against these category problems to establish basic rights for themselves in their pursuit of safety and gender authenticity. To do so they engage in activities such as gender-appropriate dress, use of gender-preferred pronouns, and hormone therapy to pursue gender authenticity.⁴⁶ Such actions become key as transgender prisoners fight against the sex segregation, transphobia, and limited resources of the prison system.⁴⁷

Even with these concerns being addressed by advocates, scholars, and prisoners themselves, very few formal policies exist to address the unique issues facing the transgender prison population. An increasing number of policies regarding transgender medical treatment have become available, but the number is still relatively small and policies are rarely formalized.⁴⁸ Many states still have no policies at all to address the treatment of transgender prisoners; and many policies lack specific guidance regarding medical care, and ultimately tend to have failed implementations.⁴⁹

44 Jenness & Fenstermaker, *supra* note 4, at 7.

45 Rosenblum, *supra* note 10, at 514.

46 Rosenblum, *supra* note 10, at 514.

47 Rosenblum, *supra* note 10, at 516; *see also* Jenness and Fenstermaker, describing how transgender prisoners often used the word “clocked” to indicate that

their ability to pass . . . is effectively denied The institutional context in which they reside determines which side of the sex categorical binary system they are thought to belong It is here where the institutionalization of sex category membership interacts so critically with gender practice.

Jenness & Fenstermaker, *supra* note 4, at 14.

48 Sumner & Jenness, *supra* note 21, at 242.

49 Sumner & Jenness, *supra* note 21, at 242. *See also* Laura R. Givens, Note, *Why The Courts Should Consider Gender Identity Disorder a Per Se Serious Medical Need for Eighth Amendment Purposes*, 16 J. GENDER RACE & JUST. 579, 583–84 (2013).

Up until May 2011, the Federal Bureau of Prisons maintained a “freeze frame” policy for transgender prisoners, whereby the treatment level that transgender inmates could receive was frozen at the level it was when they entered prison.⁵⁰ This policy—which assisted only a portion of the transgender population and had large barriers to access such as difficulty in obtaining past medical records—was successfully challenged by inmate Vanessa Adams in 2010.⁵¹ The Bureau of Prisons’ new policy provides for individualized medical and mental health evaluations for any prisoner who asserts having gender identity disorder, and medical and mental health care in accordance with accepted standards of care that will “not be precluded solely due to level of services received, or lack of services, prior to incarceration.”⁵²

This new policy is progressive and encompasses significantly more members of the transgender prison population than did its predecessor. However, due perhaps to issues such as the relative newness of the policy and the lack of transparency in the prison system, it is difficult to know how effective the policy actually is. Ultimately, the Bureau of Prisons’ memorandum does not guarantee its implementation, and given the practicalities of prison life—discrimination against transgender prisoners, lack of available doctors and therapists qualified to assess prisoners with gender dysphoria, limited resources, and general bureaucracy—the language of the policy does not appear to have been fully and thoroughly implemented in recent years. Additionally, prison policies regarding transgender inmates tend to reaffirm the sex and gender assumptions of the prison system, and promote a penological culture of control (e.g., control of prisoner’s bodies and their gender autonomy), with significant deference given to corrections administrators.⁵³

The few policies that do exist are firmly rooted in a framework that juxtaposes punishment and gender such that behavior that does not conform with the gender binary may lead to punishment, and one of the inherent sanctions of the prison system may be a lack of gender autonomy. Transgender bodies become effectively “locked up” as they are

50 U.S. DEP’T OF JUST., FED. BUREAU OF PRISONS, MEMORANDUM RE: GENDER IDENTITY DISORDER EVALUATION AND TREATMENT (2011), <http://www.glad.org/uploads/docs/cases/adams-v-bureau-of-prisons/2011-gid-memo-final-bop-policy.pdf> [<http://perma.cc/B2L9-Y2MC>] [hereinafter FED. BUREAU OF PRISONS, 2011 MEMORANDUM].

51 *Adams v. Fed. Bureau of Prisons*, 716 F. Supp. 2d 107, 107 (D. Mass. 2010); *Federal Bureau of Prisons Makes Major Changes in Transgender Medical Policy*, GAY & LESBIAN ADVOCATES & DEFENDERS, <http://www.glad.org/current/pr-detail/federal-bureau-of-prisons-makes-major-change-in-transgender-medical-policy/> [<http://perma.cc/98S2-H4U2>] (last visited May 27, 2015).

52 FED. BUREAU OF PRISONS, 2011 MEMORANDUM, *supra* note 50.

53 Sumner & Jenness, *supra* note 21, at 231.

placed within a system that does not accommodate their existence and is not adequately prepared to protect them. This creates extremely dangerous conditions. The result is that the overwhelming majority of transgender prisoners have to fight for even the most basic care, and many are excluded from transition-related care entirely.⁵⁴

Empirical research has shown that transgender prisoners face a more dangerous situation in prison than do cisgender prisoners.⁵⁵ Not only do transgender prisoners have extreme difficulty getting access to necessary medical care, but they are also thirteen times more likely to be sexually assaulted than their cisgender counterparts.⁵⁶ Ultimately transgender prisoners operate within the context of a penological crisis that itself is situated within the larger frameworks of structural violence and discrimination that pervade American society. This violence tends to be worse in sex-segregated spaces such as jails, prisons, and immigration detention facilities. As such, legal arguments regarding transgender prisoners and their care must be founded not only in an in-depth understanding of gender non-conformity and gender dysphoria, but also in a thorough understanding of the extremely problematic and gender-restrictive space that prison is.

II. The “Serious Medical Need” Standard and its Application to Mental Health

A common course of action for transgender prisoners who are denied medical care is to bring a federal lawsuit for injunctive relief under 42 U.S.C. Section 1983, which provides in relevant part that “[e]very person who . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured[.]”⁵⁷ As such, Eighth Amendment claims are brought by transgender litigants trying to secure their constitutional rights to medical treatment protected by 42 U.S.C. Section 1983. The response to these claims among the courts of appeals has been mixed,⁵⁸

54 Alison Flower, *Dee Farmer Won a Landmark Supreme Court Case on Inmate Rights. But That’s Not the Half of It*, VILLAGE VOICE (Jan. 29, 2014), <http://www.villagevoice.com/2014-01-29/news/dee-farmer-v-brennan-prison-rape-elimination-act-transgender-lgbt-inmate-rights/2> [<http://perma.cc/8788-JCFQ>].

55 Lori A. Sexton, Valerie Jenness & Jennifer Macy Sumner, *Where the Margins Meet: A Demographic Assessment of Transgender Inmates in Men’s Prisons*, 27 JUST. Q. 835 (2010).

56 *Id.*

57 42 U.S.C. § 1983 (2012).

58 Linda Chin, *A Prisoner’s Right to Transsexual Therapies: A Look at Brooks v. Berg*, 11 CARDOZO WOMEN’S L.J. 151, 169 (2004).

with courts applying Eighth Amendment jurisprudence differently. This is only somewhat surprising given the ambiguity that already exists in the way courts apply the Eighth Amendment standards set out in the seminal case *Estelle v. Gamble*⁵⁹ to mental health concerns.

In *Estelle*, the Supreme Court decided the case of Respondent, J.W. Gamble, an inmate of the Texas Department of Corrections⁶⁰ and held that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ . . . proscribed by the Eighth Amendment.”⁶¹ The Court discussed the Amendment’s purpose of concretizing the broad goals of dignity, civilized standards, humanity, and decency,⁶² and noted that prior decisions had found punishments that do not coincide with society’s evolving standards of decency to be “repugnant to the Eighth Amendment.”⁶³ Given that inmates have no choice but to rely on prison officials for medical treatment—the lack of which can result in physical torment or a lingering death—the government was found to have an obligation to provide necessary medical care.⁶⁴ This requirement extends not only to instances of torture or impending death, but also to less severe cases in which denial of medical care would result in pain and suffering that serves no penological purpose.⁶⁵

Although *Estelle* made medical care mandatory for prisoners, it did not clarify the factors to be used in completing the Eighth Amendment analysis. Subsequent cases filled in these gaps by clarifying the holding of *Estelle* through a two-prong test combining objective and subjective elements.⁶⁶ First, the medical deprivation alleged must be, objectively, “sufficiently serious,”⁶⁷ and second, the prison official(s) involved must have

59 *Estelle v. Gamble*, 429 U.S. 97, 97 (1976).

60 *Id.* at 98.

61 *Id.* at 104.

62 *Estelle*, 429 U.S. at 102 (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

63 *Id.* at 102 (quoting *Trop v. Dulles*, 356 U.S. 86, 100–01 (1958)).

64 *Id.* at 103.

65 *Id.*

66 *Givens*, *supra* note 49, at 586.

67 *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (holding that prison officials may be held liable under the Eighth Amendment for denying humane conditions only if they know that inmates face substantial risk of serious harm and disregard that risk).

a “sufficiently capable state of mind” demonstrating “‘deliberate indifference’ to inmate health or safety.”⁶⁸ Many courts have followed this two-prong test, and in doing so have articulated various standards of what constitutes a sufficiently serious medical need. While many definitions have been employed, courts are not consistent in their interpretations of what constitutes a serious medical need.⁶⁹ The standards courts apply range from a very broad definition that encompasses any condition that results in unnecessary and wanton infliction of pain to a narrow standard that recognizes a serious medical need only when it has been specifically diagnosed.

Eighth Amendment jurisprudence applies the holding of *Estelle* in both physical and mental health contexts, thus providing a general, legal gloss to the definition of “serious medical need” as it applies to mental health.⁷⁰ However, there is great ambiguity as to what a serious medical need looks like within the mental health context. Many courts will consider a mental health concern to be a serious medical need when it manifests itself in a way that causes the inmate physical harm. Focusing on physical manifestations of mental illness negates the independent seriousness of the mental health concern by conflating the mental illness with its resulting physical harms and mandating treatment only as a result of those physical manifestations.

68 *Farmer*, 511 U.S. at 834; see also COLUMBIA HUMAN RIGHTS LAW REVIEW, A JAILHOUSE LAWYER’S MANUAL, CH. 23 § B(1).

69 CTR. FOR CONSTITUTIONAL RTS., *Your Right to be Free from Cruel and Unusual Punishment*, JAILHOUSE LAWYER’S HANDBOOK (2010), available at <http://jailouselaw.org/your-right-to-be-free-from-cruel-and-unusual-punishment/> [<http://perma.cc/3HQX-295A>].

70 See, e.g., *Goodrich v. Clinton Cnty. Prison*, 214 Fed. App’x 105, 111 (3d Cir. 2007) (“A mental illness may constitute a serious medical need.”); *Sims v. Lay*, 216 Fed. App’x 599, 600 (8th Cir. 2007) (acknowledging plaintiff’s “serious mental health needs”); *Gregoire v. Class*, 236 F.3d 413, 417 (8th Cir. 2000) (“It was . . . well established . . . that a risk of suicide by an inmate is a serious medical need.”) (citing *Rellergert v. Cape Girardeau Cnty.*, 924 F.2d 794 (8th Cir. 1991)); *Pardue v. Fromm*, 94 F.3d 254, 254 (7th Cir. 1996) (addressing plaintiff’s suicidal behavior due to depression and a drug-induced psychosis as a “serious medical need” although holding that defendant was not deliberately indifferent); *Doty v. Cnty. Of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994); *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992); *Inmates of the Allegheny Cnty. Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979) (“Although most challenges to prison medical treatment have focused on the alleged deficiencies of medical treatment for physical ills, we perceive no reason why psychological or psychiatric care should not be held to the same standard.”); *Atkins v. Cnty. of Orange*, 372 F. Supp. 2d 377, 377 (S.D.N.Y. 2005) (implying that a psychotic episode is a “serious medical need”); *Viero v. Bufano*, 901 F. Supp. 1387, 1393 (N.D. Ill. 1995) (“Although *Estelle* originally used the phrase [‘serious medical needs’] in the context of physical health needs, it has since been applied to mental health needs as well.”); *Coleman v. Wilson*, 912 F. Supp. 1282, 1319 (E.D. Cal. 1995) (describing mental illness as a “serious medical [need]”).

Part of this issue stems from the fact that traditional medical care and psychiatric treatments are often inappropriately conflated.⁷¹ While it is important for courts to recognize physical consequences of mental health issues as serious medical needs requiring appropriate treatment, this potentially invalidates mental illnesses such as gender dysphoria by failing to acknowledge their own inherent severity. Focusing predominantly on the physical manifestations of mental health issues as opposed to the mental health issues themselves negates the purpose of insisting that mental health needs are addressed alongside physical needs under the *Estelle* framework.

Where courts do provide a standard by which to assess serious mental health needs, it tends to be articulated in either very general terms based on obviousness, or rather narrow terms founded on a medical diagnosis. These standards at least recognize that the mental health issues need not manifest themselves in physical harm or risk of suicide⁷² to meet the necessary threshold level of severity.⁷³ This understanding is analogous to the well-established principle that physical health concerns do not have to be life threatening or test the limits of the human ability to bear pain to qualify for treatment under the Eighth Amendment.⁷⁴

Other factors that may be considered include whether “any reasonably competent prison counselor or administrator would realize that denying a prisoner needed psychotropic drugs might trigger liability under *Estelle*.”⁷⁵ Explicit definitions of serious mental health needs are rare, leaving many courts to rely solely on medical diagnoses or prescriptions, or on their own interpretations of what an average person would find to be obviously serious. In litigation, making medical diagnoses becomes the role of an expert witness who ideally, but not always, has prison health care experience and a thorough understanding of transgender issues. The requirement of a medical diagnosis can be problematic, however, in that it may exclude from Eighth Amendment protections prisoners who suffer greatly from their mental health needs, but who experience difficulty having that recognized by the prison’s medical professionals or by expert witnesses (particularly those testifying on the prison’s behalf).

71 *Greason v. Kemp*, 891 F.2d 829, 833 (11th Cir. 1990).

72 *Viero*, 901 F. Supp. at 1393 (“Even if the Complaint had not sufficiently alleged the existence of a substantial suicide risk, it would still survive the current motion[.]”).

73 *Id.*

74 *Brock v. Wright*, 315 F.3d 158, 163 (2d Cir. 2003).

75 *Greason*, 891 F.2d at 834.

While expert witnesses are used to establish the factors necessary for a court's analysis of the serious medical need standard, a court's interpretation of those factors based on an obviousness standard is problematic. Even a court's view of whether the expert testimony proves a mental health condition is sufficiently severe may be worrying. As noted in the *Handbook of Correctional Mental Health*, the definition of a serious medical need has been criticized because a person without a medical background may not interpret the signs and symptoms of mental illness to be obvious and may not comprehend the effect of the illness on the individual.⁷⁶ As such, courts should—and some in fact do—rely heavily on well-established knowledge of the medical community, specifically the *Diagnostic and Statistical Manual of Mental Disorders*.

The DSM undergoes an intensive revision process undertaken by members of the American Psychiatric Association, a 36,000-member organization of physicians specializing in the diagnosis, treatment, prevention, and research of mental illness.⁷⁷ Although assessing serious medical need is a conclusion for a medical professional (unlike deliberate indifference, which is a legal conclusion), courts must still weigh the totality of the evidence they receive from medical professionals in finding that this objective prong has been satisfied. Courts that are guided by the DSM can avoid some of the difficulty of assessing this evidence, and can guarantee greater consistency by following widely accepted and uniform medical standards.

The courts' approach to the "serious medical need" standard as it applies to mental health provides a helpful gloss on the jurisprudence surrounding gender dysphoria. Often analyzed in terms of its physical manifestations, the standard for assessing gender dysphoria lacks uniformity and a thorough consideration of the practical factors underlying gender dysphoria. Because of a general lack of understanding of the condition, gender dysphoria rarely presents itself as "obvious" to those assessing it. In addition, it can be extremely hard for a transgender prisoner to receive a medical diagnosis, given the bureaucracy of the prison system and the limited resources and education regarding transgender issues of many prison and medical staff.⁷⁸

76 HANDBOOK OF CORR. MENTAL HEALTH (Charles L. Scott, M.D., ed., 2d ed. 2010) (quoting *McGuckin v. Smith*, 974 F.2d 1050 (9th Cir. 1992)).

77 AM. PSYCHIATRIC ASS'N, *supra* note 17.

78 See, e.g., Jenness & Fenstermaker, *supra* note 4, at 11 ("[P]rison officials do not have an agreed upon definition of transgender that is used to identify and classify inmates, and they often conflate transgender with homosexual prisoners."); 1 RTS. OF PRISONERS § 4:1.80 (4th ed. 2014) ("[The court in *Coleman v. Brown* stated] that '[s]ystemic failures persist in the form of inadequate suicide-prevention measures, excessive administrative

Given the ambiguity surrounding mental health assessments under the Eighth Amendment, it is no surprise that courts are varied in their decisions as to whether gender dysphoria is a serious medical need.⁷⁹ Some, like the Seventh Circuit, have found gender identity disorder to be a serious medical need.⁸⁰ This holding is particularly progressive in that the court did not rely on the presence of severe physical acts of self-remedy in reaching its holding, and specifically found for the plaintiffs even where none of them had attempted suicide or genital mutilation. Others, like the Fifth Circuit, lack any explicit precedent on the issue.⁸¹ Finally, other circuits such as the First, Fourth, and Eighth, have precedent suggesting that gender dysphoria requires treatment as a serious medical need, though they do not adopt a standard that gender identity disorder is a per se serious medical need.⁸² Because gender dysphoria is not a per se medical need, courts must address its severity on a case-by-case basis in order to decide if it meets the Eighth Amendment threshold. While this is essential to ensuring that run-of-the-mill medical needs do not create constitutional violations, there is no reason for the decision to turn on whether an inmate has attempted suicide or self-castration.

III. Emphasis on Attempted Suicide or Genital Self-Mutilation in Assessing Gender Dysphoria as a Serious Medical Need

Because gender dysphoria, with its specific and critical element of clinically significant distress,⁸³ is categorized as a mental health concern, the analytical framework described above is often applied by courts in assessing its validity as a serious medical need. Sub-part A outlines how this already ambiguous mental health framework is applied to the complex concern of gender dysphoria. Sub-part B then discusses the problematic ways

segregation of the mentally ill, lack of timely access to adequate care, insufficient treatment space and access to beds, and unmet staffing needs.”).

79 Givens, *supra* note 49, at 587–93.

80 See *Fields v. Smith*, 653 F.3d 550, 550 (7th Cir. 2011); see also Givens, *supra* note 49, at 592–93 (comparing how different circuits have addressed the question of whether gender identity disorder constitutes a serious medical need).

81 See *Praylor v. Texas*, 430 F.3d 1208, 1208 (5th Cir. 2005) (holding that refusal to provide hormone therapy did not violate the Eighth Amendment, while “[a]ssuming, without deciding, that transsexualism does present a serious medical need.”).

82 See *Kosilek v. Spencer*, No. 21-2194, 2014 WL 7139560, at *1 (1st Cir. Dec. 16, 2014); *De’Lonta v. Angelone*, 330 F.3d 630, 630 (4th Cir. 2003); *White v. Farrier*, 849 F.2d 322, 322 (8th Cir. 1988); see also Givens, *supra* note 49, at 588.

83 See AM. PSYCHIATRIC ASS’N, *supra* note 17.

in which courts have heavily relied on evidence of attempted suicide and genital self-mutilation in performing this serious medical need analysis.

A. Mental Health Framework as Currently Applied to Gender Dysphoria

The history of Eighth Amendment analysis of mental health needs, as described above, illuminates much of the courts' approach to defining and understanding gender dysphoria. Although the courts' analysis comports with the jurisprudence stemming from *Estelle*, it often falls short of embodying the spirit of *Estelle*—namely proscribing unnecessary and wanton infliction of pain that serves no penological purpose, and ensuring dignity and humanity for all prisoners. Noting the specific ways in which mental health standards inform the discussion of gender dysphoria for transgender prisoners reveals where some of the major analytical and practical gaps lie.

Although gender dysphoria is inherently related to both the mind and the body, courts have made clear that it falls within the category of mental illness, particularly for the purpose of applying Eighth Amendment analysis.⁸⁴ The framework of obviousness is rarely, if ever, applied in assessing gender dysphoria because of its complexity.⁸⁵ Rather than applying an explicit “obviousness” standard, courts will often pay significant attention to some of the most serious, physical consequences of a prisoner's unattended gender dysphoria. When such extreme evidence is available, courts have little difficulty qualifying gender dysphoria as a serious medical need. However, even still, they often require supplementary assessments from medical professionals due to the complex, medical nature of gender dysphoria.

Courts rely heavily on medical definitions and the opinions of medical professionals in assessing gender dysphoria. This comports with the jurisprudence dictating that a medical diagnosis is an essential factor in qualifying a mental health concern as a serious medical need. This standard, however, has been deemed problematic by some advocates in the transgender community who recognize that while medicalizing gender identity allows access to necessary treatment, it does so by painting transgender identity as a sickness⁸⁶ and

84 See Susan S. Bendlin, *Gender Dysphoria in the Jailhouse: A Constitutional Right to Hormone Therapy?*, 61 CLEV. ST. L. REV. 957, 961 (2013) (“Typically, [g]ender [d]ysphoria is diagnosed as a mental illness.”).

85 *Id.* at 962.

86 *Id.* at 961.

prohibiting treatment “unless a prisoner is pathologized via psychiatric diagnosis.”⁸⁷ These requirements put transgender prisoners in a position where “people are making choices for you and you’re not so much having a choice for yourself.”⁸⁸

This tension, which will be addressed in Part IV, has become a necessary one given the legal framework within which the mental health needs of prisoners are understood. One of the biggest sources of authority for both courts and medical professionals is the *Diagnostic and Statistical Manual of Mental Disorders*. Until the release of the DSM-5 in 2013, courts relied on the DSM-IV, which used the terminology of “gender identity disorder” to describe what the DSM-5 now labels as “gender dysphoria.” In order to satisfy the objective prong of the *Estelle* test, transgender inmates have appealed to the DSM to classify their condition as a mental illness that requires treatment like any other.⁸⁹ Courts and corrections departments have also turned to the DSM to provide a framework for establishing the clinical criteria that a transgender prisoner must meet to benefit from any existing policies regarding gender identity.⁹⁰

As mentioned in Part I, these policies themselves have undergone changes in recent years that reflect the complex nature of gender dysphoria and the need for individualized care that considers a wide range of factors. The Bureau of Prisons’ current policy regarding treatment of transgender prisoners states that prisoners who assert having gender identity disorder will have access to medical and mental health professionals trained in accordance with the DSM and approved standards of care.⁹¹ These professionals are to provide individualized assessments based on the inmate’s treatment and life experience prior to incarceration as well as his or her gender-related experiences during incarceration (such as hormone therapy, surgical interventions, and experiences and expressions of gender identity).⁹²

87 Sumner & Jenness, *supra* note 21, at 231.

88 Interview by Columbia Queer Alliance et al. with Cece McDonald at Columbia University (Apr. 15, 2015).

89 See Bendlin, *supra* note 84, at 961.

90 Cf. Sumner & Jenness, *supra* note 21, at 237; Givens, *supra* note 49, at 583–84 (“[O]f the . . . states . . . that have an official policy dictating treatment of transgender prisoners, many policies rely on standard references, like the DSM-IV, to define key terms, such as ‘transgender’ or ‘transsexual.’”).

91 FED. BUREAU OF PRISONS, 2011 MEMORANDUM, *supra* note 50.

92 FED. BUREAU OF PRISONS, 2011 MEMORANDUM, *supra* note 50.

The Department of Justice recently supported this approach to care for transgender inmates in a Statement of Interest it filed in the case of *Diamond v. Owens*.⁹³ In discussing the similarity between freeze-frame policies and blanket prohibitions against treatment, it noted “both types of policies strike an arbitrary line that preclude individualized medical evaluations and proscribe physicians’ ability to provide appropriate care.”⁹⁴ Diamond herself describes her time in prison as a “treacherous journey” in which a “minor brush with the law has turned into a death sentence” involving gross human rights violations.⁹⁵ As such, the Department of Justice categorized freeze-frame policies as unconstitutional.⁹⁶ In these ways, the various players in the care of transgender inmates seem to recognize that gender dysphoria is “a very complex medical and psychological problem” . . . [and] [t]here is no reason to treat [it] differently than any other psychiatric disorder.”⁹⁷

Yet the treatment of gender dysphoria does differ from that of other psychiatric disorders. Because gender dysphoria may be difficult to evaluate purely as a mental health issue—due to, among other things, a lack of resources, gaps in knowledge about the condition, personal bias of the correctional, judicial, and medical personnel involved, and its lack of innate physical symptoms—most courts tend to require more than a diagnosis of gender dysphoria before they will find that the serious medical need prong has been satisfied.⁹⁸ The history of Eighth Amendment analysis of mental health issues demonstrates that mental health concerns can be serious medical needs in the same way that physical needs can, yet there is a standard by which the mental health concern is not enough on its own. Exactly what one must show beyond a diagnosis of gender dysphoria is not made clear by the legal precedent, yet there is a strong suggestion that a serious physical harm stemming from gender dysphoria satisfies this pseudo-requirement.

In its Statement of Interest, the Department of Justice described gender dysphoria as easily meeting the Eighth Amendment’s serious medical need standard separate from the

93 Statement of Interest at 14–17, *Diamond v. Owens*, No. 5:15-cv-50-MTT-CHW (M.D. Ga. Apr. 3, 2015).

94 *Id.* at 16.

95 S. POVERTY LAW CTR., *Ashley Diamond, A Transgender Prisoner in Georgia, Speaks Out*, YOUTUBE (Feb. 20, 2015), https://www.youtube.com/watch?t=176&v=ho_RRIuLjpY [<https://perma.cc/6GRF-ELZG>].

96 Statement of Interest at 16–17, *Diamond v. Owens*, No. 5:15-cv-50-MTT-CHW (M.D. Ga. Apr. 3, 2015).

97 *Meriwether v. Faulkner*, 821 F.2d 408, 412–13 (7th Cir. 1987).

98 *Givens*, *supra* note 49, at 596.

evidence of self-harm documented in the case.⁹⁹ Even still, the DOJ discussed Diamond’s documented risk of self-harm, stating that “Ms. Diamond’s extensive history of attempting suicide and self-castration demonstrate that she has a second serious medical need, distinct from her diagnosis of gender dysphoria.”¹⁰⁰ The use of this language seems to urge the court to recognize the clear medical need inherent in gender dysphoria itself, while also implying an understanding that courts often look to—and sometimes even depend on—evidence of self-harm in qualifying gender dysphoria as a serious medical need.

This is not unlike some of the jurisprudence regarding mental health that evaluates a condition based on its physical symptoms, but it is nonetheless problematic in how it categorizes medical need. The use of this type of analysis “narrows the ‘eligible’ group of transgender inmates significantly, which results in a denial of a variety of treatment benefits (when they do exist) for a large group of gender variant inmates.”¹⁰¹ While denying sex-reassignment surgery or hormone therapy will not amount to cruel and unusual punishment in all cases, there are other treatments and actions, such as psychotherapy, the provision of clothing of the gender with which the inmate identifies, and housing placement, that could be denied to many transgender inmates in need due to these modes of analysis that place so much emphasis on the physical ways in which the mental condition has manifested.

Transgender inmates thus face at least two hurdles in meeting the serious medical need standard: (1) they have to obtain a medical diagnosis, and (2) they likely have to prove something more—often a physical illness or injury—as well. Acknowledging the inappropriateness of this latter standard should not take away from recognizing the difficulty in the former. Typically, any policy that does provide care for transgender inmates makes treatment contingent on the approval of medical professionals.¹⁰² However, getting a diagnosis for gender dysphoria is not a simple process. Many prisoners face

99 Statement of Interest, *supra* note 92, at 8–9 (stating that “[t]he first element is easily met in this case” and describing plaintiff’s self-harm as “separate from the underlying gender dysphoria deserving of treatment under the Eighth Amendment”).

100 Statement of Interest, *supra* note 92, at 9.

101 Sumner & Jenness, *supra* note 21, at 238 (citing *Long v. Nix*, 877 F. Supp. 1358 (S.D. Iowa 1995), in which the plaintiff sought to wear women’s clothing in a men’s correctional facility, but was denied this on the grounds that the “extent of [her] gender identity disorder [did] not constitute a serious medical need” because she refused psychiatric treatment for GID).

102 Givens, *supra* note 49, at 584.

immense bureaucracy, often tinged with bias and discrimination, in seeking out even the most basic medical consultation.

Additionally, issues of confidentiality and dual loyalty often arise in the prison health care context. While generally doctor/patient confidentiality is intended to exist in prison as it does in the outside world, certain exceptions are specific to the prison context.¹⁰³ For example, a task force undertaken by the American Psychiatric Association in 2000 found that medical confidentiality is not protected where the inmate is responsible for “the creation of disorder within the facility.”¹⁰⁴ As discussed in Part V, displays of gender non-conformity are often seen as creating disorder in the prison setting. Prisoners are likely to have difficulty seeking a diagnosis for their condition if admitting to their gender non-conformity could result in punishment. Many prison health care workers also feel a dual loyalty—to the patient and to prison security—that may impede an inmate’s ability to get a swift, thorough, and unbiased diagnosis. There is an unfortunate and ultimately dangerous lack of the resources and qualified medical professionals necessary to make these careful diagnoses for prisoners whose requests for consultation are addressed.¹⁰⁵ Once the medical analysis falls within the purview of the court, the weight of the analysis often appears to rest on the presence of extreme, physical acts of self-remedy as discussed below.

B. Improper Use of Attempted Suicide and Genital Self-Mutilation as Pseudo-Necessary Markers of Severity

Prison policies not only regularly deny transgender prisoners medical care, they also tend to risk the safety of these inmates by delaying medical treatment for as long as possible, often until the inmate has taken dangerous and drastic measures.¹⁰⁶ Courts define transgender identity in different ways, and disagree regarding what criteria should be used in assessing someone’s gender identity in terms of their medical need.¹⁰⁷ As mentioned

103 See Emil R. Pinta, *Decisions to Breach Confidentiality When Prisoners Report Violations of Institutional Rules*, 37 J. AM. ACADEMY PSYCHIATRY & L. 150, 150 (2009) (citing AM. PSYCHIATRIC ASS’N TASK FORCE TO REVISE THE APA GUIDELINES ON PSYCHIATRIC SERVICES IN JAILS & PRISONS, PSYCHIATRIC SERVICES IN JAILS AND PRISONS (2000)).

104 See *id.*

105 Givens, *supra* note 49, at 605.

106 This is unfortunately not unique to gender dysphoria, as many illnesses and ailments that occur in prison are left unattended until they have reached very dire levels.

107 Jenness & Fenstermaker, *supra* note 4, at 10.

above, gender dysphoria can present itself in many ways. Some individuals respond with feelings of extreme emotional anguish, while others exhibit signs of depression; some require only the provision of gender-appropriate garments, while others may take drastic measures if they cannot undergo physical transformation via hormone therapy or sex-reassignment surgery. However, using a standard that essentially equates seriousness of need with whether an inmate has attempted fatal acts is flawed and fails to support the purpose of the Eighth Amendment's ban against cruel and unusual punishment.

It is necessary for courts to carefully assess each case asserted by a transgender inmate to determine whether it meets the Eighth Amendment's standard. As previously discussed, just because an individual is gender non-conforming and/or identifies as transgender does not necessarily mean that that person suffers from gender dysphoria as defined in the DSM. Because gender identity occurs on a spectrum, it is admittedly difficult to adopt a per se rule that will satisfy "the objective component of an Eighth Amendment claim . . . [in which] a prisoner must allege 'a serious or significant physical or emotional injury resulting from the challenged conditions.'"¹⁰⁸ As such, while some courts have held that gender identity constitutes a serious medical need,¹⁰⁹ it has also been made clear that regardless of the holding of a particular case, it should not be assumed that gender dysphoria will meet this standard in every case in which it is alleged.¹¹⁰

108 *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (quoting *Strickler v. Waters*, 989 F.2d 1375, 1381 (4th Cir. 1993)). This is the case with many medical conditions that arise in prison, as the majority of them occur on a spectrum. Yet, the objective prong of the *Estelle* test has been deemed workable by many courts, thus implying that simply because a condition occurs on a spectrum does not mean it can't be assessed with clarity and consistency in terms of its seriousness.

109 *See, e.g., Young v. Adams*, 693 F. Supp. 2d 635, 640 (W.D. Tex. 2010) ("The appellate courts that have considered the issue have uniformly recognized gender dysphoria as a serious medical condition."). There have also been a few occurrences in which the defendant(s) has not contested the fact that "gender identity disorder" is a serious medical need. *See, e.g., Kosilek v. Spencer*, No. 21-2194, 2014 WL 7139560, at *19 (1st Cir. Dec. 16, 2014) ("That GID is a serious medical need, and one which mandates treatment, is not in dispute in this case. The parties do not spar over the fact that Kosilek requires medical care aimed at alleviating the harms associated with GID."); *Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011) ("Defendants do not challenge the district court's holding that GID is a serious medical condition."); *Brooks v. Berg*, 270 F. Supp. 2d 302, 309–10 (N.D.N.Y. 2003) ("Defendants have not argued that Plaintiff's GID is not a serious medical need.").

110 *See, e.g., Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997) ("Gender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it."); *Brooks*, 270 F. Supp. 2d at 309–10 ("Several courts have held that GID is a serious medical need . . . [although] milder gender identity disorders can be treated without resort to psychotherapy, hormone treatment, or sex reassignment therapy.").

Courts have, however, shown great uniformity in deciding that genital self-mutilation itself is a serious medical need warranting treatment such as hormone therapy.¹¹¹ While this is both important and necessary in recognizing the extreme psychological and physical struggles that some transgender inmates face, it has a tendency to create a problematic correlation between attempted suicide/self-mutilation and defining serious medical need. This method of analysis overlooks the root cause of these extreme medical needs, namely gender dysphoria itself.

Although Eighth Amendment jurisprudence makes clear that mental health concerns may be serious medical needs,¹¹² both Congress and courts have expressed, either implicitly or explicitly, that it is the physical health issues that may accompany or result from mental health needs that are of the most clear concern. Courts have expressed this in their regular reference and attention to physical manifestations of mental illness as discussed both above in Part II and in this section, and Congress made its intention clear in its 1996 passage of the Prison Litigation Reform Act (“PLRA”).

The PLRA severely limits an inmate’s ability to bring a lawsuit in federal court. Among other things, it prohibits a prisoner from filing a federal civil action for mental or emotional injury suffered while incarcerated without a showing of physical injury or the commission of a sexual act.¹¹³ This provision has been understood to mean that prisoners may seek injunctive or declaratory relief for mental or emotional injury alone, but may not do so for money damages.¹¹⁴ Because many suits brought regarding transition-related care seek injunctive relief first and foremost (e.g., hormone therapy, sex-reassignment surgery, provision of gender-appropriate clothing, etc.), this provision does not entirely conflict with the argument that physical injury should not be so decisive in determining the seriousness of gender dysphoria. Furthermore, courts are split as to whether a prisoner’s claim that her constitutional rights have been violated is barred under the PLRA absent a showing of

111 See Givens, *supra* note 49, at 594; see also *De’Lonta*, 330 F.3d at 634.

112 *Infra* Part II.

113 42 U.S.C. § 1997e(e) (2012).

114 ACLU, KNOW YOUR RIGHTS: THE PRISON LITIGATION REFORM ACT (PLRA), https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf [<https://perma.cc/3RQ9-8CVM>] (last visited May 27, 2015) [hereinafter ACLU, KNOW YOUR RIGHTS: THE PLRA]; see, e.g., *Thompson v. Carter*, 284 F.3d 411, 416 (2d. Cir. 2002).

physical injury.¹¹⁵ Regardless, however, the PLRA's insistence on a showing of physical injury demonstrates the kind of emphasis courts and Congress place on physical harm when assessing mental health claims.

This misplaced emphasis severely disadvantages potential plaintiffs who suffer greatly due to gender dysphoria but who have not made such extreme attempts to relieve their distress. The vast majority of cases that have been decided regarding medical treatment for transgender inmates have involved claims of attempted suicide and/or self-surgery.¹¹⁶ This potentially creates a self-fulfilling cycle in which the only claims that are brought are those that have these particular facts because they are the ones most likely to succeed. Courts might incorrectly infer from this that all potentially serious cases involve attempted suicide or self-mutilation. As noted by Jennifer Sumner and Valerie Jenness, the patterns of progress seen as more courts acknowledge gender dysphoria as a serious medical need "are at least partly due to cases that point to [these] severe withdrawal symptoms."¹¹⁷

In *De'Lonta v. Angelone*, for example, the Fourth Circuit characterized one plaintiff's serious medical need as being related predominantly to "her compulsion to mutilate herself."¹¹⁸ The court described the plaintiff's complaint as "[alleging] facts sufficient to establish that the denial of the treatment for her compulsion to mutilate herself constitutes deliberate indifference to her medical needs," mentioning gender identity disorder subsequently as a "[claim] she could prove."¹¹⁹ *De'Lonta* is an important and progressive case. It reversed the district court's order dismissing the suit, stating that De'Lonta had

115 See, e.g., *Allah v. Al-Hafeez*, 226 F.3d 247 (3d Cir. 2000); *Rowe v. Shake*, 196 F.3d 778 (7th Cir. 1999) (holding that a prisoner is entitled to judicial relief for violation of First Amendment rights regardless of physical injury); but see, e.g., *Sisney v. Reisch*, 674 F.3d 839 (8th Cir. 2012) (holding that a claim of physical injury is necessary to receive compensatory damages for a First Amendment claim); *Thompson v. Carter*, 284 F.3d 411 (2d Cir. 2002) (holding that the PLRA's requirement of a showing of physical injury applies to constitutional claims); see also ACLU, KNOW YOUR RIGHTS: THE PLRA, *supra* note 114.

116 See, e.g., *Kosilek v. Spencer*, No. 21-2194, 2014 WL 7139560 (1st Cir. Dec. 16, 2014) (in which plaintiff attempted to commit suicide twice, and attempted to castrate herself by tying a string around her testicles); *White v. Farrier*, 849 F.2d 322 (8th Cir. 1988) (in which plaintiff went on hunger strikes, threatened to commit suicide, and attempted self-castration four times using a razor, a sharpened metal cup, glass from a smashed television set, and glass from a radio. Prison officials did not provide any treatment for plaintiff's gender dysphoria, but rather treated only the resulting physical injuries and placed plaintiff in administrative confinement).

117 Sumner & Jenness, *supra* note 21, at 240.

118 *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003).

119 *Id.*

“adequately [stated] a claim for relief” that could be proven.¹²⁰ Yet the court’s strong reliance on De’Lonta’s attempts to “[stab] or cut her genitals on more than 20 occasions [since termination of hormone treatment]” indicates that De’Lonta’s case may not have been as strong without this factual background, thereby potentially creating a legal barrier for transgender inmates who do not resort to such extreme acts.

Similarly, in *Adams v. Federal Bureau of Prisons*, although the prison finally began providing hormone treatment before the case was decided, the plaintiff, Vanessa Adams, experienced four years of extreme psychological and physical trauma prior to receiving any treatment.¹²¹ Six years after entering the prison system, Adams was diagnosed with gender identity disorder but was denied hormone treatment.¹²² As a result, she attempted to hang herself in her cell, causing the prison psychologist to warn the prison that Adams presented a substantial risk of self-harm.¹²³ Regardless, no treatment was provided, and two weeks later Adams attempted to cut off her testicles using a razor.¹²⁴ Rather than begin treatment at this time, the Bureau of Prisons punished Adams for violating the prison’s policy against self-mutilation.¹²⁵ Approximately a year later, Adams was transferred to a different facility where she again requested hormone therapy and surgery.¹²⁶ When her request was once again denied, she made another attempt at self-mutilation.¹²⁷ Three years later, just days before Adams initiated court action, she was again refused treatment. At this point, Adams once again attempted self-surgery, this time fully severing her penis with a razor.¹²⁸

Circumstances like De’Lonta’s and Adams’ are disturbingly common as courts rely on physical markers and manifestations of gender dysphoria in assessing its severity. Unfortunately, for these inmates whose gender dysphoria manifests few physical signs, it is suicidal ideation, depression, and attempts of self-mutilation that become their most

120 *Id.*

121 *Adams v. Fed. Bureau of Prisons*, 716 F. Supp. 2d 107, 107 (D. Mass. 2010).

122 *Id.* at 109–11.

123 *Id.*

124 *Id.*

125 *Id.*

126 *Adams*, 716 F. Supp. 2d at 110.

127 *Id.*

128 *Id.*

effective factual tool in receiving the health care they deserve. In this way, gender dysphoria is addressed, not on its own, but in relation to and in terms of its most severe consequences. A pattern like this completely ignores the complexity of gender dysphoria. Rather than associating gender dysphoria's inherent seriousness with a plaintiff's desperate attempts to remedy the situation him or herself,¹²⁹ courts must recognize "that transsexualism is a very complex medical and psychological problem . . . [and therefore] is a serious medical need."¹³⁰

IV. The Tension Caused by Necessary Pathologization

The framework of Eighth Amendment analysis is based in medicalization. Meeting the serious medical need prong thus requires that courts and advocates describe being transgender not only as a gender identity, but as a sickness, an abnormality, and a medical need requiring a cure. Given the gendered context of prison as described in Part I, this tension between a need for treatment and a desire not to be pathologized creates a sense of double imprisonment that requires the plaintiff to present his or her gender identity as a medical phenomenon.¹³¹ Critics of this model note that medicalizing one's gender identity not only pathologizes, but also stigmatizes, the transgender community, while reinforcing an oppressive gender binary.¹³² This is similar to the ways in which homosexuality was seen as an abnormal disease of the mind deserving of a definition within the DSM until 1986.¹³³

129 *Cf.* *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) ("Gender dysphoria . . . is a serious psychiatric disorder, as we know because the people afflicted with it will go to great lengths to cure it if they can afford the cure." Here the court strongly associates the determination of gender dysphoria as a serious medical concern with what a plaintiff is willing to do in search of a "cure." The court, correlating seriousness of the medical need with "mutilation," also notes that "[s]omeone eager to undergo this mutilation [involved in sex-reassignment surgery] is plainly suffering from a profound psychiatric disorder.").

130 *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988).

131 *Rosenblum*, *supra* note 10, at 506.

132 *Sumner & Jenness*, *supra* note 21, at 238.

133 Gregory M. Herek, *Facts About Homosexuality and Mental Health*, SEXUAL ORIENTATION: SCIENCE, EDUCATION, AND POLICY, http://psychology.ucdavis.edu/faculty_sites/rainbow/html/facts_mental_health.html [<http://perma.cc/KF64-MD75>] (last visited Feb. 3, 2015) (describing the definition of ego-dystonic homosexuality in the DSM-III as being marked by "(1) a persistent lack of heterosexual arousal, which the patient experienced as interfering with initiation or maintenance of wanted heterosexual relationships, and (2) persistent distress from a sustained pattern of unwanted homosexual arousal").

There is already a severe lack of understanding regarding gender non-conformity, and the transgender community both inside and outside of prison faces a disproportionate amount of harassment, discrimination, and violence.¹³⁴ Yet the law as it stands offers few opportunities for transgender prisoners to advocate for their medical needs without contributing to many of the oppressive forces that have worked against them in the first place. In medicalized terms, “transgender prisoners are marked by disorder and pathology effectively categorized as a departure from a ‘normal’ or ‘healthy’ gender type around which correctional policies and practices in prisons for *men* and prisons for *women* are organized.”¹³⁵ In the struggle to openly express one’s gender non-conformity, a transgender person has to openly and vehemently state that he or she is “ill, sick, wrong, out of order, [and] abnormal”¹³⁶ and then prepare to “suffer a certain stigmatization as a consequence of the diagnosis.”¹³⁷ Thus, paradoxically, stigma and self-denial become the necessary foundation for open and honest gender expression while incarcerated.

This view, although requisite for legal success, does not necessarily correspond with the transgender community’s own perception of gender identity. The predominant understanding among transgender individuals is that “transgendered identity is not a principally medical condition, although physical and psychological treatments and therapies can aid a transgendered person to arrive at a healthy gender identity. Rather than finding a ‘cure’ for gender dysphoria, a healthy gender identity involves resolving the relationship among the various factors constituting gender.”¹³⁸ Such an articulation of transgender identity does not negate the role of medicine in accomplishing a full expression of one’s gender identity. However, it places the focus not only on the medicalization of gender, but also on the factors that underlie our interpretations of gender and an understanding that gender is a broad term that is not limited to only male and female.

When asked her thoughts regarding the pathologization of transgender individuals, transgender activist Cece McDonald noted, “[F]or a lot of [trans-women in prison] . . .

134 See, e.g., *Anti-Transgender Violence*, GLAAD, <http://www.glaad.org/tags/anti-transgender-violence> [<http://perma.cc/W985-UMAA>] (last visited Feb. 3, 2015) (providing a collection of articles about harassment, discrimination, and violence against transgender individuals throughout the world); *Discrimination Against Transgender People*, ACLU, <https://www.aclu.org/lgbt-rights/discrimination-against-transgender-people> [<https://perma.cc/D3TZ-SRGG>] (last visited Feb. 3, 2015).

135 Sumner & Jenness, *supra* note 21, at 253 (emphases in original).

136 Maruri, *supra* note 22, at 811.

137 Maruri, *supra* note 22, at 811.

138 Rosenblum, *supra* note 10, at 507.

they do have to go through those means of legally arguing ‘oh, I’m dealing with gender dysphoria’ and then that [comes with] the demonizing and dehumanizing of trans bodies in institutions of oppression . . . which is very damaging to the ideas of what trans-ness is.”¹³⁹ Pathologizing the transgender community “reifies the notion that those outside of the gender binarism are diseased”¹⁴⁰ and in doing so reinforces the gender dichotomy in which so much of the hatred and virulence towards transgender people is based.

The rhetoric of transgender identity itself has developed over time to reflect a turn away from conceptions of illness and disorder. The use of the word “transgender” as opposed to “transsexual” reflects a shift away from the “historical primacy of medical treatment, toward a growing awareness of the psychological element of gender identity.”¹⁴¹ Much more than a mere change in semantics, use of words such as “transgender” and “gender dysphoria” instead of “transsexual” and “gender identity disorder” show a hostility toward and discontentment with the medicalized perception of these forms of gender non-conformity—an attempt of a marginalized community to define itself and strip away the stigmatization by the medical community and society at large.¹⁴²

Medical language, however, allows courts to focus on narrow aspects of transgender identity, ignoring the broad spectrum and fluidity inherent within it. Even in the seminal case of *Farmer v. Brennan*—decided twenty-one years ago at a time when the rhetoric around transgender identity was highly medicalized—the Court described transgender people as victims of a “rare psychiatric disorder,”¹⁴³ likely not to perpetuate problematic

139 Interview with CeCe McDonald, *supra* note 88.

140 Rosenblum, *supra* note 10, at 536–37.

141 Rosenblum, *supra* note 10, at 507; *see also* GLAAD, *Media Reference Guide*, *supra* note 33 (“Transsexual . . . [is] [a]n older term that originated in the medical and psychological communities.”)

142 *See* Sumner & Jenness, *supra* note 21, at 237:

[U]ntil recently, transgender people were those diagnosed with gender identity disorder (GID) as it was written in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* The DSM-V . . . released in 2013, however, includes a significant change in which *gender dysphoria* replaces *gender identity disorder*. In this case, the change signals an effort to remove the stigma associated with the prior diagnosis while still providing an avenue for treatment.

143 *Farmer v. Brennan*, 511 U.S. 825, 829 (1994); *see also* Rosenblum, *supra* note 10, at 539:

Farmer v. Brennan demonstrates the degree to which gender transformation has become entangled with medical discourse. Precisely because Justice Souter . . . defined

views of this community, but to afford them necessary and life-saving legal protections. But that is the flaw in working within a system that is set up in this way—the boundary between protection and pathologization is extremely blurred. This leaves courts to assess gender non-conformity in terms of discrete medical factors, including, as described above, the presence of physical acts of self-harm. In essence, this medicalization—whether by means of language or legal analysis—“limits the legitimate breadth of transgender identity”¹⁴⁴ so that those who do not fall within the narrow medical or legal understanding of transgender cannot receive legal protection for the treatment they need.¹⁴⁵

While some legal scholars have taken notice of this tension, few have asked what it means for advocates or whether this tension is necessarily problematic in the fight for transgender rights. It is possible to conceptualize this tension as a battle between two different fights for justice. In essence, an advocate is left choosing between presenting a strong legal argument that, if successful, can prevent both serious physical and psychological trauma, or pushing for a new understanding of gender that allows for gender non-conforming people to exist comfortably within the existing system instead of being seen as a disruption or aberration to it. Within this setup, a true win is nearly impossible as success in one arena signals a loss in another. An advocate’s best option may be to search for alternative legal arguments that have merit, and yet do not rely on the medicalization of the transgender community. Part V will discuss this further. For decades, however, the Eighth Amendment’s ban on deliberate indifference towards serious medical need has been seen as the most realistic and successful means for securing medical care for transgender prisoners.

Can this tension exist—unmitigated—and yet not be damaging? The success of legal claims ultimately secures rights for transgender individuals in a way that allows them to gain more full and complete control of their gender identity. While medical rhetoric is necessary to accomplish this goal within the context of incarceration, perhaps we can see this as a necessary pathologization—a medical and legal aspect to gender identity that exists only in these two realms and that does not in any way fully define the community it is intended to help. One of the major critiques of the medical and legal definitions of transgender and gender dysphoria is that they do not consider the breadth of this gender identity. In arguing that pathologizing gender dysphoria in a legal context negates social

transsexualism as “[a] rare psychiatric disorder,” the prison’s treatment of Ms. Farmer was found to violate the Eighth Amendment Had her “condition” been viewed as a choice, the harm she suffered might be viewed, albeit erroneously, as her own responsibility.

144 Rosenblum, *supra* note 10, at 539.

145 Rosenblum, *supra* note 10, at 539.

progress regarding gender identity, we fall into a similar trap of failing to notice that this tactic of legal rhetoric does not describe or provide a full picture of transgender identity.

It may be possible that the two interests—legal justice and social progress—can co-exist even though, on the surface, they seem mutually exclusive. As progress continues, education and understanding increases, and perceptions change, a different legal standard may take shape that not only goes beyond the current narrow definition that problematically limits treatment for gender dysphoria to extreme cases, but also sustains legal arguments that rely on an affirmative right to gender identity and expression. Ultimately, the relationship between the Eighth Amendment and the transgender prisoners who seek its protection remains complicated due to medical, legal, and societal factors that influence not only the discourse, but also the outcome of legal proceedings. There remains a “tension between the desire of transgender people to access the means to achieve self-definition through transitioning and the compromise of self-definition that transgender people must make by accepting a [gender identity disorder] diagnosis.”¹⁴⁶ While new approaches to making a case for treatment may erode this tension over time, it is likely a tension that the transgender community and its advocates will have to work within as the law around medical care for transgender prisoners continues to develop.

V. Alternative and Complimentary Approaches for Securing Transgender Prisoners’ Medical Care

Although the Eighth Amendment provides the most oft-used and likely the strongest argument in securing medical care for transgender prisoners, there may be alternative arguments that could be used on their own or alongside the Eighth Amendment. Sub-part A will outline an alternative constitutional approach, specifically utilizing a Substantive Due Process analysis. Sub-parts B and C will provide suggestions for how to work creatively within the preexisting framework of the Eighth Amendment, by positing an alternate serious medical need framework borrowed from the Second Circuit and by strategically utilizing the Bureau of Prisons’ own language regarding prisoner safety respectively. Sub-parts D will then put forth broader suggestions for increased education and resources that are necessary under any approach to assisting transgender prisoners.

146 Maruri, *supra* note 22, at 821–22.

A. Substantive Due Process Analysis

As discussed above, the most frequently cited legal basis for securing medical care for transgender prisoners is the Eighth Amendment.¹⁴⁷ This constitutional foundation provides a strong legal argument in support of transgender prisoners, and there has already been a significant amount of progress in the development of Eighth Amendment jurisprudence in regard to transgender prisoners' medical needs. While the Eighth Amendment undoubtedly provides the strongest legal argument, it is not always easily applicable to the many aspects of prison life in which a government duty ought to arise.¹⁴⁸ There are, however, opportunities within the Fifth and Fourteenth Amendments, specifically the Due Process Clauses, that are largely ignored. While these rights are much more difficult to secure and have far less legal precedent supporting them, they provide an opportunity to advocate for medical treatment of transgender prisoners without having to describe them as psychologically ill. The Fifth and Fourteenth Amendment legal arguments operate through the assertion of a constitutional substantive due process right to gender identity. While the Supreme Court has not articulated the right to gender identity or expression as constitutionally protected, certain cases have provided a foundation upon which the argument can be made. If this could successfully be done, it would “fundamentally ameliorate the rights of transgendered prisoners . . . [and] easily [outpace] current Eighth Amendment analysis that centers on the medicalization of transgendered prisoners.”¹⁴⁹

Plaintiffs have already attempted to use the Fourteenth Amendment's Equal Protection Clause to secure rights to treatment for their gender dysphoria. These arguments—urging that transgender individuals should constitute a protected class—have been largely unsuccessful, with courts holding that “transsexuality [does] not meet the traditional indicia of a suspect classification because transsexuals are not a discrete and insular minority, and because [it has not been established that] ‘transsexuality is an immutable characteristic determined solely by the accident of birth’ like race, or national origin.”¹⁵⁰ Precedent such as this makes the Equal Protection argument very difficult for transgender prisoners seeking medical

147 See, e.g., Maruri, *supra* note 22, at 810; Kosilek v. Spencer, No. 21-2194, 2014 WL 7139560 (1st Cir. Dec. 16, 2014); Fields v. Smith, 653 F.3d 550 (7th Cir. 2011); Long v. Nix, 86 F.3d 761 (8th Cir. 1996); Brooks v. Berg, 270 F. Supp. 2d 302 (N.D.N.Y. 2003).

148 Philip M. Genty, *Confusing Punishment with Custodial Care: The Troublesome Legacy of Estelle v. Gamble*, 21 VT. L. REV. 379, 380 (1996).

149 Rosenblum, *supra* note 10, at 568.

150 Brown v. Zavaras, 63 F.3d 967, 971 (10th Cir. 1995) (quoting Holloway v. Arthur Anderson & Co., 556 F.2d 659, 663 (9th Cir. 1977)).

treatment, although there is recognition that with the recent medical, sociological, and psychological research that concludes that gender identity may be inherent in an individual, and the current legal landscape regarding issues of gender and sexual orientation, there is the possibility that courts will reevaluate their approach to Equal Protection analysis as it pertains to transgender individuals.¹⁵¹

The Due Process Clauses of the Fifth and Fourteenth Amendments, however, have rarely—if ever—been cited by a plaintiff as a basis for receiving gender-transitioning medical treatment while incarcerated. The relevant constitutional language states that no person shall be “deprived of life, liberty, or property, without due process of law.”¹⁵² The Fifth Amendment applies this right federally, while the Fourteenth Amendment is specific to the states. As such, the former is relevant in federal prisons, and the latter in state prisons.

Certain legal actions, such as the decision in *Fields v. Smith*,¹⁵³ which struck down Wisconsin’s broad statutory ban on providing hormone therapy or sex re-assignment surgery to incarcerated individuals, “support[] the view of several scholars that the Due Process Clause of the Fourteenth Amendment limits legislatures’ ability to restrict access to medical treatment.”¹⁵⁴ The Supreme Court’s decisional privacy and liberty jurisprudence, which has held that there are constitutional rights to determine whether and how to conceive a child, to express one’s sexual orientation, and to be intimately associated with the partner of one’s choosing, is also particularly instructive.¹⁵⁵ This jurisprudence has utilized the Due Process Clause’s right to privacy to protect the decisional autonomy of individuals.¹⁵⁶ Decisional autonomy and privacy protects

[a] realm for expressing one’s self-identity or personhood through speech

151 *See id.* (“Recent research concluding that sexual identity may be biological suggests reevaluating *Holloway*.”).

152 U.S. CONST. amend. V; *see also* U.S. CONST. amend. XIV, § 1 (“nor shall any state deprive any person of life, liberty, or property, without due process of law”).

153 *Fields v. Smith*, 712 F. Supp. 2d 830, 830 (E.D. Wis. 2010).

154 Case Comment, *Constitutional Law — Eighth Amendment — Seventh Circuit Invalidates Wisconsin Inmate Sex Change Prevention Act.* — *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), 125 HARV. L. REV. 650, 650 (2011).

155 Sydney Scott, Comment, “*One is Not Born, But Becomes a Woman*”: *A Fourteenth Amendment Argument in Support of Housing Male-to-Female Transgender Inmates in Female Facilities*, 15 U. PA. J. CONST. L. 1259, 1285–88 (2013).

156 *Id.* at 1285–86.

or activity. It protects the ability to decide to continue or to modify one's behavior when the activity in question helps define oneself as a person, shielded from interference, pressure, and coercion from government or from other individuals [It] limits external social control over choices about lifestyle and enhances internal control over self-expression.¹⁵⁷

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court articulated a broad concept of the liberty interest in decisional autonomy and demonstrated that the right to choose what to do with one's own body, without interference from the state, is central to one's concept of existence.¹⁵⁸ Although the Court spoke specifically to matters of family relations, its language may inform the argument that gender identity should be similarly protected. The Court described matters that involve "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy" as being "central to the liberty protected by the Fourteenth Amendment."¹⁵⁹ At the crux of this protection is "the right to define one's own concept of existence . . . [beliefs which] could not define the attributes of personhood were they formed under compulsion of the State."¹⁶⁰ Similarly, some transgender advocates note that *Lawrence v. Texas*,¹⁶¹ which in some ways created a foundation upon which to argue there is a fundamental right to autonomy for self-definition, demonstrated the Court's recognition of "some form of respect for relational[,] . . . sexual[,] . . . and personal autonomy."¹⁶²

Phrasing the case for transgender prisoners as a right to gender identity similar to the rights of bodily autonomy and self-definition articulated in cases like *Casey* and *Lawrence* brings the argument within the purview of the Fifth and Fourteenth Amendments. Gender identity, understood as being similar to issues of personal autonomy, is at the crux of the legal and social argument for treatment of transgender prisoners.¹⁶³ Beyond being a medical necessity, this frames the discussion within the broader and more empowering rhetoric

157 Judith Wagner DeCew, *In Pursuit of Privacy, Law, Ethics, and the Rise of Technology*, in *PRIVACY LAW TODAY* 22, 23–24 (Anita L. Allen ed., 2011).

158 Scott, *supra* note 155, at 1286.

159 *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

160 *Casey*, 505 U.S. at 851.

161 *Lawrence v. Texas*, 539 U.S. 558, 558 (2003).

162 Maruri, *supra* note 22, at 816.

163 Rosenblum, *supra* note 10, at 565.

of self-autonomy. This alternate way of viewing the legal issues surrounding transgender prisoners' rights is significant in how it addresses "the claims of people subjected to compulsory gendering [and] permits them to define their own gender identity without fear of discrimination."¹⁶⁴

The argument is a rather difficult one to make, however, as individual autonomy and privacy are severely restricted in the prison setting. Cases such as *Casey* and *Lawrence* were not decided against the backdrop of an inherently restrictive and penal setting, and attempting to broaden their holdings both in terms of gender identity and into the prison context would likely prove difficult given the well-established understanding that one's rights and agency are limited in prison in a way they would not be in the outside world.

Some may argue that even if gender identity were to be secured as a constitutional right, expressing one's gender would not necessitate expensive medical treatments or procedures, particularly while one is incarcerated and being provided for by tax-paying citizens. However, understanding the complexities of gender identity requires an acknowledgement that "[g]ender choice includes the ability to control and change one's own body, cosmetically, hormonally, or surgically . . . [and allowing one] to pursue a gender identity with competent medical and professional care."¹⁶⁵ Furthermore, the cost of treatment, specifically hormone therapy, is no more than that of other routine medical treatments administered to prisoners, such as provision of antipsychotic drugs or surgeries such as a kidney transplant.¹⁶⁶

Although a prisoner's right to gender expression would most likely be limited by the nature of prison,¹⁶⁷ redefining gender expression in prison would not have to mean negating it entirely or actively affirming it only in situations of the most severe and potentially fatal

164 Rosenblum, *supra* note 10, at 566 (Rosenblum also urges that "we must look behind current sex discrimination and equal protection law for the lurking fundamental right to gender identity, whose recognition would provide justice and clarity to those laws").

165 Rosenblum, *supra* note 10, at 567.

166 *See, e.g.,* *Fields v. Smith*, 653 F.3d 550, 555–56 (7th Cir. 2011) (noting that the defendants stipulated that the cost of hormone therapy was less than that of providing antipsychotic drugs—specifically approximately \$1,000 per inmate per year compared to approximately \$2,500 per inmate per year, and noting that sex reassignment surgery, although expensive, costs no more than a coronary bypass or a kidney transplant. Defendant, in fact, disclaimed any argument that prohibiting treatment is justifiable on the basis of cost savings).

167 Rosenblum, *supra* note 10, at 569 ("The fundamental right to gender identity, like other rights enjoyed by people in the free world, would necessarily undergo modification for its guarantee to prisoners, but would nonetheless provide a basis for challenging discriminatory placement and treatment practices.").

medical need. Opportunities for positive and affirmative gender expression, such as being housed based on gender, receiving clothing based on gender identity, having a trained and knowledgeable medical professional available for consultation, and providing hormone therapy or sex re-assignment surgery when such a medical professional deems it necessary for the well-being of the inmate, could potentially be made available under a due process argument.

One of the main issues addressed by advocates of this alternate approach is that even if it were to be successful on its merits, it would not create an affirmative action on the part of prison officials to assist an inmate in realizing his or her gender identity. If anything, it would only prohibit prison employees from discriminating on the basis of inmates' gender identity or prohibiting them from expressing their gender. This makes the Due Process argument "less likely . . . [to] yield significant protection in the prison context."¹⁶⁸ Typically, a win on Due Process grounds does not necessarily trigger a duty of affirmative action on the part of the State; it "does not create positive rights to government aid."¹⁶⁹ However, *Turner v. Safley* found that "a prison inmate 'retains those [constitutional] rights that are not inconsistent with his status as a prisoner or with the legitimate penological objectives of the corrections system' . . . [although] [t]he right . . . is [nonetheless] subject to substantial restrictions as a result of incarceration."¹⁷⁰

The difficulty of this is that to be successful the inmate must show that providing the relief requested is not inconsistent with a legitimate penological interest proffered by prison officials. As discussed below, specifically in Sub-part C, prison officials often reference safety and security interests when defending their actions and prison policies, and often cite reduction of sexual assault as a reason for limiting access to transition-related care. A prisoner would thus have to rebut this idea and show that no legitimate penological interest is served by withholding or limiting transition-related care. While strong arguments can be made to advance this position, great deference is given to corrections officials under *Turner* in establishing the link between the action and the legitimate interest and in balancing other factors such as the availability of alternatives and the impact on prison resources.

168 Maruri, *supra* note 22, at 816–17 (“[T]o the extent that such a model is an operative means of viewing transgender rights, this model may not aid transgender prisoners. Prison, by definition, allows the deprivation of certain fundamental rights. Incarceration inherently infringes upon fundamental rights[.]”).

169 Maruri, *supra* note 22, at 829.

170 *Turner v. Safley*, 482 U.S. 78, 95 (1987).

While overcoming this deferential standard established in *Turner* is no easy task, there is Supreme Court precedent suggesting that the context of prison may be one of only two limited instances (mental institutions being the other) in which the relationship between the individual and the State is so heavily interdependent that an affirmative duty may arise under the Due Process Clause. It is in these particular environments—places where the basic needs of individuals are left entirely in the hands of those who house and supervise them—that a higher standard may apply. For while there are other situations in which the State may owe a great duty or responsibility to those it provides for, virtually none are like the unique context of prison.

In *Deshaney v. Winnebago County Department of Social Services*,¹⁷¹ though the Supreme Court held that the Due Process Clause did not impose an affirmative action on the defendant, it noted that this analysis may be different when applied in the context of incarceration. Because prison inherently involves “the deprivation of [an inmate’s] liberty [to] care for himself,”¹⁷² affirmative duties have been placed on the State based on constitutional provisions such as the Eighth Amendment.¹⁷³ After examining *Youngberg v. Romeo*¹⁷⁴—which held that the Due Process Clause creates an affirmative duty for the State to provide involuntarily committed mental patients with services necessary to ensure their reasonable safety—the Court in *Deshaney* stated that such precedent “[stands] . . . for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.”¹⁷⁵

This, of course, echoes many of the concerns central to the Eighth Amendment and thus can be argued on the same basis that much of the current litigation about treatment for transgender prisoners already is. But the Court went on to say that any failure of the State to provide for such basic human needs “transgresses the substantive limits on state action set by the Eighth Amendment *and* the Due Process Clause.”¹⁷⁶ Thus, “[i]n the substantive due process analysis, it is the State’s affirmative act of restraining the individual’s freedom

171 *Deshaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 189 (1989).

172 *Id.* at 199 (internal quotations omitted).

173 *Id.* at 198–99.

174 *Youngberg v. Romeo*, 457 U.S. 307, 307 (1982).

175 *Deshaney*, 489 U.S. at 199–200.

176 *Id.* at 200 (emphasis added).

to act on his own behalf . . . which is the ‘deprivation of liberty’ triggering the protections of the Due Process Clause.”¹⁷⁷ The Court here shifts the focuses from the boundaries of acceptable punishment—an Eighth Amendment concern—to an emphasis on protective care resulting from the deprivation of liberty. The State owes a duty under a Substantive Due Process analysis because its method of punishment restrains the freedom of prisoners to the extent that it becomes the sole custodian of these individuals who have lost the ability to provide for themselves.¹⁷⁸ If the language of the cases regarding decisional autonomy can successfully be used regarding gender identity, cases like *Deshaney* may create an obligation by which prisons would have an affirmative duty to ensure the safety of prisoners and the expression of gender identity under the Due Process Clause.

One of the main benefits of the Fourteenth Amendment argument is also one of its biggest weaknesses—namely that it de-medicalizes gender dysphoria. While this helps remove the stigma of gender dysphoria, it also removes gender-transitioning treatment from the scope of a prison’s medical professionals and places it instead in the hands of its correctional officers. And while there is much improvement to be had on the medical side of prison,¹⁷⁹ the gap in tolerance, knowledge, and understanding on the correctional side is far greater. Corrections officers often perceive transgender prisoners as a source of “in-prison disorder” and “attendant management problems”¹⁸⁰ and often lack necessary knowledge about various issues relating to gender non-conformity. As such, judges, advocates, and members of the transgender community alike have advocated for leaving the issue of transgender treatment to the prison medical staff¹⁸¹ and have even mandated that it be left to medical professionals in some instances.¹⁸²

177 *Id.*

178 *See Genty, supra* note 148, at 399 (“[T]he duty of care derives not from the state’s power to *punish*, but rather from the state’s power to *take into custody*.”).

179 *See* 1 RTS. OF PRISONERS § 4:36, *supra* note 24 (“[M]any doctors . . . are unable to unemotionally [diagnose] problems relating to sex and erroneously still see this condition as a sign of serious psychiatric illness or as a desire for simple cosmetic changes.”); Chin, *supra* note 58, at 169 (“Prison healthcare policies are often unequipped to deal with prisoners seeking treatment for GID.”); Rosenblum, *supra* note 10, at 515 (“Doctors sometimes abuse or take advantage of transgendered people who depend on them for their transformation.”).

180 Jenness & Fenstermaker, *supra* note 4, at 12; *see also* 1 RIGHTS OF PRISONERS § 4:36, *supra* note 24 (“There can . . . be no serious dispute that many prison officials, including doctors, are ignorant about transsexuality and are often cruel to transsexual inmates.”).

181 *See* Chin, *supra* note 58, at 174.

182 *Brooks v. Berg*, 270 F. Supp. 2d 302, 310 (N.D.N.Y. 2003) (“[C]ourts have held that the treatment plan for an inmate with GID must be formulated by a medical professional and not by prison administrators.”).

While the rhetoric of a Due Process argument may be beneficial for the transgender community as a whole, transgender prisoners do benefit from ensuring that their care stays within the hands of medical professionals and not corrections officers. In this way medicalization, once again acting as a double-edged sword, “[emphasizes] the lack of choice in transgender identity”¹⁸³ and ensures that those who typically have the most knowledge and least bias in the prison system are those in control of transgender prisoners’ treatment. Again, deconstructing the power of the medical discourse can be done only while simultaneously balancing the interest of the individuals who rely on certain rhetoric to define themselves and can just as easily be oppressed by it.¹⁸⁴

In performing this balancing of the interests, one may decide that the current, heavily medicalized route ultimately provides the most beneficial legal argument for transgender prisoners. As an alternative to the Substantive Due Process method then, one might utilize the existing *Estelle* framework, but adapt the factors that are considered in making the serious medical need determination so as to take a more holistic approach to the condition of gender dysphoria.

B. Borrowing From Serious Physical Medical Need Standards

As discussed in Part II, the framework of analyzing serious medical needs within mental health is inconsistent, fairly ambiguous, and disadvantages transgender prisoners who often have difficulty receiving an accurate diagnosis while incarcerated, and whose condition does not necessarily present in obvious ways. The standards that courts apply in cases involving transgender prisoners rarely value the plaintiff’s own account of his or her trauma or seek to understand how the plaintiff’s gender dysphoria affects him or her on a daily basis unless it is corroborated by a medical expert. Instead, focus is placed almost exclusively on how extreme the plaintiff’s own responses to his or her psychological distress have been. While this inquiry is very important and contributes to a finding both that the plaintiff is in clear need of medical care and that a diagnosis of gender dysphoria is appropriate, there are other standards that have been articulated in the jurisprudence on serious medical need that could be very helpful in evaluating transgender plaintiffs.

The Second Circuit in particular has articulated a multi-factor analysis for assessing serious medical need. While this approach was not defined specifically in terms of mental health concerns, it can easily be applied to both physical and psychological medical concerns

183 Rosenblum, *supra* note 10, at 537.

184 Rosenblum, *supra* note 10, at 538.

and fills many of the gaps that the ambiguous mental health standards leave open. The multi-factor approach considers three, non-exhaustive factors: “(1) whether a reasonable doctor or patient would perceive the medical need in question as ‘important and worthy of comment or treatment,’ (2) whether the medical condition significantly affects daily activities, and (3) ‘the existence of chronic and substantial pain.’”¹⁸⁵ These factors have been applied in at least one case involving a transgender prisoner seeking medical treatment.¹⁸⁶

The benefit of this approach is its holistic view of the impact that a medical need—physical or psychological—can have on an individual. Rather than relying on obvious signs of ailment—which will inherently be particularly dangerous and will often show that a prisoner has gone untreated for far too long—or on a narrow diagnosis, this multi-factor approach considers all of the ways in which a medical condition can manifest itself as a serious problem worthy of medical attention. The focus on not only what a reasonable doctor, but also a reasonable patient perceives as serious gives a great deal of agency to the individual prisoner. Transgender prisoners, in particular, are stripped of much of their agency while incarcerated. Returning some of that agency to them by valuing their own perception of their trauma provides key insight into the real distress of their condition that would aid courts in conducting the serious medical need analysis and in understanding gender dysphoria on an individual basis.

The multi-factor approach does not rely only, however, on the reasonable perception of the prisoner, it also emphasizes the degree of the condition based on the pain it causes and its effect on an individual’s daily functioning. While a thorough medical diagnosis may speak to these factors, courts themselves rarely focus on them in making their determinations. But these factors speak to the purpose of the Eighth Amendment and uphold the spirit of *Estelle*. While gender dysphoria might not—and indeed should not—result in attempted suicide or genital self-mutilation, it certainly may cause chronic and substantial pain, both physically and mentally, in particularly serious cases; and it is exactly these kinds of cases that the threshold of severity is meant to safeguard. The multi-factor approach does not create a low bar by which all untreated discomforts create Eighth Amendment violations; rather, it utilizes a holistic analysis to determine when the severity threshold has been crossed to ensure that the bar does not become unreasonably and dangerously high. Furthermore, it is explicitly a non-exhaustive list, thus allowing courts flexibility to still consider important factors such as physical manifestations, harmful acts of self-remedy, medical definitions,

185 *Brock v. Wright*, 315 F.3d 158, 162 (2d Cir. 2003) (citing *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998)).

186 *See Brooks*, 270 F. Supp. 2d at 309.

and medical diagnoses. Just by its design, however, it prompts courts to consider the totality of the illness rather than narrow the focus onto one particular point.

Within this analysis there is space to discuss not only the facts particular to the individual plaintiff, but also the broader concern for the plaintiff's safety based on the knowledge that untreated gender dysphoria can have fatal consequences. The Bureau of Prisons itself often touts prisoner safety as one of its main concerns. Utilizing this language can be useful for advocates working within an Eighth Amendment framework.

C. Capitalizing on the Bureau of Prisons' Own Emphasis on Safety

The Bureau of Prisons often describes its main mission as ensuring safety on all levels—protecting the safety of the public while also keeping inmates safe during their incarceration.¹⁸⁷ In fact, much of transgender correctional policy is shaped by safety and security concerns that the Bureau of Prisons sees as essential to the proper management of America's prisons.¹⁸⁸ The Bureau claims that one of the expectations of all of its employees is to “uphold . . . laws, regulations, and procedures that ensure institution [sic] security and protect the safety of inmates.”¹⁸⁹ The Bureau describes many of its mandates and decisions in terms of how they contribute to prisoner safety. For example, the Bureau emphasizes how its inmate “programs and activities” (e.g. skills development, mandatory prison work programs, Federal Prison Industries factory work, and religious services) serve to maintain “safety of staff and inmates” by keeping inmates “constructively occupied.”¹⁹⁰

187 U.S. DEP'T OF JUST., FED. BUREAU OF PRISONS, ABOUT THE FEDERAL BUREAU OF PRISONS (2011), <http://www.bop.gov/resources/pdfs/ipaabout.pdf> [<http://perma.cc/G6BC-RRMS>] (“The Bureau’s employees help the agency meet its obligations to protect public safety and provide security and safety to the staff and inmates in its facilities.”). This is also true for the vast majority of state correctional departments. *See, e.g.*, FLA. DEP'T OF CORR., <http://www.dc.state.fl.us/vision.html> [<http://perma.cc/V5TF-PEXU>] (last visited Mar. 9, 2015) (“Our Mission: To promote safety of the public, our staff and offenders by providing security, supervision, and care”); LA. DEP'T OF PUBLIC SAFETY & CORR., *Missions and Goals*, <http://www.doc.la.gov/pages/about/mission-and-goals/> [<http://perma.cc/NE9N-BJ4B>] (last visited Mar. 9, 2015) (“The mission of Corrections Services is to enhance public safety through the safe and secure incarceration of offenders”); OR. DEP'T OF CORR., *About Us*, http://www.oregon.gov/doc/RESRCH/pages/about_us.aspx [<http://perma.cc/N8DA-CJ9P>] (last visited Jan. 22, 2015) (“We are a committed, creative, and productive organization which recognizes safety and security as an essential business practice.”); VA. DEP'T OF CORR., <https://vadoc.virginia.gov> [<https://perma.cc/C426-9XCT>] (last visited Mar. 9, 2015) (“Ensuring that the physical and psychological safety of the public, staff and individuals in the care of Corrections is paramount and evident in all we do.”).

188 Sumner & Jenness, *supra* note 21, at 234.

189 ABOUT THE FEDERAL BUREAU OF PRISONS, *supra* note 187.

190 ABOUT THE FEDERAL BUREAU OF PRISONS, *supra* note 187.

Similarly, in defending their denial of treatment to transgender inmates, prison officials have routinely pointed to the potential safety risk that providing treatment such as gender-appropriate clothing, hormone therapy, and sex-reassignment surgery could create. Prison officials have attempted to make this denial of medical care look like a display of concern for prisoner safety, and they have done this largely by capitalizing on another issue affecting many transgender prisoners: sexual assault. The Prison Rape Elimination Act, promulgated in May 2012, put all prison officials on notice of “the particular vulnerabilities [to sexual assault and gender-based violence] of inmates who are [lesbian, gay, bisexual, transgender, and intersex] or whose appearance or manner does not conform to traditional gender expectations.”¹⁹¹ Rather than focus on how to better protect this marginalized population, prison officials have used this information to claim that providing treatments such as hormone therapy to inmates—particularly transgender women housed in men’s facilities—would put them at greater risk of sexual assault by enticing the sexual aggression of the opposite gender prisoners around them.

For example, Eugene E. Atherton, the defendants’ security expert in *Fields v. Smith*,¹⁹² claimed that an inmate’s “personal appearance can make that inmate more vulnerable to sexual assault,” and explained that, for example, “if an inmate is . . . effeminate . . . then that makes that inmate an automatic target for inmates who are interested in sexual aggression or sexual relationships.”¹⁹³ Atherton thus concluded that “feminizing male inmates is [not] consistent with the mission of the [Department of Corrections] because ‘it raises the level of risk in general populations’ . . . The implication is that inmates and staff are going to get hurt.”¹⁹⁴ Rooting his concerns in “correctional needs, security, and safety,” Atherton resolved that hormone therapy was suspect in that it “may or may not . . . have something to do with physical appearance which are [sic] one of the many ingredients that may contribute to something that supports sexual attraction from one inmate to another which may or may not arise in the form of an assault.”¹⁹⁵ The defense in *Long v. Nix* made a similar argument, stating that they could not accommodate the plaintiff’s request to wear women’s clothing and undergarments because “permitting Long to crossdress would be contrary to prison policy,

191 See ACLU, PRISON RAPE ELIMINATION ACT (PREA) TOOLKIT: END THE ABUSE – PROTECTING LGBTI PRISONERS FROM SEXUAL ASSAULT, <https://www.aclu.org/sites/default/files/assets/012714-prea-combined.pdf> [<https://perma.cc/S38B-WGBC>] (last visited Feb. 4, 2015).

192 *Fields v. Smith*, 712 F. Supp. 2d 830, 830 (E.D. Wis. 2010).

193 *Id.* at 854.

194 *Id.*

195 *Id.*

draw attention to Long's uniqueness, allow Long to broadcast his [sic] sexual availability, and invite sexual assault from other inmates."¹⁹⁶

The Prison Rape Elimination Act, although promulgated after these cases, does not state anywhere in its text that denying transgender inmates access to medical treatment is a means of protecting them from sexual assault. Yet, if prison officials are so intent on using theories of prisoner safety to deny requests for gender-transitioning treatment, advocates should also use this rhetoric to demonstrate why providing treatment is so essential, namely because it keeps prisoners safe.

The case law and scholarship on medical care for transgender inmates demonstrate quite clearly that inmates who are not treated to an appropriate degree—be that with psychotherapy, provision of gender-appropriate garments, hormone therapy, or sex-reassignment surgery—often resort to attempts of suicide and/or acts of genital self-mutilation. In *Konitzer v. Frank*, for example, the court describes the grueling experience whereby the plaintiff “used a razor blade to cut open his scrotal tissue, leaving one testicle exposed and losing a lot of blood . . . [H]e was [later] moved to the [Wisconsin Resource Center] due to disfigurement attempts involving use of a nail clipper to wound his scrotum.”¹⁹⁷ Unfortunately, situations like Konitzer's are not altogether unusual.¹⁹⁸ This

196 *Long v. Nix*, 877 F. Supp. 1358, 1361 (S.D. Iowa 1995).

197 *Konitzer v. Frank*, 711 F. Supp. 2d 874, 879 (E.D. Wis. 2010).

198 *See, e.g., Fields*, 653 F.3d at 553 (“The feelings of gender dysphoria can vary in intensity. Some patients are able to manage the discomfort, while others become unable to function without taking steps to correct the disorder. A person with GID often experiences severe anxiety, depression, and other psychological disorders. Those with GID may attempt to commit suicide or to mutilate their own genitals.”); *Sundstrom v. Frank*, No. 06-C-112, 2007 WL 3046240, at *7 (E.D. Wis. Oct. 15, 2007) (“DOC medical personnel admit that for some individuals, failure to provide medically necessary hormone therapy could cause adverse consequences to psychological well-being, including ongoing gender dysphoria, depression, anxiety, and, for some, even suicidal ideation. Other risks of not providing hormone therapy to a person with GID include ‘a higher risk of alcohol and drug use or dependency issues . . . [and] some increased risk of borderline behaviors which could involve cutting on one’s self, as an example.’ Hormone therapy might relieve the desire to self-castrate that is sometimes caused by GID.”); Complaint at 14–15, *Manning v. Hagel*, No. 1:14-cv-01609 (D.D.C. Sept. 23, 2014) (“Dr. Randi Ettner, an expert in the diagnosis and treatment of gender dysphoria . . . noted that Plaintiff [Manning] is experiencing significant distress and is at high risk for serious medical consequences, including self-castration and suicide, if such medically necessary treatment is not promptly provided.”); *id.* at 5, (“Incarcerated individuals, particularly male-to-female transsexuals . . . are at a particularly high risk of engaging in self-harm including self-castration when treatment is withheld.”); Rosenblum, *supra* note 10, at 501–02 (“Trapped, not only in her body, but in a prison that refuses to recognize and respect her gender identity, she castrates herself with glass and used razors . . . Shockingly, several transgendered women have experienced similar ordeals.”); *id.* at 547 (“Many transgendered prisoners who are denied hormone treatment in prison

is why, as mentioned in Part I, specific treatment guidelines are available to manage gender dysphoria before it reaches these levels. Ultimately there is agreement in the medical community that “gender dysphoria is a serious condition that, without treatment, can lead to serious medical problems, including clinically significant psychological distress, dysfunction, debilitating depression, self-surgery, and suicidality.”¹⁹⁹

It is clear that untreated gender dysphoria can be extremely dangerous. In order to be safe and to be protected from the potentially fatal consequences of untreated gender dysphoria, transgender prisoners need to be treated from the early stages of their gender dysphoria with appropriate treatments that are assessed and altered if necessary as the inmate’s condition changes and develops overtime. While this is largely common sense, and rooted in basic concerns for human dignity and well-being, phrasing it within the language of safety that the Bureau of Prisons and many prison officials so heavily rely on would force the Bureau of Prisons and its officials to accept that they cannot use the safety of prisoners as both a sword and a shield.

The Bureau of Prisons holds a lot of power in the rhetoric it uses given the deference that courts often show when deciding prison-related cases. With the balance of power being heavily in favor of prison officials, judges, and administrators, it is essential that these groups have the adequate knowledge and resources necessary to make decisions regarding the care of prisoners. So many basic facts regarding transgender identity, gender dysphoria, and gender non-conformity are misunderstood or ignored, and greater access to transgender-related education and resources is necessary to remedy this.

D. Increasing Education and Resources

As mentioned multiple times, there is a chronic lack of understanding of transgender issues within both the prison and judicial systems. While advocating for greater education via workshops, publications, mandatory trainings, continuing legal education programs, etc., may seem too ordinary or self-evident to be important, the fact is such efforts are often ignored although they are central to adequately providing for and protecting transgender

experience grave effects, not only in their physical gender but in their health.”); Maruri, *supra* note 22, at 812; *but see* Kosilek v. Spencer, No. 21-2194, 2014 WL 7139560, at *10 (1st Cir. Dec. 16, 2014) (“[As noted by Dr. Stephen Levine, the court-appointed, independent expert in *Kosilek*,] ‘large gaps’ exist in the medical community’s knowledge regarding long-term effects of SRS and other GID treatment in relation to its positive or negative correlation to suicide ideation.”).

199 Complaint at 5, Manning v. Hagel, No. 1:14-cv-01609 (D.D.C. Sept. 23, 2014).

prisoners. Additionally, advocating for increased education provides a helpful supplement to attempting to change the system within which transgender prisoners operate—a daunting and lengthy task. As noted by transgender activist CeCe McDonald, “We have to think of other ways of fighting these systems instead of using the ideas of legalities and laws to argue the rights of trans-women.”²⁰⁰

The safety, physical health, and psychological stability of transgender prisoners depends on those who have the power to affect their lives also having sufficient knowledge about the issues most pressing to this population. This includes the most recent medical and sociological data, current statistics regarding the transgender prison population, and an in-depth understanding of the daily impact that gender dysphoria has on the lives of some transgender individuals. Even ensuring a basic understanding of terminology would go a long way to reducing the bias against this often oppressed population and increasing their access to a variety of necessary things such as medical treatment, appropriate housing accommodation, and protection from self-harm as well as violence and sexual assault.

These recommendations are analogous to those made in the Prison Rape Elimination Act, which calls for agencies to “train all employees who may have contact with inmates on: . . . [h]ow to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates.”²⁰¹ Instituting mandatory trainings for all prison staff including but not limited to prison officials, corrections officers, and medical staff, and providing more opportunities for legal education through, for example, continuing legal education programs—particularly for judges and legal administrators—would provide an essential foundation that would narrow the gap that so severely disadvantages the multiply-marginalized transgender prison population.

CONCLUSION

Prison is inherently and intentionally a setting of punishment and deprivation. Inmates are deprived of their freedom, comfort, material possessions, and much of the agency they had prior to being incarcerated. However, adverse actions and inflictions of harm that serve no penological purpose are contrary to the Eighth Amendment’s ban against cruel and unusual punishments, and to human dignity as a whole. Transgender inmates whose gender dysphoria is left untreated suffer immensely, and are at risk of extreme physical and

200 Interview with CeCe McDonald, *supra* note 88.

201 28 C.F.R. § 115.31(a)(9) (2012).

psychological trauma. While prison has not traditionally been a nuanced space concerned with the complexities of gender identity and expression, withholding treatment for the serious medical needs of these prisoners has no legitimate correctional purpose and does nothing more than put prisoners in danger.

Eighth Amendment attacks on prisons' refusals to treat transgender prisoners have had some success, and created some helpful precedent for future plaintiffs and advocates. The fact that some courts have recognized gender dysphoria as a serious medical need is an important step, and shows a willingness from the judiciary to consider the extreme emotional and physical distress that so often accompanies gender dysphoria.

However, the pattern of identifying gender dysphoria as a serious medical need predominantly in instances where a plaintiff has attempted suicide or genital mutilation is extremely troubling. The reluctance of the Bureau of Prisons and various Departments of Corrections to provide treatment until the condition has reached such catastrophic levels shows a complete lack of concern for the safety of transgender prisoners, and a deficiency in education and understanding of transgender issues. Courts should be guided more strongly by the well-established research in this field, specifically the DSM-5 and the standards promulgated by WPATH, which express the complexity of gender dysphoria and make clear the treatment required. Additionally, courts should consider utilizing a framework that reflects the complexity of gender dysphoria, such as the multi-factor approach used in the Second Circuit, to ensure that no one factor takes preference over others.

We must also consider the ways in which advocacy for transgender rights affects the transgender community both positively and negatively. While other alternatives for challenging prisons' refusals of treatment may potentially exist, the Eighth Amendment currently provides the strongest legal foundation to secure transgender prisoners' medical care. As such, it is important to strike a balance—assuming one is possible—between securing legal, medical rights and supporting the transgender community in its self-identification. We may begin by focusing on how the Eighth Amendment argument can become more workable, inclusive, and representative of the transgender incarceration experience. Understanding the complexity of the condition so as not to narrow its analysis onto just one or two predominant factors is a crucial first step in that process.