Transgendered and Incarcerated: A Review of the Literature, Current Policies and Laws, and Ethics

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Being transgendered, described as feeling that one is of the opposite gender, can be a difficult experience in today's culture. Those who are transgendered and incarcerated experience much more stress. There is a significant population of transgendered individuals in today's prison system, with estimates suggesting that the number is higher proportionally than in the general population. The question of how to treat these individuals while maintaining the safety and security of the institutions remains unanswered. In this article, we review the epidemiology of transgendered individuals in the general population and correctional facilities, describe current guidelines for the standard of care, and discuss how various correctional systems in this country apply them. We will also review case law with respect to the management and treatment of transgendered incarcerated individuals. Finally, we discuss the challenges involved in serving this population, such as provision of safe housing and medically necessary treatment. This review is provided to help in educating the forensic expert on current questions and potential future directions in the management of this population.

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According to media reports,[1] Skylar Deleon is currently on death row at San Quentin State Prison (an all-male inmate facility) in California for the murder of a couple on a yacht. She reportedly stated that she had always wanted sexual reassignment surgery and felt like a woman to the point that she attempted to castrate herself. "I basically took a sheet and tied it around my lower extremity. . . . I tied it around and I went to cut it off," she told ABC News. Media records also note that Deleon had put down a deposit on a sex-change operation, scheduled for two weeks after the murders occurred.[2] Deleon's current incarceration at San Quentin State Prison provides an example of the many problems faced by incarcerated transgendered individuals, such as the availability of diagnosis and treatment, safety and management of housing in the general prison population, financial aspects of treatment, and difficulties associated with living as a member of the opposite sex in prison, all of which will be discussed in this review.

The term transgendered, used to describe an individual who was born of one sex but feels aligned with the other, has different specific definitions, depending on whether you ask a clinician, a legal representative, a judge, or a person who is transgendered. In the field of psychiatry, the term is often used to describe the group of people who meet the diagnostic criteria for gender identity disorder (GID). In the realm of corrections and the law, the term often raises many questions and opinions about the proper management of individuals who are transgendered. Courts and other officials often look toward clinicians working in the correctional or forensic setting to provide guidance regarding diagnosis and proper management of individuals, including those who are transgendered. Little research has been published on the incarcerated transgendered individual. In this article, we begin with an introductory explanation of terms, definitions, and treatments specific to the transgendered population; describe the various institutional policies and legal cases relating to transgendered inmates; and delve into a discussion of the ethics involved in working with these individuals.

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Terms and Definitions

Multiple terms are used in discussions of transgendered individuals,[3] which can make those discussions more difficult for clinicians, judges, and others. The term transsexualism is defined as a:

> . . .disturbance of gender identity in which the affected person has overwhelming desire to change anatomic sex stemming from the fixed conviction that he or she is a member of the opposite sex; such persons often seek hormonal and surgical treatment to bring their anatomy into conformity with their belief [Ref. 4, p 1735].

This term entered the nomenclature in the 1950s, and it first entered the official psychiatric and psychological arena as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980.[4,5] In the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), the diagnosis is gender identity disorder (GID).[6] To meet the criteria for GID, one must have a strong and persistent cross-gender identification coupled with a persistent discomfort with his or her own biological sex and a sense of the inappropriateness of the gender role of that sex. The symptoms must cause significant distress and impairment in the social, occupational, or other domains of life.

The committee exploring the sexuality and gender category of the DSM has released information regarding the direction of these changes.[7] It has been recommended that the term gender identity disorder, determined by some to be pejorative, be replaced with gender dysphoria. Gender dysphoria is different from gender nonconformity, which 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" (Ref. 8, p 168). Only some people with gender nonconformity find themselves experiencing gender dysphoria. In the lesbian, gay, bisexual, and transgender (LGBT) community, there is also a view that the term GID is stigmatizing and should not be viewed as a disorder, but instead as a medical condition for which the desired outcome is to attain the physical gender characteristics that align with the individual's psychological gender.

So much discourse and confusion have surrounded the definitions of transsexualism that, in the legal literature, it has been given the name "the jurisprudence of transsexualism."[9] This term refers to all legal matters related to transgendered individuals, including discrimination in employment, health care funding, and service in the military, as well as lawsuits brought against the correctional institutions. The Supreme Court, in a landmark case (to be discussed later in this review), defined transsexual as "one who has '[a] rare psychiatric disorder in which a person feels persistently uncomfortable about his or her anatomical sex,' and who typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change" (Ref. 10, p 829). The definition was adapted from the American Medical Association.[11]

There is also a need to distinguish the terms transsexualism and transgender from other commonly confused terms. There are several paraphilias noted by DSM-IV, for example, that may be inappropriately associated with transgendered individuals. Most often confused is transvestic fetishism, which refers to a heterosexual male who experiences sexual arousal to cross-dressing.

Finally, appropriate pronoun use can be challenging for those working with transgendered individuals. Many clinical patients prefer to be referred to in the gender with which they identify, regardless of whether they have yet fully transitioned. That is, a male-to-female transgendered person would want to be referred to as she. Others have declined to associate any pronoun with themselves. This refusal can lead to challenges in the legal community, and different judges have responded in opposite ways, as will be discussed later.

Epidemiological Data

The transgendered population has not been studied in depth in the correctional system, and therefore data regarding the prevalence of GID in jails and prisons are sparse. This deficit in informative analyses also holds true in the general population, in part because of the difficulty with definitions. For example, some studies of prevalence look at the number of individuals who seek gender reassignment surgery, whereas others focus on self-report measures.[12] Much of the data come from international communities, particularly European countries with national databases. In The Netherlands, for instance, estimates of prevalence of transsexualism are 1:11,900 males and 1:30,400 females.[13] The estimates are similar for Belgium[14] and are much higher in New Zealand.[15] Overall, many Western countries estimate a 3:1 male-to-female to female-to-male prevalence.

One study of inmates with gender identity disorder estimated that there were approximately 750 transgendered inmates in custody in the United States in 2007.[16] Of note, the number of incarcerated individuals (estimated at more than 2 million) suggests a much higher rate of GID in the penal system than in the general population. Several theories have been postulated regarding this difference, such as the marginalization of this population in the community, leading to poor social and occupational situations and therefore more frequent contact with the legal system. Alternative explanations include the possibility of higher rates of criminal behavior in these individuals, due to mental distress or different means of data collection between studies of inmates and studies of the general population. The offenses most common to this population include substance use-related crimes and prostitution.[17]

As expected, few studies have examined comorbidity with other mental health conditions in those with GID.[18] One such retrospective survey of several hundred patients at a gender clinic noted the most common comorbid mental health condition to be substance use. More specifically, they found that 26 to 29 percent of their study participants reported a history of substance abuse. The next most common diagnosis was depression. Another study of 31 patients in Zurich found that, unlike in the aforementioned study, many patients with GID met diagnostic criteria for lifetime psychiatric comorbidities, including 71 percent for an Axis I disorder (primarily mood and anxiety disorders), 45 percent for substance use disorders, and 42 percent for Axis II disorders (primarily cluster B).[19] It is important to keep in mind that these surveys were of patients currently presenting for treatment at gender dysphoria clinics, which may be a different sample than those who are not in treatment.

Current Treatment

In understanding the appropriateness of the treatment provided in correctional institutions, it is helpful to consider guidelines developed by the major professional organization concerned with GID, the Harry Benjamin International Gender Dysphoria Association, now known as the World Professional Organization of Transgendered Health (WPATH). The guidelines that were used at the time this article was originally prepared were the Harry Benjamin International Standards of Care, 6th Version (2001).[20] The standards of care (SOC) focus on a triadic model, a combination of real-life experience, hormones, and surgery. The concept of real-life experience refers to adopting a new gender role or presentation in daily life. For initiation of hormone treatment, the recommended eligibility criteria include being 18 years of age, demonstrating an understanding of the risks and benefits of the treatment, and either three months of real-life experience in the chosen gender role or three months of psychotherapy. To proceed with surgery, the patient should have had 12 months of continuous hormone treatment and 12 months of continuous real-life experience. This public transition to the chosen gender role includes, for example, attending school or work in the preferred gender role, acquiring a gender-appropriate first name, and being able to demonstrate that individuals other than the therapist know the person in his chosen gender. For both hormone and surgical treatments, the guidelines require a letter from a mental health professional to the medical professional who will be providing the hormone treatment or surgical intervention (two letters for genital surgery).

These guidelines also consider correctional populations. Specifically, the standards of care state that individuals currently in treatment should be allowed to continue "medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality" (Ref. 20, p 14).

There are several options for hormonal management of GID. For the male-to female transgendered individual, it involves feminizing hormones. Estrogen can be administered orally, via injection, or transdermally, generally along with progesterone. At the same time, an antiandrogen medication is prescribed, such as spironolactone (most commonly used) or Lupron. For the female-to-male individual, the treatment involves administration of testosterone. All these options come with potential risks, such as abnormal bleeding or thrombosis, emotional lability, and neoplasms. Therefore, it is also imperative that patients participating in these treatments work with a physician who is able to obtain laboratory studies and monitor the results.

For the surgical candidate who is transitioning from female to male, the first surgery undertaken is usually a mastectomy, often the only surgical proce-

dure that the individual undergoes. Breast augmentation is an option for male-to-female individuals whose breasts have not enlarged on hormone therapy alone. Surgical procedures for the male-to-female patient may involve orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. For the female-to-male patient, surgical options include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. The average cost of these surgeries in the United States is just under $13,000 per individual.[21]

The 6th version of the Harry Benjamin Standards of Care (SOC) was published in 2001. Since then, there have been more data and information on the care and management of transgendered individuals in incarcerated settings. More specifically, the 2001 guidelines had only a single paragraph (under the broader heading of Hormonal Treatments) referring to the care of incarcerated individuals with GID. Brown,[22] who has studied transgendered inmates, suggested that the lack of guidance has led to tacit discrimination against this population and recommended that revisions of the guidelines include an independent section on incarcerated transgendered individuals. This version would contain information on all forms of treatment, including psychotherapy and real-life experience, as well as detailed descriptions of the management of these individuals with respect to housing, safety, and medical consultations.

Development of the latest revision of the SOC began in 2006, with the revision published in 2012 (available online)[23] and approved by the WPATH Board of Directors. This newest version is noted to include "changes based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery."[23] More specifically, it includes sections on the management of children and adolescents with gender dysphoria, on voice and communication treatment, on preventive care, and on individuals living in institutional environments. Although this revision kept the recommendation that surgical candidates have previous exposure to 12 months of continuous hormone treatment and real-life experience, it changed the mental health recommendations such that mental health treatment, while recommended, is no longer an explicit criterion for surgery, nor is it a requirement for hormone treatment. With respect to institutionalized individuals, the 2011 SOC recommend that housing not be based solely on external genitalia and recommended against the freeze-frame approach discussed later in this article.

Review of Institutional Policies on Treatment

Although the major organization of health care professionals concerned with GID has developed consensus guidelines for the treatment of GID (as described above), policies in correctional settings vary from state to state and at the federal level, as well as internationally. In 1996, prison systems throughout North America, Europe, and Australia were surveyed, with a response rate from 64 recipients of 62 percent.[17] Only 20 percent of institutions that returned the surveys had any formal policies regarding the health care and housing of transgendered individuals, and only another 20 percent had informal policies.[17] Among the different jurisdictions, there was variety in how institutions determined who would be classified as transgendered and where and how these individuals would be housed. With regard to hormone treatment, the majority (34 of 64 respondents) stated that they would not initiate treatment. Almost half (45%) stated that they would continue hormone treatment if it had already been initiated. Eighty-two percent (53 of 64) also stated that reassignment surgery would not be allowed during incarceration. An interesting element of this survey was the inclusion of questions regarding the institution's perceptions of risk of assault on transgendered individuals in the prison setting. Almost half reported that they did not believe this population had an increased risk of being sexually assaulted compared with the general inmate population. (As will be discussed later in this review, this belief contrasts with empirical research showing that transgendered inmates are at increased risk of sexual assault.) One reason that has been cited for excluding the possibility of hormonal therapy in prisons is to prevent an increase in the risk of sexual assault. The discrepancy between perceived risk and actual risk in this population is significant and speaks to the need for further education.

Subsequently, a 2007 survey of U.S. prison systems was conducted, with letters sent out to all states and the federal system, pursuant to the Freedom of Information Act, inquiring about the policies of

these systems.[16] Nineteen states (six did not respond) reported that they had no official policies regarding transgendered inmates, with some (e.g., Arkansas) stating that they are in the process of developing policies. The states that had formal policies included definitions from the DSM and the Harry Benjamin Institute, among other references. Of the states that have a policy, many use the freeze-frame treatment approach. That is, if an individual arrives at the correctional institution in treatment (psychotherapy or hormonal), that treatment is continued, but new diagnoses and treatment are not initiated. The rationale for the freeze-frame approach is based on three factors: the artificiality of the prison environment, the difficulty with assessment of gender dysphoria in this environment, and the lack of the real-life experience test, which is essential in the management of gender dysphoria.[24]

The 2007 survey reported that 22 states allow for a continuation of hormone treatment, and 11 allow for the possibility of hormone initiation.[16] None of the states allows sex reassignment surgery (SRS), except Illinois, where it is permitted in extraordinary circumstances. There has not yet been such a circumstance. Massachusetts' policy regarding SRS is currently in litigation. Several states use a case-by-case approach, and a committee makes the decision about treatment and housing. Several policies explicitly state that treatment will not be provided. Florida's policy is that:

> . . . a genetic male, incarcerated in a male institution, presents no medical necessity for treatment, nor for continuation of treatment, hormonal or surgical, to attempt to change his sex from male to female. In those cases wherein a male inmate is receiving such hormonal therapy, it is to be discontinued [Ref. 16, p 284].

The Federal Bureau of Prisons' policy allows for the possibility of continuation or initiation of hormone therapy, uses the freeze-frame approach, and does not allow for SRS. Apart from Virginia (which conducts a case-by-case review) and California (which has a variable policy), all the states that report having policies house inmates according to biological gender. Several states allow for an outside consultant, such as a psychologist or endocrinologist.[16]

Review of the Legal Literature

Much of the current policies on the management and care of transgendered individuals in jails and prisons come from individual cases that sparked change or the need for clarification of the rules.[25] Several courts, primarily trial or district courts, have recently ruled on the care of transgendered inmates. The cases include those that focused on the right to treatment; on individuals who were male to female and much more rarely, female to male; on housing and safety; and on self-mutilation and those that challenged legislation on the incarcerated transgendered. For our legal review, we conducted a LexisNexis search of available cases and media reports with the search terms transgender and transsexual and then further expanded the review by exploring the references and footnotes in the sources found.

Right to Treatment

Lawsuits brought by inmates against correctional institutions have generally been predicated on several key prior decisions. In the 1976 landmark decision in *Estelle v. Gamble*,[26] the Supreme Court ruled on violations by prison officials of the Eighth Amendment, specifically the "unnecessary and wanton infliction of pain" when their actions or failures to act in response to prisoners' health conditions demonstrate "deliberate indifference to serious medical needs of prisoners." As a caveat, the judges in this opinion made it clear that mere negligence in diagnosis or treatment does not meet the definition of deliberate indifference and "medical malpractice does not become a constitutional violation merely because the victim is a prisoner."[26] That is, deliberate indifference, but not medical malpractice, constitutes a violation of the Eighth Amendment. The following year, in the case of *Bowring v. Godwin*,[27] psychiatric conditions were deemed to be a form of medical problem, therefore requiring the same standards as noted above. That is, if a mental illness is diagnosed in an inmate by a clinician, it would be a violation of the inmate's Eighth Amendment rights not to provide treatment for that illness.

There have been many cases regarding the right to treatment. For example, the opinion in *Brooks v. Berg*[28] by the U.S. District Court in New York stated that inmates with GID must receive some form of treatment. However, it was noted that "mere disagreement over the proper treatment does not create a constitutional claim."[28] That is, while the inmate must receive some form of treatment, it may not be the treatment that he prefers. Of note, in its opinion, the court chose to use the male pronoun because the inmate was biologically male, although the court was

aware of the inmate's preference for female pronouns. However, a court in New Hampshire,[29] hearing a case of a biological male who attempted suicide and self-castration multiple times, stated that "although the plaintiff is biologically male, it is painful to her to be referred to with a male pronoun; therefore. . .I will refer to Barrett as 'she.'"

A similar right-to-treatment case, *Kosilek v. Maloney*,[30,31] has been ongoing in Massachusetts since 1992. In this case, after being denied treatment, the inmate attempted to castrate himself twice. In a groundbreaking opinion, the court ruled that GID is a serious medical need that warrants treatment, even in the prison setting. It ruled that a real-life experience is possible in prison; that hormones may be initiated in prison if deemed medically appropriate, as determined by health care personnel, not administrators; and that biological males with GID in prison can have access to the same items that women in prisons have, such as cosmetics. This ruling led to Michelle (formerly Robert) Kosilek's being granted access to hormone treatment, electrolysis for hair removal, cosmetics, women's underwear, and the possibility of being evaluated for SRS. The landmark part of the decision was handed down in September 2012, when Judge Wolf ruled that inmate Kosilek must be granted the right to surgery. In his 128-page opinion, he noted that it would be in bad faith to deny her adequate medical care because of a fear of controversy or criticism and that doing so would violate the Eighth Amendment.[32] This decision was appealed in early October 2012.

Appropriate Housing

One of the earliest and most notable cases involving transgendered inmates is that of *Farmer v. Brennan.*[10] In this case, an inmate who was biologically male underwent hormonal therapy, received breast implants, and attempted testicle-removal surgery before being incarcerated. Upon conviction, the individual was sent to a male federal prison and was usually kept segregated from the general population (for both safety and disciplinary reasons). The prisoner was then transferred to a penitentiary in Indiana and placed in the general population and, within two weeks, reported being beaten and raped by another inmate. The inmate filed an action against various prison officials stating that the placement occurred even though the officials knew that this penitentiary had a history of inmate assaults and that this inmate, given feminine dress and behavior, would be particularly vulnerable to assault, which constitutes deliberate indifference and therefore a violation of the individual's Eighth Amendment rights. After the District Court granted the defendant summary judgment and the Court of Appeals for the 7th Circuit affirmed, the U.S. Supreme Court heard the case, vacated the decision, and remanded to the trial court. The Court spoke to the definition of deliberate indifference, which "entails something more than negligence, but is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result. Thus, it is the equivalent of acting recklessly."[10] The opinion went on to say that recklessness can take subjective or objective forms and that, in this case, the definition may be used that the official was subjectively aware of the risk.

A case followed in Wyoming[33] in 2007, when a transgendered female with male genitalia was housed with women in a jail and then transferred to a female prison where she spent the next 14 months (438 days) in administrative segregation. She sued, citing violation of her Fourteenth and Eighth Amendment rights. The federal judge concurred that her Fourteenth Amendment due process rights had been violated, in that she was housed in administrative segregation without being allowed to contest that decision. The judge also found that the inmate's Eighth Amendment rights had not been violated, based on the Supreme Court's previous rulings regarding the definition of cruel and unusual punishment as it relates to medical indifference.[26,27,32]

Legislative Intervention

Wisconsin presents an interesting case of legislation forbidding prison physicians from prescribing hormones to incarcerated transgendered people, entitled Act 105, passed in 2005.[34,35] This law was struck down by the district court as cruel and unusual punishment. The Act would have led to the abrupt cessation of hormone therapy in several inmates. There would have been the risk of numerous physiological and psychological sequelae to rapid discontinuation of hormone treatment, including menopause-like symptoms in those taking feminizing hormones and psychological symptoms of anxiety, depression, and suicidal thinking.

On the other side, a state assemblyman introduced a bill in California that would require the Depart-

ment of Corrections and Rehabilitation (CDCR) to add the sexual orientation and gender identity of an inmate to the list of characteristics considered in housing classification to promote safety.[36] This action by a California legislator followed multiple lawsuits brought by transgendered inmates.[37,38] After passing through the Public Safety Committee, the Senate Public Safety Committee, and finally the Senate, it was vetoed by Governor Schwarzenegger.

Management and Related Ethics

Safety and Housing

One of the first topics that comes to mind when discussing the care and management of transgendered individuals in prisons and jails is safety and appropriate housing. Violence and sexual assault in prisons is not uncommon. Since the enactment of the Prison Rape Elimination Act (PREA) of 2003, the U.S. Bureau of Justice has collected yearly statistics about sexual violence in jails and prisons.[39] According to the data, 3.1 to 4.5 percent of inmates responding to the 2007 and 2009 surveys reported sexual victimization within the past year. In addition to collecting information, the PREA calls for the development of national standards to prevent sexual violence and ensure more accountability of correctional facility administrators for such incidents.

However, violence against transgendered individuals in prisons is substantially higher than in the general inmate population. One study (conducted as a face-to-face interview of 315 prisoners at 27 different institutions across California) reported that 59 percent of GID inmates in California had been sexually assaulted.[40,41] Part of this much higher rate may be influenced by housing regulations for transgendered prisoners.[42] The rule for placement used in many U.S. correctional institutions is based on biological gender. However, this is not the case in other countries, nor is it uniform in the United States. For example, in Filipino prisons, transgendered individuals are housed together. There is also a specialized unit within the California Department of Corrections and Rehabilitation (part of the California Medical Facility, Vacaville) that houses transgendered individuals. These facts lead to the ethics question of what the most appropriate means of assigning housing might be. Should it be assigned based on natal gender, self-identification, or another criterion? Who should be involved in the assignment? Prison housing decisions generally are made by prison administrators and correctional staff, but perhaps in cases of transgendered individuals, consultation with medical professionals would be beneficial in increasing safety.

Medical Necessity

The question of medical necessity has also been raised with regard to the treatment of GID in correctional systems.[43] For some, this is an ethics-based concern; for others, it is a legal question. One potential clinical answer stems from the statistics on suicide and self-mutilation by individuals with gender dysphoria.[44] In a noncorrectional study sample,[45] researchers noted a self-report of eight percent of male-to-female and one percent of female-to-male individuals having engaged in genital mutilation. In this study, the incidents included taping, hitting, or squeezing the genitals out of frustration; in only a few did the mutilation involve a knife. In the same study, when participants were asked about prior suicide attempts, a range of 12 percent of male-to-female individuals and 21 percent of female-to-male individuals reported at least one. Of note, none of the patients reported any suicide attempts after therapy was initiated for GID. There are no available studies of correctional populations, but there is one case series.[46]

In his opinion, released September 4, 2012, Judge Wolf of the U.S. District Court of Massachusetts addressed what he defined as a "serious medical need."[31,32] He noted that there was sufficient evidence at trial to prove that Kosilek is at a substantial risk of suffering serious harm (a phrase first raised as previously noted in *Farmer v. Brennan*[10]) if his severe gender identity disorder is not appropriately treated. Judge Wolf noted the improvements in Kosilek's functioning (including less suicidality) since being started on hormone treatment and given the hope of surgery in the future.

Financial Considerations

The costs associated with transgenderism are also relevant. As noted earlier, SRS is expensive: approximately $10,000 for male to female and $17,000 for female to male.[21] The costs of counseling, electrolysis, hormones, and surgeries range up to $40,000. At the same time, there are expenses for the medical treatment of the complications associated with self-mutilation, suicide attempts, or sexual assault of

transgendered inmates. Questions arise as to what is medically necessary or adequate. Some state that the level of care made available for prisoners should be minimally adequate. This opinion leads to discussions of what exactly is meant by minimally adequate. Questions also arise about what is feasible. For example, a critical step in the WPATH standard of care for the treatment of GID involves the real-life experience of living as a person of the opposite gender. How can such an experience be ensured in a prison environment?

Future Changes

The diagnosis of GID and studies of individuals with GID are relatively recent developments. Currently accepted standards are in flux. For instance, there is controversy in the lesbian, gay, bisexual, and transgender (LGBT) community regarding whether any psychiatric diagnosis related to GID (whether labeled GID or another term) should be included in the DSM.[47] Advocates of this position argue that, like homosexuality, transgenderism should not be considered a mental health condition and that it should be treated as any medical condition, with appropriate endocrine and surgical interventions. It remains to be seen whether or when the legal system and the penal system will adopt this perspective.

Conclusion

Transgendered individuals in the community experience numerous difficulties in gaining acceptance by the public and finding the appropriate medical and psychological treatments.[48] These difficulties become much more complex for those who are incarcerated. In recent years, there have been multiple cases of incarcerated transgendered individuals suing the prison system and government for providing improper care and inadequate safety. Moreover, despite the belief in some corrections systems that transgendered individuals are not at increased risk for assault, some data suggest that their risk of being targeted for assault is substantially higher. There is considerable debate surrounding the legal aspects and the ethics of the appropriate management of transgendered prisoners from the perspectives of housing, safety, and available treatment. At the same time, data are sparse with respect to this population, in part because of the low prevalence of the condition in both the clinical and the correctional communities. Moving forward, as new diagnostic categories are developed and recommendations regarding the treatment of transgendered individuals evolve, it will be important to ensure that those who are incarcerated are also considered. It is therefore important for forensic mental health experts to participate by keeping informed about this unique population and the complexities in its management and treatment.

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