The Medicalization of Transgenderism

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The medicalization of trans-identity has been documented throughout history, although it is markedly more evident in the contemporary age of advancing technology and science. The medical fields’ enveloping of culturally significant elements, such as the lives of transgenders, is noted by Richard Ekins and Dave King, who point out that “medicine has become the culturally major lens through which gender blending is viewed in modern western societies” (8). Many scholars invested in various fields, including queer theory, medicine and psychiatry, have investigated the concept of medicalized gender transgression in modern societies. For example, Judith Butler probes the connections between medical and linguistic interpellation of gender, posing the question “through what regulatory norms is sex itself materialized?” (10) Butler states that “‘sex’ is a regulatory ideal whose materialization is compelled, and this materialization takes place…through certain highly regulated practices” (1). One could easily read these “highly regulated practices” to include that of medicalization. However, Butler’s persistently vague theoretical language use illustrates the fact that very few gender theorists have focused on the real life implications medicalization has posed for transgender individuals themselves. As Viviane K. Namaste routinely points out, queer theorists rarely take into account the people whose lives they are placing under scrutiny. In other words, theory is often inaccessible to the very people to whom it pertains.

It is imperative that the medicalized control over transgenders’ bodies and psyches be subject to scrutiny. An understanding of the various implementations of the medical/psychiatric monopoly as they are currently socially accepted and even promoted, as well as the effects of such control, are essential to a comprehension of trans-identity. By no means should all people who transgress the socially expected sex/gender dyad be assumed to share the exact same life experiences. However, all persons who have interacted with the medical community while subverting societal notions of sex/gender have to some degree been subjected to a medicalized perception of their bodies and/or identities. The liberation of transgendered individuals from such controlling social institutions will only follow a comprehensive survey of the means with which those institutions retain their authoritative domain over the sexed/gendered lives of their ‘subjects’.

Trans-identity may well be cultivated throughout one’s course of life, and accordingly, the medicalization of trans-identity exhibits itself at all stages of one’s life course. While exact
numbers regarding the frequency of births of intersexed persons have been obscured by the medicalized institution of shame, it is clear that many people violate the socially appropriate sex/gender dyad at birth with their given bodies. The lived experiences of many other transgenders, while obviously exhibiting individual differences, follow similar, specific stages, all of which have been incorporated and regulated by the field of medicine. The options available to trans-identified people who wish to feel more comfortable with their bodies and/or to better ‘fit’ into the socially regulated sphere in which they live are rigorously controlled by medical professionals. These professionals themselves often exhibit highly judgmental perspectives regarding transgenders. It appears that the future of ‘transgenderism’ will continue to be subject to the regulations of the medical communities’ interpretations of the culturally appropriate sex/gender dyad and it’s subversion.

The Medicalization of Intersexed Infants

“Follow-up care including the denial of accurate medical information to the intersexed person as they age is believed to allow ‘the intersexed child [to] develop a gender identity in accordance with the gender assignment.’”

The exact number of births of intersexed infants is difficult to ascertain for many reasons. One primary purpose for the medicalized treatment of intersexual infants is precisely to cover up the very existence of intersexuals. The erasure of sexual ambiguity attempts to create a social space free of any individuals whose corporeal existences challenge the expected binary system of sex and gender. It is also difficult to substantiate frequency data pertaining to intersexuals because of the many aspects of sex/gender ambiguity. Researchers often find it nearly impossible to locate something which one can’t define in absolute terms. Estimates regarding the frequency of intersexuality reflect the disparate attempts to define intersexuality. The many discrepancies notwithstanding, it is fairly obvious that births of intersexed infants are far from ‘rare’ occurrences.

The standard protocol for doctors who negotiate the bodies of intersexed infants has been highly influenced by the work of Dr. John Money. As Suzanne Kessler notes:

“Almost all of the published literature on intersexed infant case management has been written or cowritten by one researcher, John Money, professor of medical psychology and professor of pediatrics, emeritus, at the Johns Hopkins University and Hospital…Even the publications that are produced independently of Money reference him and reiterate his management philosophy.” (7, n9)

Money’s theories revolve around his notion that one’s gender identity is fluid until approximately the age of eighteen months. Following the precedence established by Money, many medical personnel manipulate language and terminology in order to normalize intersexuality for the parents of intersexual children. They then construct genitals appropriate to the assigned gender, and introduce hormones accordingly. Follow-up care including the denial of accurate medical information to the intersexed person as they age is believed to allow “the intersexed child [to] develop a gender identity in accordance with the gender assignment” (Kessler 7). Money’s theories are succinctly summed up by Kessler, who reports Money’s
position as believing that “gender and children are malleable; psychology and medicine are the tools used to transform them” (8). The ironic nature of this attitude is evident when we accept that psychology and medicine are agents which serve to perpetuate the socially mandated sex/gender dyad, and that this dyad is highly inflexible, as demonstrated by the medical field’s compulsion to regulate the bodies of intersexed infants.

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Contrary to the few case studies provided by Money and his associates⁶, the aftermath of medical interjection upon intersexuals’ bodies frequently bears negative consequences to the lives of those intersexed individuals. Cheryl Chase asserts that “the child is left genitally and emotionally mutilated, isolated, and without access to information about what has happened to them.” Chase also discusses the magnitude of the pain and shame which is endured throughout the lifespan of intersexed persons. Laurent describes the effects of medical treatments upon intersexed individuals, pointing out that “surgery destroys genital anatomy and many intersexual children are subjected to repeated surgeries…Genital surgery disrupts the infant’s erotic development and interferes with adult sexual function” (2).

Western medical technology serves to impose and reinforce the socially expected sex/gender dyad by attempting to prevent the existence of adult individuals whose sex/gender alignment is deemed ‘inappropriate’. This ideology is not a product of medical advances; rather the technological and medical advances are the products of this ideology. There is historical documentation that in “patriarchal, sex-segregated societies in Greece and Rome, for example, intersexual babies were burned alive, or otherwise murdered” (Feinberg, Transgender Warriors 104). Intersexed babies have been ‘dealt with’ throughout history in many different ways; some societies held them as sacred, others despised and feared them. In modern Western societies, where infanticide is viewed highly unfavorably, yet aberrations of the sex/gender dyad are equally disdained, medical technology has formed new ways of negotiating intersexed bodies. These negotiations revolve around the medical construction of sexed and gendered bodies which project the (often artificial) illusion of obeying modern Western societies’ notions of sex and gender.

Dr. Anne Fausto-Sterling provides insight into the medicalized institutional regime which she suggests is extremely invested in the ideologies perpetuating the myth of the existence of only two sexes. She points out that surgical and hormonal manipulations of intersexed bodies by the medical community are supported by social institutions because, “for questions of inheritance, legitimacy, paternity, succession to title, and eligibility for certain professions to be determined, modern Anglo-Saxon legal systems require that newborns be registered as either male or female” (Feinberg, Transgender Warriors 103). Fausto-Sterling’s claims are further supported by Butler, who states that “the uncontested status of ‘sex’ within the heterosexual dyad secures the workings of certain symbolic orders…” (16). The patriarchal values imbedded in the complex web of social institutions of modern Western societies encourage the medicalized control over intersexed individuals.
Recent movements have emerged which aim to reduce the frequency of the medical communities’ depreciating conduct towards intersexed infants, while simultaneously attempting to alleviate the social stigmas surrounding intersexuality. Organizations such as the Intersex Society of North America (ISNA) voice opposition to “‘normalizing’ cosmetic surgery performed on infants and children who cannot provide informed consent” and believe that “with appropriate emotional support, intersexual infants and children would fare better without genital plastic surgery” (Laurent 3). ISNA also advocates a complete change in our cultural ideologies regarding sex and gender, noting that we should become more accepting of variances from the sex/gender dyad rather than forcing individuals to assume one of two sexes.

Activist groups involved in transgender rights often include the rights of intersexed infants in their agendas. Social reform activists such as Cheryl Chase have criticized Western feminist ideology for the impetuous denunciations of genital mutilation in non-Western countries, while seeming to be oblivious to similar practices in their own societies. These acts of Western genital mutilation/reconstruction are in fact sanctioned by governing institutions, such that in1996, “congress passed Pat Schroeder’s ‘Female Genital Mutilation’ bill, which prohibited clitoral surgery- except the sort practiced on intersexuels” (Feinberg, TransLiberation 91).

Medicalized Options Available to Transsexuals

“You Americans are so childish about sex!…Operate on the brain, perform a lobotomy, create a whole new personality– but operate on a testicle and everybody explodes!”

Transgendered people who wish to alter their sex/gender representation are similar to intersexuals in that they also have transgressive gender identities which subvert the dominant sex/gender dyad. However many transsexuals choose, at some point in their lives, to invite medicalized alterations to their physical bodies for the purposes of recognizing their inner gender identity. The professional treatments of transsexuals provide several options, all of which are constrained by the medical communities’ enforcement of specific regulations and criteria for sex re-assignment, and the virtually absolute control which medical communities’ hold over transsexuals’ lives.

Some, but not all, transsexuals desire access to hormones which would presumably alter their physical bodies. Transsexuals often employ methods such as testosterone and estrogen injections or ingestions to achieve their desired corporeal modification. Other non-surgical options available to transsexuals who wish to renegotiate their sexed bodies include electrolysis and speech therapy. Non-surgical transformation options utilized by many transgendered individuals are just as regulated by the medical/psychiatric fields as surgical procedures. Hormone distribution is conservatively guarded by medical personnel, and options such as electrolysis and speech therapy are only available from licensed members of the medical community, provided the desired end result is of high quality.

A wide variety of surgical operations are available to transsexuals in modern Western societies. Technological advancements have allowed modern Western societies the capabilities to perform complex operations regarding sex reassignment, however, cultural attitudes have not evolved at the same pace as technological and medical developments. Conservative social sentiments are
illustrated by comments made by Danish psychiatrist Dr. Georg Sturup referring to the typical American attitude toward sex re-assignment surgery: “You Americans are so childish about sex!…Operate on the brain, perform a lobotomy, create a whole new personality– but operate on a testicle and everybody explodes!” (Califia 21).

Female-to-male (FTM) transsexuals may opt for a breast reduction, hysterectomy, and/or for the development of a phallus. The creation of a phallus for an FTM may involve phalloplasty or metoidioplasty (genital free-up surgery) 9, although there are currently no surgical procedures which provide transsexual men with entirely ‘normally’ functioning penises. Male-to-female (MTF) transsexuals may opt for breast enhancement surgery and/or the transformation of their genitals into a vagina 10. The surgical construction of a vagina, from the medical attendants’ point of view, is generally easier than that of a penis, as illustrated by one surgeon’s insensitive comment that “it’s easier to dig a hole than to build a pole” (Looking…2).

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Many rigidly defined rules regulate transsexuals’ access to medical assistance necessary for their transition. While many transsexuals have been found to manipulate different areas of the medical community in order to circumvent some of these regulations, most transsexuals must adhere to the criteria set forth by the medical institutions governing their transition. If they fail to comply, they risk losing any financial assistance in their transition, and very few people would be able to afford the extremely high costs of sex re-assignment surgery without aid. As Pat Califia points out:

“The DSM-IV 11 …serves as the official source book for the names of disorders that insurance companies will recognize and offer reimbursement to treat…DSM-IV categories impact on transsexuals because sex-reassignment surgery (SRS) is very expensive. Some insurance companies will cover SRS provided the individual is being treated by licensed medical and psychiatric professionals who describe his or her condition in terms of GID. “(263)

There are several components of criteria that must be met in order to receive the diagnosis of Gender Identity Disorder (GID). Califia outlines several of these components as they are presented in the DSM-IV as ‘‘a strong and persistent cross-gender identification’ as well as ‘evidence of a persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex’’ (263-64). Vernon Rosario also provides examples of these criteria by including the strong desire, or preoccupation, with ridding one’s body of her or his given sex characteristics.

Focusing on the general practices followed by the Gender Identity Clinic (GIC) of the Clarke Institute of Psychiatry in Toronto, Namaste provides an excellent case study of the procedures that transsexuals are regulated by when securing sex re-assignment consultation. According to Namaste:
“The GIC has established guidelines for their patients to be eligible for SRS [sex reassignment surgery]. The individual must live in the chosen gender (the ‘opposite sex’) full-time for at least two years…After one year of cross-living, the individual becomes eligible for hormones…After two years of cross-living, the individual becomes eligible for surgery. Before being recommended for surgery, however, a candidate must fulfill several other conditions: be legally divorced, if once married; be at least twenty-one years of age; have no evidence of psychosis; and have no recent record of criminal activity. “(198-99)

In 1979 most North American gender identity clinics adopted the Harry Benjamin International Gender Dysphoria Association’s Standards of Care. The Standards of Care restricted hormone and surgical access to transsexuals who were involved in long-term consultation with psychiatric therapy, and admonished medical professionals who consented to providing hormonal or surgical sex re-assignment ‘on demand’. Holly Devor summarizes many of the Standards of Care stipulations by stating that

participants who used the services of gender clinics or of professionals who followed the Standards of Care during this period were supposed to submit themselves to a minimum of three months of psychotherapy before they could get a prescription for hormone therapy. In addition, they were to undergo another three months of therapy with the same therapist, plus at least one other evaluation with another clinician, and live full time [in the 'opposite sex'] for a full year before they could be referred for breast or genital surgery. (385)

Some contradictions between theory and practice are obvious as the policies outlined by the Standards of Care, and those followed by the GIC and most other gender identity clinics, refuse to offer SRS to any patient who exhibits evidence of ‘psychosis,’ yet gender dysphoria is itself treated as a psychological condition.

Much of the criteria established by the DSM-IV and the Standards of Care that have been employed by GIC and similar gender identity clinics are being contested by many transgender activists. Waiting periods, the real-life test, and mandated admittance of a psychological disorder are often seen as unnecessary and unfair by transsexuals and transgender activists. One very common objection, discussed by both Namaste and Devor, involves the unreasonable demands that transsexuals must pass the real-life test in order to access hormones. Mandated attempts at ‘passing’ without the desired medical assistance often creates many dangerous situations for transsexual individuals, especially MTFs who are unable to successfully pass without the aid of hormones.

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The regulations imposed on transsexuals do not always present them with the obstacles that may have been intended by the governing institutions, however. Transgendered individuals are not passive agents in the medicalized realm of their existence; rather they have become quite educated about how the system works. As Califia, among other scholars such as Namaste, points out, “the gender community has at this point accumulated a lot of folk wisdom about what you
need to tell the doctors to get admitted to a gender-reassignment program” (Califia 224).

Namaste points out that “transgendered people read what psychiatrists write about them…so that they can enter the clinical setting, present the ‘classic’ transsexual narrative, and receive the health care and medical technology they desire” (192). Transsexuals who ‘work the system’ suggest in their actions the general feelings of despair and disillusionment shared by transgenders toward the medicalization of their bodies. The evidence that transgendered individuals find it necessary to circumvent the rules governing their access to legitimate and adequate health care, often through means of dishonesty and/or embellishments, brings one to question the very existence of those regulations they must work within and against. Any institutional structure which causes people to provide their health care providers with less than entirely honest information is subject to scrutiny.

Califia presents the image of a transgender community which is fairly pro-active regarding the persistent medicalization of their bodies’, stating that “rather than being grateful for any help they are given, transsexuals today are questioning the authority of the medical and mental-health professionals who function as gatekeepers of sex reassignment” (224). This struggling rise of ‘transgender warriors,’ as Feinberg terms those activists within the trans-movement, provides a slightly optimistic view of the future heath care provided to transgenders. However, the ideologies impeding the rise of trans-awareness are still far too overpowering and almost entirely supported by the complex network of social institutions including medicine.

The Current Role of Transgendered People Within Medicine

The current relationship between transgendered people and the medical/psychological communities is fairly contentious. There certainly appears to be “a deep conflict among transsexuals and psychiatrists” which “reinforces the institutional exclusion of transsexuals and transgendered people” (Namaste 190). A general lack of awareness and/or sensitivity to transgenders in the health community is evident by many personal case stories of maltreatment at the hands of professional health care providers. The assignment of transgenderism as a psychological condition and recent refusals by transgender activists to accept this categorization has also provided evidence for the tenuous nature of the relationship between transgenders and the medical communities. Similarly, theoretical debates revolving around suggestions that transgenderism, as a categorical existence, is wholly or partially dependent on modern medicine, invoke a variant perspective on the uneasy relationship between the medicalizing ruler(s) and the medicalized subject(s).

Medical associates within gender identity services have repeatedly exposed themselves to be less than understanding of transgender experiences. Activist Dallas Denny notes that “psychiatrists exhibit attitudes of condescension, disrespect, and contempt for transgendered people in their ‘professional’ publications” (Namaste 192). One woman involved in Namaste's research conveys an experience in which her psychiatrist used her as a lecture subject without ever having procured consent. At the time, she realized that what was occurring was illegal and certainly unethical. However, she still went through with the ‘interview’ as she recognized the subordinated position in which she was held by the medicalizing institution reigning over her possible sex re-assignment procedures.
Medical service providers outside of gender identity clinics have also exhibited innumerable acts of intolerance towards transgendered people, often causing very dangerous, sometimes fatal, situations. One striking example of this involves the death of Tyra Hunter, a transgendered woman, who was seriously injured in an automobile accident in 1995. While attending to her,

“An Emergency Medical Service (EMS) technician is reported to have jumped back from her body when he cut her pants off, to enable him to treat one of her injuries, and saw her penis. This EMS technician…is said to have shouted, ‘That ain’t no bitch!’ Treatment of Hunter’s injuries came to a halt while other technicians gawked at and ridiculed her.” (Califia 233)

Hunter died shortly after this display of intolerance and trans-phobia by representatives of the medical community.

Transgender identity is claimed by the psychiatric community as a “disorder,” or “condition.” Anne Bolin’s research “interrogates the uniform nature of psychiatric categories of transsexualism and transvestism,” and clearly “exposes the regulatory functions of psychiatric practices” (Namaste 26). These ‘regulatory functions’ include the necessity for transsexuals to claim ‘illness’ before being considered for sex re-assignment hormones and/or surgery. This ‘illness’ is itself transsexuality, and unless one accepts transsexuality as an ‘illness’ and as a component of their own personality, they will be excluded from most sex-reassignment programs.

While discussing the concept of transsexuality as a psychiatric condition, Karen Nakamura points out that,

“Many in the transsexual community challenge the Benjamin SOC [Standards of Care] because it forces transsexuals to declare themselves as mentally ill before they can receive treatment. They rightly argue that no other medical treatment– even those of a drastic nature such as tubal ligation, vasectomies, or breast implants– requires the approval of a mental hygiene specialist.” (185-186)

The International Conference on Transgender Law and Employment Policy, Inc. (INCTLEP) has drafted the International Bill of Gender Rights (IBGR) which includes clauses demanding “the right to control and change one’s own body, the right to competent medical and professional care, and the right to freedom from psychiatric diagnosis or treatment” (Feinberg, Transgender Warriors 173-74).

Many theorists have identified difficulties in so radically ‘demedicalizing transsexualism’ by removing it as a psychiatric category. Kate Bornstein comments:

“The demedicalization of transsexualism is a dilemma. There is a demand for genital surgery, largely as a result of the cultural genital imperative…. Transsexuals, especially middle-class pre-operative transsexuals, are heavily invested in maintaining their status as ‘diseased’ people. The demedicalization of transsexuality would further limit surgery in this culture, as it would remove the label of ‘illness’ and so prohibit insurance companies from footing the bill.” (Califia 260-61)
Califa later comments in resonance with Bornsteins’ fears while further discussing the potential risks accompanying a sudden psychiatric demedicalization of transgenders, including an even more limited availability of surgical procedures (268).

In accordance with these concerns are suggestions that a simultaneous move to adjust socio-cultural attitudes accompany the demedicalization of transgenderism. In a speech presented at the Second Transgender Health Conference, Feinberg proclaims that “the only way we can begin to create change in the care of trans people is to open up a dialogue with health workers,” (TransLiberation 82) going on to suggest that “we have a right to demand that health care institutions provide mandatory sensitivity classes…” (TransLiberation 83) with an emphasis on education for understanding trans identity12. The International Bill of Gender Rights (IBGR), adopted June 17, 1995, contains several clauses which explicitly call for changes in the current health care provision provided to transgenders. Two of the clauses in the IBGR include the demands that “all human beings have the right to control their bodies, which includes the right to change their bodies cosmetically, chemically, or surgically, so as to express a self-defined gender identity,” and that “no individual should be denied access to competent medical or other professional care on the basis of the individual’s chromosomal sex, genitalia, assigned birth sex, or initial gender role” (Feinberg, Transgender Warriors 173).

It is clear that the investigations surrounding transsexualism’s place within medicine and psychiatry will continue for a long time to come, and that all participants in various aspects of the contentious issues therein will continue to espouse their own beliefs. Both transgenderism and gender identity psychiatry, as social entities, have grown and suffered with each other, and it is unlikely that the two will ever become fully disentangled. Just as intertwined are the abstract theoretical notions of the categories of transgenderism and modern Western medicine. Exactly how these two cultural phenomena are related is a source of intense debate within queer theory and the various medical fields.

Several theorists, such as Janice Raymond and Bernice Hausman, have proposed a relationship of complete co-dependence between modern Western medicine and transgenders. In her 1979 publication, The Transsexual Empire: The Making of the She-Male, Janice Raymond asserts that “transsexuals are created through medicine,” and that “psychiatric evaluation as well as the availability of surgery function to produce transsexuals” (Namaste 33). Raymond “clearly stated that she believed it morally unethical to use advanced medical technologies to allow individuals to escape…the confines of their originally assigned sexes and genders” (Devor 41). More recently, in 1995, Bernice Hausman published Changing Sex: Transsexualism, Technology, and the Idea of Gender, in which she “meticulously details the dependence of the category ‘transsexual’ on medical technologies…” and proposes that “by demanding technological intervention to ‘change sex’, transsexuals demonstrate that their relationship to technology is a dependent one…demanding sex change is therefore part of what constructs the subject as a transsexual…” (Halberstam 160).

“There is often evidence in the lives of transgendered persons living in various historical and cultural settings that in the absence of modern Western medicine and technology, their lived gender identities were less subject to rigid institutional scrutiny and more freely allowed individual autonomy.”
To summarize and expound upon the theories of Raymond, Hausman, and many other like-minded scholars, transsexuals (as tangible individuals) and transsexualism (as a categorical theory) could not exist independent of modern Western medicine and technology. Because the contemporary definition of the term ‘transsexual’ mandates some desire to attain attributes of the ‘opposite sex,’ and because modern Western medicine holds a firm monopoly over the various possible means with which to achieve those ends, the current medical definition of ‘transsexual’ does imply some dependence of that category on modern medicine and technology. Because modern Western medicine and technology were not present in historical periods and are virtually absent from various non-Western cultures, the category denoted by the term ‘transsexual’ could not have existed. It is difficult to imagine that people existing in cultures without modern Western medicine (and therefore without the medicalized options granted to transsexuals) could have conceived of surgically and/or hormonally altering their sex in the methods now practiced by modern Western medicine. Without this desire, which is a central component in the definition of ‘transsexual,’ it seems that without modern Western medicine, ‘transsexuals’ could not possibly exist.

In order to fully understand this position, however, one must acknowledge the semantic imperatives of the category ‘transsexual’. Of course it is logistically impossible for ‘transsexualism’ to exist outside of modern Western medicine precisely because ‘transsexualism’ is defined in terms of modern Western medicine. However, it has been demonstrated by many scholars that persons who would today be classified as ‘transgendered’, if not ‘transsexual’, have indeed existed in various historical and cross-cultural arenas. In what seems to be a response to theorists such as Raymond and Hausman, Feinberg points out that:

“It’s true that the development of anesthesia, and the commercial synthesis of hormones, opened up new opportunities for sex-reassignment. However, the argument…doesn’t take into account ancient surgical techniques of sex-change developed in communal societies that offered more flexible sex and gender choices.” (*Transgender Warriors* 105)

The failure of the linguistic and medical category of ‘transsexualism’ to present itself does not diminish the legitimacy of these transgendered existences. There is often evidence in the lives of transgendered persons living in various historical and cultural settings that in the absence of modern Western medicine and technology, their lived gender identities were less subject to rigid institutional scrutiny and more freely allowed individual autonomy.

Countless anthropologists and gender theorists have remarked upon the existence of fluid gender distinctions and the embrace of what would now be called ‘transsexualism’ in many Native American societies. In fact, well over 100 tribal communities west of the Mississippi River have been documented as observing fluid sex/gender representation in “two-spirit” persons. Descriptions of Native American’s fluid perceptions of sex and gender poignantly illustrate that transgendered individuals accessed recognition of their gender identities without the aid of modern Western medicine or technology. In her search to locate FTM transsexuals across historical periods, Devor found evidence of transgender individuals in classical times, the Middle Ages, and the 16th, 17th, and 18th centuries. Social anthropologist Mark Johnson documents the existence of transsexuals in societies of the Southern Philippines. Although the details of the lived experiences of transgendered individuals in cross-cultural/historical settings implore further
inquiry, their presence is verified in a wide variety of situations which are/were free from modern Western medical technology.

**The Search for Causes of Transgenderism**

“‘It still remains unclear, however, what influences produce the many permutations which we call gender, sex, and sexual orientation.’”

A preoccupation with discovering the ’causes’ of varying aspects of our existences has embodied a distinct control over many scholarly fields, including feminism and queer theory. A great deal of this fascination revolves around and within the highly formulated ‘nature/nurture’ debate. The academic search for the ’cause’ of transgenderism has similarly fallen into this controversial whirlwind. Proponents of the ‘nurture’ side of this debate have argued, for example, that “FTMs had been ugly, non-cuddly babies” (Rosario 39) who had been forced into substituting for their father’s masculine role when their mother’s were facing male-abandonment. Harry Brierley devotes much of his discussion regarding the ‘treatment’ of transsexuals to the use of aversion shock therapy, suggesting that in some instances one’s transgendered identity can be conditioned ‘back to normal’. However, according to the Looking Glass Society, a non-profit organization dedicated to increasing awareness and acceptance of transgendered individuals, “no amount of psychotherapy, psychoactive drugs, aversion therapy or any other psychiatric method has ever ‘cured’ a true transsexual” (6).

Historically, most scholars in the field of transgender studies have believed that origins of a transsexual identity could be traced to psychological causes. Robert Stoller was a pioneer in this school of thought who placed a high degree of responsibility upon the dynamics of transsexuals’ families. Stoller focused on the “psychological trauma” which he felt caused female-to-male transsexualism, suggesting that “the transsexual process begins with grandparents who instill in the mothers of female-to-male transsexuals-to-be a sense that being female is of little value” (Devor 54). According to Stoller, due to this disregard for the female sex, mothers of FTM transsexuals-to-be restricted attention given to their daughters. These neglected daughters then sought emotional support from their fathers, who in turn taught “them that they should be little men” (Devor 54).

Dr. Harry Benjamin has been an extremely influential person in the study and ‘treatment’ of transsexuals, and initiated the professional sentiment that transsexuals “were not in fact mentally disordered” (Califia 15). Having treated Christine Jorgensen, Benjamin made many strides in his efforts for creating a more accepting atmosphere for transsexuals. Benjamin disputed “the belief of psychiatrists that ‘disturbed gender role orientation’ was a mental disorder caused by childhood trauma, and could be cured by psychoanalysis” (Califia 15), and instead attributed transsexualism to “hormonal imbalance or genetic abnormalities” (Califia 16).

Investigations concerning the ‘cause’ of transsexuality have more recently witnessed a trend of seeking biological factors that may cause sex/gender transgressions. Following this medicalized field of inquiry, Devor points out that “the most basic question to be asked is whether there is a genetic basis for transsexualism” (59). Other potential biological sites of difference which have been researched, to varying extents, discussed by Devor include “the histocompatibibility-Y (H-
Y) antigen status” (60), various sites of the brain (hypothalamus, anterior commissure, corpus callosum), and the presence/levels of hormones (testosterone, estrogen).

Zhou, Horman, Gooren and Swaab recently conducted a study on the possible relation between brain composition and transsexuality. These researchers provided information that “the volume of the central subdivision of the bed nucleus of the stria terminalis (BSTc), a brain area that is essential for sexual behavior, is larger in men than in women.” According to the researchers, evidence from their study revealed that “a female sized BSTc was found in male-to-female transsexuals”(1). Although these scientists have triumphantly proclaimed to have found the absolute biological cause for transsexualism, many flaws in the researchers’ methods can be isolated, and bring many of their conclusions into question.  

After much scientific consideration, the question of biological origins of transsexuality seems, for the moment, unanswerable. As Devor states herself, 

“It still remains unclear, however, what influences produce the many permutations which we call gender, sex, and sexual orientation. There may be a genetic coding for gender identity, or sexual orientation. There may be centres in the brain which differentiate between women and men and between homosexual and heterosexual persons. Little is known with any certainty.” (65)

Rosario agrees with the above statement, asserting that no definitive differences have been discovered by researchers between transsexuals and non-transsexuals.

In researching transgenderism, it should become apparent that what matters is the lived experiences of transgendered individuals, and that the supposed reasons for their sexed/gendered identities must be de-emphasized. By searching for the ‘cause’ of transgenderism, scientists are often skirting the real issues involved in assuming social responsibility as they consistently subject an entire ‘classification’ of people under medical/psychiatric scrutiny. As Califia poignantly states,

“By allowing the quest for a ’cause’ to continue, the encroaching threat of a ‘cure’ becomes much more visible.”

It doesn’t matter whether sex deviation is caused by social learning or biology; or at least, it doesn’t matter to the ‘deviate.’ If it weren’t for loneliness, discrimination, and stigma, most sexual-minority members would never consider giving up or altering their fantasies and pleasures. But it does matter to the doctors and scientists and researchers because these issues give them government grants, publishing contracts, and tenure at universities. (81)

Whether the ‘cause’ of transsexualism is psychological, biological, genetic, hormonal, learned, or conditioned, it seems clear that it will remain obscure for some time to come. If, as Butler proposes, both ‘gender’ and ‘sex’ are cultural constructs, and transgender identities are distinctly situated in a subversive zone of sex/gender, how could it even be possible to isolate a corporeal ’cause’ of transgenderism?
Perhaps the most detrimental aspect of the medicalized nature of transgenderism is that there is often an underlying end goal in scientific searches for explanations of human variance. When seeking a 'cause' it is extremely likely that the next practical step, after ascertaining that 'cause,' is to seek a 'cure.' Califia cogently asserts that

Transsexuals became the abused darlings of sexologists and medical doctors because they could be ‘cured’ by using hormones and surgery. Those who see themselves as gender scientists are invested in trying to discover a physiological explanation for human sexual variation. Instead of simply accepting this variation as a normal part of the spectrum of human experience, and seeing its intrinsic worth, these people inappropriately apply a medical model of health versus disease to gender identity and pleasure-seeking behavior. (80)

Ekins and King, discussing the overwhelming power of medical fields, state that “medicine has provided us with a language through which the activities of [transsexuals] are apprehended as pathologies which can be diagnosed, treated and, perhaps ultimately prevented” (7).

Eve Sedgwick discusses the dangers of identifying the origins of human sexual orientation in the subset of Axiomatic “Axiom Four.” These propositions correlate very clearly with the medicalized search for the origins of transgenderism. Warning of the extensive scope of social institutions whose underlying goals may be to impede the development of a GLBT presence, Sedgwick voices her concern that

‘The special volatility of postmodern bodily and technological relations may make such an attempt [to determine a 'cause'] peculiarly liable to tragic misfire. Thus, it would seem to me that gay-affirmative work does well when it aims to minimize its reliance on any particular account of the origin of sexual preference and identity in individuals.” (331)

Sedgwick makes poignantly clear that the risks greatly outweigh potential benefits when the queer community is being threatened with the technological powers of modern Western medicine. Feinberg also discusses the impossibilities of an objective, truly scientific search for a ’cause’ of queer identities. In a shockingly poignant analogy, Feinberg states that

“The search for a gay gene in a society in which gay and lesbian love is illegal and brutalized is about as “objective” as a scientific study of potential differences between Jewish and Gentile brains would be if it was conducted in Germany during the rise of fascism.” (TransLiberation 31)

By allowing the quest for a 'cause' to continue, the encroaching threat of a ‘cure’ becomes much more visible. Sedgwick and Feinberg attempt to alert their readers to the dangers of allowing too much scientific control over the search for the causes of variant sexualities. Given the precarious position of transgender individuals in contemporary society, those dangers highlighted by the aforementioned scholars are multiplied when medical researchers are attempting to isolate the cause of transgressive sex/gender representations.
“Agents of the medical profession, either within or outside of the specific field of gender identity studies, have consistently failed to exhibit acceptable levels of respect and/or consideration toward transgender individuals.”

Modern Western medicine has cultivated its forcefully possessive nature over transgender individuals through several varying means. The surgical and/or hormonal construction of sex for intersexed infants, in an attempt to uphold the culturally sanctioned notions of the heterosexual sex/gender dyad, provides a stunningly clear image of the medical manipulation of subversively sexed/gendered bodies. The various options allowed transsexuals who wish to pursue some degree of transition are strictly monitored and controlled by the medical/psychiatric fields. Agents of the medical profession, either within or outside of the specific field of gender identity studies, have consistently failed to exhibit acceptable levels of respect and/or consideration toward transgender individuals. Physical injury, mental anguish and social stigma have been direct products of the medicalized notion of transgendered individuals as sexed/gendered ‘anomalies’. The relatively recent pursuit of a medicalized explanation of transgenderism in biological/psychological terms has only served to highlight the control that the medical community has held, and continues to hold, over the transgendered community. This medicalized quest for a ‘cause’ is a precursor to a medicalized quest for a ‘cure,’ demonstrating the threat that the future of transgenderism will continue to exist under the regulatory ideologies represented by the medical/psychological communities.

Recourse to an examination of socio-cultural attitudes toward sex and gender is vital to the acceptance and growth of transgressively gendered individuals. The provision of surgical and/or hormonal options to transgendered individuals should be viewed as the ‘right’ that they are, rather than the ‘privilege’ that the controlling medical community insists they are. All social institutions, including medical fields, should advance their attitudes to exhibit an embrace of sex/gender variations, rather than insisting in their perceived threat. The shameful practices of denying accurate information, withholding desired medical attention, and pathologizing differences must become subjects of scrutiny. The battles between transgendered communities and social institutions such as modern Western medicine and technology will continue to rage until sex/gender minorities are granted the respect and understanding they deserve by these overpowering social institutions.

1. An example of a convergence of the medical and linguistic interpellation of gender is provided by Butler when she suggests that the reader “consider the medical interpellation which…shifts an infant from an ‘it’ to a ‘she’ or a ‘he,’ and in that naming, the girl is ‘girled,’ brought into the domain of language and kinship through the interpellation of gender…The naming is at once the setting of a boundary, and also the repeated inculcation of a norm” (7-8). Back to article

2. This refers to heterosexually dominated ideologies which insist upon a two-sexed, two-gendered system in which biological females are expected to exhibit ‘feminine’ characteristics and biological males are expected to exhibit ‘masculine’ characteristics. Back to article
3. An intersexed infant is one whose anatomical variations exhibit characteristics that are neither clearly male nor female. Back to article

4. Kessler summarizes the four main components of this “normalizing” process: “First, physicians teach parents normal fetal development and explain that all fetuses have the potential to be male or female…Second, physicians stress the normalcy of the infant in other aspects….Third, physicians (at least initially) imply that it is not the gender of the child that is ambiguous but the genitals…Finally, physicians tell parents that social factors are more important in gender development than biological ones, even though they are searching for biological causes” (15-17). Back to article

5. Kessler reports many different methods in which physicians fail to accurately inform intersexed adolescents of their intersexual status. For example, she points out that many physicians will tell those raised as females that their ovaries or uterus had to be removed at an early age because of maldevelopment, neglecting to state that these sex organs had never actually presented themselves in the first place. Back to article

6. In fact, one often cited case study is now referred to as the “John/Joan” story. After penile mutilation was caused by a poorly executed circumcision, one member of a set of twin infant boys born in the early 1960’s was subjected to genital reconstruction and raised as a girl. Money proclaimed this individual’s development “into a woman named Joan” to serve as supportive evidence for his theories. However, in the mid-1990′s, John came forward, stating that “he had never been comfortable as a girl, that as a teen he had refused additional ‘feminizing’ genital surgeries and hormones, and that he was now once again living as a man” (Chase 92). Back to article

7. Eve Ensler’s The Vagina Monologues acknowledges that “100 million women have been genitally mutilated worldwide,” (xxii) however, many intersex activists have denounced Ensler’s vagina-embracing piece for her apparent ignorance of ‘genital mutilations’ occurring each year in America. Ensler is one of the many Western feminists criticized for ethnocentrically condemning other societies for their practice of genital mutilation while overlooking the imposed genital mutilations of intersexed infants within Western societies. Back to article

8. The introduction of “male-to-female hormone treatment causes development of breasts, usually rather small, as well as redistribution of body fat and a general feminisation of the figure, hair and skin. Body hair is often reduced but not removed…” (Looking…8) The use of testosterone hormones by female-to-male transgenders usually incites hair growth, redistribution of body fat, and a slight lowering of the vocal range. Emotional and libidinal changes have been observed by individuals who partake in cross-sex hormonal injections, although the exact effects are difficult to determine empirically. Back to article

9. Phalloplasty surgeries are often “extremely costly, involve multiple surgeries spanning a number of years, and produce phalluses which [are] cosmetically questionable, generally oversized, awkward for intercourse, and probably unusable for urination” (Devor 406). In her study of FTM transsexuals, Devor found that “metoidioplasties, or genital free-up operations…were considerably more attractive to a few participants than were phalloplasties”
Metoidioplasties involve freeing the clitoris from the surrounding tissue in order to raise and enlarge the clitoris, forming a mini phallus. Often testicular implants are then put in place of the labia. Back to article

10. In the surgical construction of a vagina for a MTF transsexual, the phallus is often inverted, using the present organ to create the walls of the constructed vagina. Back to article

11. The Diagnostic and Statistical Manual of Mental Disorders Back to article

12. Feinberg also advocates an complete upheaval of the current health care practices, which she compares to the corporate business world, suggesting that all forms of health care should be free and readily available to all (TransLiberation). Back to article

13. The use of the term “two-spirit” to refer to traditional Native American transgenders is not without contestation. However, “two-spirit” is much more widely accepted by Native American scholars than previously utilized terms, such as the offensive label “berdache.” “Berdache” stems from the Spanish word bardaje and the French word bardache, both of which roughly translate to ‘male prostitute.’ Back to article

14. In 1967, Christine Jorgensen published her autobiography, Christine Jorgensen: A Personal Autobiography, which, according to Califia, “would set the terms of public understanding and debate about transsexuality for decades to come” (15). Jorgensen obtained sex reassignment surgery in the 1950s in Denmark from Dr. Christian Hamburger, after having endured the treatment of a series of medical professionals. Jorgensen was apparently so impressed with Dr. Hamburger that “after sex reassignment, she would take a feminized version of Dr. Hamburger’s first name…Jorgensen idolized her doctors as the only people who fully understood her dilemma and offered her a solution” (Califia 20). Back to article

15. “The BSTc volume in heterosexual men was 44% larger than in heterosexual women. The volume of the BSTc of heterosexual and homosexual men was found not to differ in any statistically significant way….A small volume of the BSTc was found in the male-to-female transsexuals. Its size was only 52% of that found in the reference males and 46% of the BSTc of homosexual males. Although the mean BSTc volume in the transsexuals was even smaller than that in the female group, the difference did not reach statistical significance” (Zhou…4). Back to article

16. The sample size for this study was extremely small and non-representative; only six male-to-female transsexuals were included in the study, along with control groups of heterosexual males, homosexual males, and heterosexual females, several of whom were infected with AIDS. All of the transsexuals involved with the study had undergone hormone treatment, including the ingestion of estrogen. The effects of this on the study are considered by the researchers, who unconvincingly attempt to dispute the relevance of these hormonal manipulations with ‘counter evidence’ stemming from one or two subjects. It is clear that the sample size in this study was far too limited and problematic to deduce any definitive conclusions regarding BSTc size and transsexuality. Back to article
Works Cited


