The Paradox of Authenticity: The Depoliticization of Trans Identity

THESIS

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Abstract

The language of authenticity that valorizes the mind over the body is embedded in Cartesian dualism, which thereby inspires an entirely personal understanding of self-fulfillment. Within the trans community, this language depoliticizes trans issues by framing nonnormative gender presentation as a personal issue. This paper examines the relationship of Cartesian dualism to the paradoxes of authenticity in trans medico-scientific discourse. For example, to express authenticity and gain social recognition within the medical model of trans identity, an individual must articulate her/his desire within the normative language of the medical establishment; therefore, the quest for authenticity is already foreclosed through the structures of normalization. This paper argues that, while medical procedures typically normalize one’s body to “pass” as the other sex, these procedures are also necessary for many trans individuals to gain social recognition and live a bearable life.

The notion that trans individuals are “trapped” in the wrong body has been the dominant paradigm since at least the 1950s. This paper argues that centering gender in the body constructs gender as ahistorical and thereby erases the political, economic, and cultural significance of trans oppression and struggle. This paper concludes that the systematic pathologization of nonnormative sex/gender identification has historically constituted the notion that gender trouble is indeed a personal problem that should be cured through medical science. I then outline alternatives to the medical model that trans
activists and academics have created to politicize trans identities and make the personal a political issue as a way to think beyond the Cartesian dualism rooted in the language of authenticity.
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The classification of mental disorders in the United States was initially developed in the 1840 census as a system to collect statistical information on the frequency of “insanity” in the population. This system produced a site of regulating those that strayed from normative understandings of mental health and thereby became an established apparatus for cultivating what has since been named biopower. In the first volume of *The History of Sexuality*, Michel Foucault famously defines the difference between sovereign power and biopower as the transition from the right to take life to the power to cultivate life.1 The power to cultivate life shaped the development of techniques for subjugating bodies and controlling populations that valued the “normal” over the “natural.” Biopower signals the new operation of power through normalization wherein difference from the norm became a matter of regulation. The normalizing effects of the binary distinction between “sane” and “insane” resulted in an erupting categorization of mental disorders as a means to uphold, enforce, and regulate normative standards of mental health. In 1952, the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provided a framework to implement the classification of mental disorders in a clinical setting and, subsequently, developed into the definitive guide for diagnosing individuals with mental disorders.

Remarkably, also in 1952, Christine Jorgensen gained recognition in the U.S. media as the first out male-to-female transsexual in when she returned from Denmark after obtaining a successful sex change operation. While she was not the first to obtain

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medical intervention, the spectacle of her media coverage brought about a growing awareness of non-normative gender identities and began popularizing the use of the term transsexual. However, the medical establishment failed to recognize transsexuality as a classified mental disorder until decades later. In 1980, transsexuality became an official diagnostic category as a mental disorder in the DSM, thus shaping medical professionals’ and transsexuals’ understanding of this disorder. The criteria of the category insist on the existence of only two sexes and genders, where one’s natal sex must normatively align with one’s gender. Those individuals who deviate from the binary sex/gender system are pathologized and scrutinized for their nonnormative gender behavior, categorized as transsexuals.

The DSM thus relies on the binary sex/gender system as a naturalized and objective phenomenon. Following a long-standing western scientific epistemology, it disavows the historical context of its classifications, framing these classifications as objective rather than subjective categories created by individuals from a specific time and place. The introduction to the current edition of the DSM, the DSM-IV-TR (2000, Fourth Edition, text revision), claims that mental disorders are behavioral or psychological conditions that materialize in the individual, with no attention to or account for historical context. The manual states, “Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the
individual.”

“True” mental disorders are anchored within the individual, not within society: I will argue that this depoliticizes trans issues by making all symptoms of transsexuality personal.

To undertake this argument, I place the history of the DSM in the larger conceptual framework of the relationship of Cartesian dualism and the paradoxes of authenticity in the medico-scientific discourse. I maintain that, while the medical procedures involved in transitioning from one sex to another typically normalize one’s body to “pass” as the other sex, these procedures also rely on the language of “an authentic self” and are necessary for many trans individuals to gain social recognition and live a bearable life. The notion that trans individuals are “trapped in the wrong body” has been the dominant paradigm since the 1950s. This paper argues that the systematic pathologization of nonnormative sex/gender identification has historically constituted the notion that gender nonnormativity is indeed a personal problem that should be cured through medical science. To historicize this discourse, I will discuss the history of scientific racism and the sexological classification of sexual inversion in relation to the construction of transsexuality as a mental disorder. In conclusion, I outline alternatives to the medical model that trans activists and academics have created to politicize trans identities and make the personal a political issue as a way to think beyond the Cartesian dualism rooted in the medicalized language of authenticity.

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3 In Undoing Gender, Judith Butler utilizes the term “livable life” in relation to “certain normative terms that must be fulfilled for life to become life” (39). I am using “bearable life” in a similar manner, to emphasize the normative terms as well as the fact that surgical procedures make one’s life more tolerable, to say the very least.
Conceptualizing Authenticity

This section explains the main concepts at work in this paper—Cartesian dualism, authenticity, and the sex/gender system—in relation to the DSM diagnosis of transsexuality in order to establish the analytic framework of my thesis. According to Cartesian dualism, mental phenomena are nonphysical, immutable, and have an entirely separate ontology from the body—the body is merely a vessel for the mind. Consequently, detaching an arm or a leg can sever the body, but the mind is indivisible. Descartes argued that a nonmaterial mind (psyché/soul) expresses itself in a mechanismically controlled body; therefore, the mind controls the body. He believed that mental phenomena affect physical phenomena through causally interacting in the pineal gland. In short, Descartes’s form of dualism was interactionism, which explained how the nonmaterial mind could interact with the material body.

Descartes’s mind/body dualism shapes much of contemporary western culture’s inescapable sense of inwardness—the concern with one’s inner self. Scripting the inner self as the Cartesian mind and the outer self as the Cartesian body, we can see how an individual’s inner self becomes the key to discovering her/his “true” self. According to Charles Guignon, “The inner/outer opposition is clearly valorized: the inner is regarded as higher or more real than the outer. Our outer avowals can be called ‘authentic’ only to

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4 The pineal gland is a small endocrine gland in the vertebrate brain that produces melatonin. Although Descartes did not have such a sophisticated understanding of the pineal gland, it played an important role in his philosophy. While the pineal gland was merely a site of interaction for the mind and the body, Descartes did believe that the gland was the primary seat of the mind (soul). See http://plato.stanford.edu/entries/pineal-gland/ for more information of Descartes’s use and understanding of the pineal gland.

5 Taylor, Charles. Sources of the Self, 160.
the extent that they can honestly and fully ‘express’ the inner.”
In other words, one’s inner self, i.e., authentic self, becomes an issue of morality—one must discover her “true self” in order to live a meaningful life. If an individual ignores her inner voice, she misses the deeper meaning of her life. The quest for authenticity values the inner self over the body, which reinforces Cartesian dualism by epistemically privileging beliefs about one’s mind over one’s body, as summed up by Descartes’s “Cognito ergo sum” (I think, therefore I am).

For a transsexual, these dynamics of mind/body and inner/outer are taken up through the normative schema of a binary sex/gender system. According to the medicalized discourse of the DSM that I am exploring here, the inner voice of a transsexual reflects her “authentic” gender and therefore she must alter her body to match her true gender identity. Moreover, authenticity posits a normalized gendered inner voice that reinforces an essentialized sex/gender binary as well as assumes humans as “natural” rather than socially established and regulated. The dominant understanding of the sex/gender system in the U.S. is a dualistic account of sex as biological and gender as socially constructed in the normative system of sex/gender that regulates bodies in contemporary U.S. culture.

Although gender is constructed, it must properly align with

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7 Fausto-Sterling, Anne. *Sexing the Body*, 20-22. In *Bodies that Matter*, Judith Butler reconfigures the relationship of sex to gender. She states, “If gender is the social construction of sex, and if there is no access to this ‘sex’ except by means of its construction, then it appears not only that sex is absorbed by gender, but that ‘sex’ becomes something like a fiction, perhaps a fantasy, retroactively installed at a prelinguistic site to which there is no direct access” (5). While sex may in fact be a fantasy, for a transsexual, the body is made exceptional through medical science’s insistence on the binary sex/gender system. In other words, sex cannot be absorbed by gender because there needs to be both to maintain the medical diagnosis of transsexuality. Moreover, gender is constructed as the “prelinguistic site,” not sex. Butler’s reconceptualization represents one main difference between transgender and queer theory. A
one’s sex. In other words, sex is determined at birth and gender should naturally and normatively follow. When sex and gender do not normatively line up, an individual is pathologized and understood as abnormal.

Within the transgender community, the language of authenticity that is promulgated by the medical model of the DSM depoliticizes trans issues by framing nonnormative gender presentation as a personal issue. Centering gender in the body disavows the political, economic, and cultural significance of trans subjection and struggle. The DSM insists that transsexuality is a mental disorder and thereby pathologizes and depoliticizes gender nonnormativity and constructs transsexuality as a personal identity disorder. The depoliticization of transsexuality in medico-scientific discourse, which is currently called Gender Identity Disorder (GID) in the DSM-IV-TR, conceptualizes the identity disorder with a disalignment of mind (psychiatry) and the body (medicine), which thereby inscribes a Cartesian dualism into the foundation of transgender genealogy.

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8 In this paper, I will use the terms “transsexual,” “transsexuality,” and “transsexualism” to discuss the medical model of nonnormative gender identity, wherein “transsexual” refers to the individual who desires to obtain medical procedures and live as the “opposite” sex. This is also the dominant category for individuals prior to the 1990s, when “transgender” entered the trans community’s vernacular. According to Katrina Roen, who is paraphrasing Susan Stryker, transgender politics are “informed by postmodern conceptions of subjectivity, queer understandings of sexuality and gender, radical politics of transgression, and the poststructuralist deconstruction of binaries” (“‘Either/Or’ and ‘Both/Neither,’” 502). The term “transgender” has become an umbrella term used to cover a wide range of sexual and gender minorities, such as transsexuals, gender queers, butch dykes, and drag queens as well as individuals who resist passing as one sex.

9 In Normal Life, Dean Spade utilizes the term “subjection” rather than “oppression” because he believes that “it indicates that power relations impact how we know ourselves as subjects through these systems of meaning and control—the ways we understand our own bodies, the things we believe about ourselves and our relationships with other people and with institutions, and the ways we imagine change and transformation.” He also states that subjection highlights the fact that power is more complicated than one group of people dominating another group of people. For example, psychiatry not only has power over trans individuals, but trans individuals have power over psychiatry through possessing the ability to choose what one reveals through the diagnostic process.
transsexuality. Interestingly, the introduction to the *DSM-IV-TR* states, “The term *mental disorder* unfortunately implies a distinction between ‘mental’ disorders and ‘physical’ disorders that is a reductionistic anachronism of mind/body dualism.” However, as the next section illustrates, transsexuality, as described by GID, insists on the normative connection of sex to gender where one’s physical sex must normatively align with one’s psychic gender. Therefore, the *DSM’s* classification of GID naturalizes trans individual’s relationship to the Cartesian dualism rather than transcends it.

**Situating Authenticity**

The *DSM’s* classification of GID fails to transcend Cartesian dualism because it dehistorizes the scientific classification of transsexuality and its relationship to sexual inversion. Therefore, in this section, I will historically locate the naturalization of the sex/gender binary through the rise of psychiatry and the creation of the *DSM* classification of transsexuality to illuminate the erasure of cultural concerns within the diagnosis of gender identity disorder. The notion of authenticity informs GID through the metaphor of being “trapped in the wrong body.” According to Charles Taylor in *The Ethics of Authenticity*, a new notion of authenticity was developed at the end of the eighteenth century. Prior to this, one’s authentic (inner) voice informed an individual of the right thing to do, but at the end of the eighteenth century, the authentic (inner) voice became “something we have to attain to be true and full human beings.” The cultural

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11 Taylor, 26.
narrative of authenticity rooted in the mind refutes that authenticity has a historical and political meaning. This history provides a way to interrogate the development of Cartesian dualism in and through modern scientific epistemologies and the medical models they spawned.

Transsexuality, as a diagnosis, originated through the sexological classification of sexual inversion in the late 19th century. During the wake of the Enlightenment, science became more authoritative and specialized as a result of industrialization and modernization. Moreover, by the middle of the 18th century, the Cartesian epistemology of certitude shaped scientific understanding of the human: scientists were uniquely objective observers while their objects of study embodied deviancy. In other words, deviants could never disavow their bodies, and therefore could never be objective. Science was conceptualized as a value-neutral realm of knowledge production that was not influenced by cultural, economic, or political factors, which thereby reduced the space for individuals to challenge the biological determinism increasingly embedded in scientific methodologies.

By the middle of the 19th century, human and social sciences created the “taxonomic revolution,” where deviants were taxonomized into distinct types that created specific identity categories. During the “taxonomic revolution,” racialized understandings of deviancy shaped scientific methods of classification, developing into scientific racism. Ladelle McWhorter states, “From the 1840s forward, race would no

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12 Stepan, Nancy Leys and Sander Gilman. “Appropriating the Idioms of Science,” 175.
13 In How Sex Changed, Joanne Meyerowitz uses the term “taxonomic revolution” to describe the explosion of taxonomic classifications that separated different types of deviants into specific scientific types.
longer be simply a matter of physical appearance; instead, it would be a matter of organic function and physiological development... Racial inferiority would become a matter of measurable deviation from established developmental norms.”\textsuperscript{14} Comparative anatomy was one popular method scientists employed to quantitatively measure the differences between the races. For example, Samuel George Morton measured the brain size of different races from his vast collection of skulls (he had over one thousand when he died in 1851) as a means to objectively rank the races by intellect.\textsuperscript{15} He discovered, perhaps unsurprisingly, that Anglo-American men had the largest brains, i.e., the greatest capacity for intellect. Comparative anatomy also was utilized to illustrate that prostitutes, black women, and female inverts have larger clitorises than white, heterosexual women.\textsuperscript{16}

Scientists strived to distinguish a range of abnormalities and deviations from rational norms as a means to read individual bodies. For example, Cesare Lombroso created the “born criminal” around the same time sexual inverts were constructed as a distinct type in the medico-scientific literature. In the late-nineteenth-century, the creation of the “criminal body” as “objects of knowledge” relied on mathematical technologies that focused on reshaping crime as a cultural and scientific issue. Lombroso believed that the body was somehow hiding the truth and that pain connected the exterior to the interior of the body. The more pain one feels, the more sane and civilized he is in comparison to the criminal and other lower beings whom hardly feel any

\textsuperscript{14} McWhorter, Ladelle. \textit{Racism and Sexual Oppression in Anglo-America}, 120-121.
\textsuperscript{15} See Stephan Jay Gould’s article “American Polygeney and Craniometry before Darwin” for more information of Morton’s brain study.
\textsuperscript{16} See Siobhan Somerville’s “Scientific Racism and the Invention of the Homosexual Body” for more information.
Lombroso’s use of comparative anatomy contributed to the history of scientific racism and other scientific methodologies that subjugated individuals who strayed from the norm.

Siobhan Somerville posits that “the structures and methodologies that drove dominant ideologies of race also fueled the pursuit of scientific knowledge about the homosexual body.” Sexologists used comparative anatomy to prove the inferiority of sexual inverts to heterosexuals as well as shaped the classification around notions of white supremacy embedded in the biopolitical techniques of science, such as the Eugenics movement. Sexological conceptualizations of sexual inversion utilized the Cartesian dualism to explain the incongruencies between anatomy and psychological characteristics. While one’s inner gendered self was conceived as innate from the beginning, the origin of sexual inversion was debated: it was an acquired or congenital disease?

In 1864, Karl Ulrichs was the first person to construct a scientific theory of same-sex desire by positing that a male invert (“Urning”) was a male-bodied individual with a female soul, which later turned into his notion of a “third sex” whose nature was inborn. He felt that the female aspect of the “Urning” was an innate part of their nature and that the primary factor of this female aspect was their sexual attraction to men. Ulrichs’ theories were used to construct the medico-scientific classification of sexual inversion from sexologists, such as Richard von Krafft-Ebing and Havelock Ellis, and psychogenists such as Sigmund Freud. Krafft-Ebing’s *Psychopathia Sexualis*, which

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primarily consists of case studies, was first published in German in 1886, followed by seventeen revised editions between 1886 and 1924. Until the last edition, Krafft-Ebing believed sexual inversion was a sign of degeneration that manifested as a neuropathic and psychopathic state that developed without external causes. But by the last edition of *Psychopathia Sexualis*, he viewed inversion as a simple anomaly rather than degeneration.

In *Studies in the Psychology of Sex, Volume Two: Sexual Inversion* (1896), Havelock Ellis provides an in-depth overview of sexology’s conceptualization of sexual inversion as well as an analysis of his own case studies. Ellis states, “Inversion is bound up with a modification of the secondary sex characteristics. But these anomalies and modifications are not invariable, and not usually a serious character, inversion is rare in the profoundly degenerate.” Therefore, according to Ellis, sexual inversion is a congenital anomaly with psychic affiliations. Around ten years later, Sigmund Freud published his *Three Essays on the Theory of Sexuality* (1905), which begins with a section on sexual aberrations. Freud argues that innateness can only be ascribed to absolute inverts—i.e., individuals only attracted to people of the same sex. Significantly, he separates sexual object, “the person from whom sexual attraction proceeds,” and sexual aim, “the act towards which the instinct tends.” This separation provided the theoretical framework for sexologists to separate homosexuality from transsexuality. In 1910, Magnus Hirschfeld coined the term ‘transvestite’ in *Die Transvestiten* to describe

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19 Ibid, 74.
sexual intermediaries – individuals who existed somewhere between the borders of male and female. The debate around the origin of inversion, whether it was biological or psychological, continued even after Hirschfeld separated sexual intermediaries from homosexuals.

By the 1940s, psychiatry had become the dominant paradigm for dealing with deviancy and most psychiatrists viewed transsexuals (still called ‘transvestites’) as mentally ill and in need of institutionalization. The notion of gender, as a way to classify individuals within the binary sex/gender system, had not entered the medical realm. Therefore, doctors used the term “psychological sex” to define the mental sense of self that was separate from the body. In 1955, psychologist John Money utilized the term “gender role” to discuss “all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman,” and ‘gender’ to describe “outlook, demeanor, and orientation.”22 In later publications, Money along with John and Joan Hampson, utilized the term “gender role and orientation” and believed that child rearing and environment contributed more to a person’s gender orientation than biological sex.

Then in 1964, psychiatrist Robert Stoller and colleague Ralph Greenson refined the notion of gender with the term “gender identity,” which eventually became the standard in the literature on transsexualism. Stoller and Greenson defined gender identity as “one’s sense of being a member of a particular sex.”23 The adoption of the term “gender identity” in place of “gender role” created a clearer distinction between the

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23 Ibid, 115.
personal sense of self and the behaviors connected to masculinity and femininity. Once transsexuality became a separate category in 1949, with the publication of David Cauldwell’s “Psychopathia Transexualis” in *Sexology* magazine, the sex of the transsexual’s body needed to align with the gender of her/his mind. Doctors and psychiatrists thus inscribed the Cartesian dualism at the core of the medical understanding of transsexuality. When medico-scientific literature on transsexuality officially developed in the late 1950s, both doctors and psychiatrists implemented this fundamental framework and created plausible criteria that could be applied objectively and easily repeated from case to case.

Significantly, after the media frenzy around Christine Jorgensen’s story in the early 1950s, sexologists, psychiatrists, and doctors began to focus almost exclusively on male-to-female (MTF) transsexuals. Susan Stryker discusses the fact that Jorgensen’s popularity resulted not only from her beauty, poise, and youth, but also because she was a G.I. in World War II.  

24 Stryker says, “There had been a great deal of attention to male homosexuality in the military during World War II, and maybe, some thought, gender transformation represented a solution to that perceived problem.” 25 During the 1950s, nationwide defamation and scapegoating of homosexuals cultivated anxieties over homosexuality and homosexual sex crimes, most often linked or even standing in for post-Cold War anti-communist phobias. This fear of effeminate men, what Eve

Sedgwick called “effeminophobia,”\textsuperscript{26} led to an increase in medical and media attention around transsexuality, and its relationship to homosexuality.

The focus on MTF transsexuals was also shaped by the Cartesian dualism influencing medico-science’s perception of transsexuality. The female body had always been more closely scrutinized, measured, and cataloged than the male body. Therefore, the incongruence between the mind and body for a man who desired to be a woman was more regulated than the woman who desired to be a man. Judith Butler states, “The classical association of femininity with materiality can be traced to a set of etymologies which link matter with \textit{mater} and \textit{matrix} (or the womb) and, hence, with the problematic of reproduction.”\textsuperscript{27} Women always had been tied to the body through reproduction and menstruation, whereas (white) men could disavow their bodies to focus on the mind. The media not only focused on MTF transsexuals, but also eroticized them by printing stories about trans burlesque dancers. These stories represented trans women as normatively feminine in appearance.

In the late 1960s, Harry Benjamin’s \textit{The Transsexual Phenomenon} became the guideline for diagnostic criteria for transsexualism. Benjamin made use of Karl Ulrich’s’ “Urning” but modified it to discuss correcting one’s body to match the gender of one’s mind (inner self). Gender was thus conceived as immaterial and therefore unchangeable, which must be realized to express one’s “true” self. In other words, gender represents one’s authentic self hidden beneath the body; and, therefore, s/he must have access to surgical procedures to authenticate her/his body to match her/his “true” gendered self.

\textsuperscript{26} Sedwick, Eve Kosofsky. “How to Bring Your Kids up Gay,” 20.
\textsuperscript{27} Butler, Judith. \textit{Bodies that Matter}, 31.
Authenticity thus became central to the dominant understanding of transsexuality, thereby constructing transsexuality as an identity disorder, i.e., mental disorder, rather than a dilemma with the hegemonic notion of the binary sex/gender system. Benjamin argued that transsexualism was a somatic condition that could not be cured through psychotherapy alone. He advocated for surgical intervention at a time when doctors and psychiatrists opposed such procedures.

Preoperative transsexuals read Benjamin’s book and used the language to gain acceptance for medical intervention. Their behavior mirrored the standards of the book almost exactly and it took doctors many years (and numerous journal articles later) to realize that their patients had read the book as well. addition, the patients helped one another rehearse and prepare for the interviewing process to appear as conventional feminine women. But doctors did not want transsexuals to create a community and often advised and even required their patients to say they would not socialize with other transsexuals. They wanted their patients to become “normal” members of society—i.e., disappear—and only accepted candidates who would conform to the dominant norms of gender and sexuality.

Doctors worked to stabilize the connection between the normal and abnormal through utilizing terms such as “adjustment” and “conformity” as a means to regulate and

29 Denny, Dallas. “Transgender Communities in the United States in the Late Twentieth Century,” 177. Denny further states, “After surgery, the clinic doctors told them that they were now normal men and women and should blend into society; most did” (177).
30 Ibid.
subordinate those who did not “fit in.” Jennifer Terry says, “The norm, while a mutable construct, was, after all, a means for marking the deviant and thus could be used to mobilize methods for bringing the deviant into conformity with the majority or for further marginalizing such a character in the interest of maintaining majoritarian social order.”

Doctors worried that ideals of gender transgression would enter into transsexuals’ consciousness and thereby disrupt norms constructed by the binary sex/gender system. Those who did not or would not conform to the normative understanding of the sex/gender system were refused medical intervention.

In 1966, John Hopkins opened the first gender clinic that performed sex-change operations in the United States. Although John Hopkins’s clinic was the impetus for other universities to open gender clinics, John Hopkins’ clinic rarely actually accepted any patients for surgery. University of Minnesota, University of California, Los Angeles, University of Washington and Stanford opened gender clinics within years of John Hopkins, which provided more opportunities for trans individuals to gain access to surgery in the United States. Stanford took it a step further and opened a grooming school inside the clinic to teach MTF transsexuals how to talk and act like proper ladies. As Sandy Stone states, “The origin of the gender dysphoria clinics is a microcosmic look at the construction of criteria for gender. The foundational idea for the gender dysphoria clinics was first, to study an interesting and potentially fundable human aberration;

31 Terry, Jennifer. *An American Obsession*, 158.
33 Denny, 177.
34 Meyerowitz, 221.
second, to provide help, as they understood the term, for a ‘correctable problem’. ”

Doctors understood transsexualism as an identity disorder that can be cured through hormones and surgery, thereby reinforcing transsexuals’ relationship to Cartesian dualism. In short, a transsexual can be cured of her/his identity disorder by normalizing the body to match cultural paradigms of masculinity and femininity.

Constructing accurate criteria for the process of diagnosis was justified through ensuring successful gender transitions, which meant anyone who could realistically “pass” as a “normal” woman or man. Surgical procedures associated with transsexuality thereby construct a paradox for trans individuals. Hormones and surgery are a means to normalize binary gender regulations and conform trans individuals to the Cartesian binary by altering one’s body to match her/his mind; yet at the same time, many trans individuals cannot live a bearable life without such procedures and face extreme violence, poverty, and suicide without medical intervention. The criteria for diagnosing an individual with gender identity disorder reflect this paradox: it eases one’s agony, but at the same time, it strengthens one’s agony by pathologizing her/his desire to alter her/his body. In other words, the diagnosis actually acts as its own social force, causing suffering, setting up desire as pathological, and strengthening the regulation of individuals who communicate these desires in institutional situations.

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35 Stone, Sandy. “The Empire Strikes Back,” 227. Arlene Istar Lev discusses the medical model’s role in constructing a “true” transsexual in “Disordering Gender Identity.” She states, “According to this model, only ‘true’ or ‘primary’ transsexuals should be eligible for medical and surgical treatments and distinguishing between ‘true’ transsexuals and all other gender variant and gender dysphoric people became the focal point of much of the research as well clinical evaluation” (43). University gender clinics in the 1960s and 1970s were not set up to necessarily help individuals achieve a more bearable life but to collect data to create better criteria for diagnosis.

36 Butler, Judith. Undoing Gender, 100.
Once diagnostic criteria were established for transsexuality (Benjamin’s *The Transsexual Phenomenon* is considered the beginning of this criteria), psychiatrists and doctors assessed candidates for surgery on their ability to realistically and successfully perform their gender choice. Doctors thus required that a trans individual could pass as an authentic man or woman, yet many psychiatrists and doctors were still opposed to sex reassignment surgery for transsexuals, maintaining that transsexuals were delusional and needed psychotherapy. Moreover, many doctors had ethical concerns about removing healthy body parts and, as a result, most trans identified individuals were not receiving the surgical procedures necessary to gain social recognition as the sex of their choice. The institutions of normalization embedded in the immense network of biopolitical machinery needed to recognize transsexuality as a serious illness that required surgical intervention for doctors to intervene and begin accepting patients. The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provided just that.

The first two editions of the *DSM* (1952, 1968) did not include transsexualism as a diagnosable mental disorder. By the middle of the 1970s, a task force was established to develop the third edition of the *DSM* by the “Council of Research and Development of the North American Psychiatric Association.” Robert Spitzer, the manual’s editor and chair of the task force, constructed the structure of the *DSM-III* around a neo-Kraepelin framework that focused on diagnostic research rather than clinical practice. Emil Kraepelin (1856-1926) was a famous German psychiatrist who classified mental disorders in relation to physical diseases. The *DSM-III* classifications of mental disorders

37 Meyerowitz, 121.
38 Young, Allan. *The Harmony of Illusions*, 94.
mirrored one of the methodologies of sexological taxonomy of the early twentieth century. Analogies and metaphors were used by sexologists to create a connection between women and “lower” races through relating similar causes for each group’s “natural” inferiority to white men. These analogies represented well-known, established metaphors as well as provided the lenses for people to view differences between sexes, races, and classes. Moreover, racial and sexual analogies were naturalized in science, thereby erasing the metaphorical quality.

Although the DSM-III did not employ the metaphor “trapped in the wrong body” for defining the criteria of transsexuality, this metaphor did shape the language in the classification. Nancy Leys Stepan states, “[B]ecause a metaphor or analogy does not directly present a preexisting nature but instead helps ‘construct’ that nature, the metaphor generates data that conforms to it, and accommodates data that are in apparent contradiction to it, so that nature is seen via the metaphor and the metaphor becomes part of the logic of science itself.” The metaphor “trapped in the wrong body” helped construct the classification of transsexuality by shaping psychiatrists’ understanding of the disorder, which thereby naturalized the Cartesian dualism inherent in the metaphor itself. In short, the metaphor “trapped in the wrong body” reinforced the notion that the body needed to be altered to authenticate one’s true self hidden within oneself.

This neo-Kraepelin epistemology gave priority to epistemological clarity rather than clinical experience through constructing diagnostic criteria that could be repeated across a variety of cases. The new emphasis on careful classification of mental disorders

40 Ibid, 371.
created a space to include transsexualism as a nosology while John Money, Robert Stoller, and Harry Benjamin’s research and clinical work influenced the decision to include transsexuality in the *DSM-III*. The *DSM-III* acquired the status of the authoritative text within psychiatry and, therefore, these classifications were considered scientific truth. Spritzer and his task force worked to institute a scientific nosology through creating criteria “explicit enough to obviate any need for interpretations based on tacit knowledge.”

The diagnostic criteria for transsexualism in the *DSM-III* was revised to “Gender Identity Disorder” (GID) in the fourth edition, first published in 1994 and then revised in 2000. The current criteria (*DSM IV-TR*) states:

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. C. The disturbance is not concurrent with a physical intersex condition. D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The medico-scientific establishment of transsexualism and then GID provided a way for trans individuals to gain access to hormones and surgical procedures. On the one hand, the diagnosis authenticated trans peoples’ desire to alter their bodies to live a bearable life. On the other hand, the diagnosis further pathologized gender variant individuals.

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The medical discourse of transsexualism insists that ‘man’ and ‘woman’ are natural categories, and in turn denies transsexuals the right to authentically belong to these categories. Criterion A in the *DSM-IV*, stated above, explains in adolescents and adults that this “persistent cross-gender identification” is evident through regular passing, desire to be regarded as the other sex, and/or “the conviction that he or she has the typical feelings and reactions of the other sex.”\(^{44}\) This criterion interprets sex as natal sex.\(^{45}\) Therefore, even if an individual transitions to the other sex, s/he will always have GID because s/he will always be passing as the other sex. Criterion A also assumes that normal men are appropriately masculine and normal women are appropriately feminine. If a woman has “typical feelings and reactions” of a man, then she is deviating from the norms of the binary sex/gender system and therefore has a mental disorder. Passing as a man offers one solution to fixing her disorder.

Examining the history of transsexuality as a medical diagnosis in the *DSM* exposes the prejudice of these so-called objective classifications by revealing “an underlying psychomedical gaze that has intentionally sought out human deviance with the intention of establishing institutionalized social control.”\(^{46}\) For example, Kenneth Zucker, psychologist and head of the child and adolescent Gender Identity Clinic at Toronto’s Centre for Addiction and Mental Health, was selected as a member of the American Psychiatric Association’s Task Force on Gender Identity, Gender Variance, and Intersex Conditions in 2007 and then as chair of the workgroup on “Sexual Identity

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\(^{44}\) Cohen-Kettenis and Pfäfflin, no page numbers.

\(^{45}\) Ibid.

Disorders” in 2008 for the 2012 (which is now 2013) edition of the DSM-V. Zucker is infamous for his use of “reparative therapy:” he helps children accept their natal sex and associated gender, which he put subtly when stating that young boys must “drop the Barbie.” In short, Zucker “cures” children of their gender variant behavior through teaching boys how to be masculine and girls how to be feminine. As shown above, Gender Identity Disorder is not constructed through scientific evidence of mental illness but through cultural and political bias couched as science.

Moreover, the inclusion of GID in the DSM illustrates how cultural norms shape the classifications in the manual. In fact, renaming transsexualism as Gender Identity Disorder in the DSM highlights psychiatry’s view of gender transgression as a form of dis-order. In other words, the term disorder suggests that psychiatry regulates social norms and works to reinscribe normative behavior to those individuals who contest or unsettle those norms. The term disorder also infers a purely somatic understanding of human beings, which thereby reinforces transsexuals’ need for hormones and surgery. Moreover, “disorder” implies that there is a non-disordered means of expressing and experiencing gender identity, which further strengthens hegemonic gender norms. As the next section discusses, confessing one’s gender identity disorder to the proper medical professional initiates the process of hormones and surgery.


Confessing Authenticity

This section examines the relationship of authenticity to the construction of a normative transsexual narrative that centers on discovering one’s “true” self. A transsexual must confess her/his story in a normative, intelligible way, which means that s/he must often ignore, distort, or lie about aspects of her/his very existence. Given that the confession is at the heart of psychoanalytic practice, confessions of gender disorder is central to the diagnostic criteria. Foucault discusses the “medicalization of the effects of confession,” which means that the confession was “placed under the rule of the normal and pathological.”49 The confession needs to expose that hidden truth which lives in one’s immediate consciousness. For the transsexual, this meant discovering one’s inner gendered essence, and confessing the inconsistency of the inner self and the body to the proper medical professional. In short, a transsexual’s insides must be confessed so that her/his outsides can be altered to match her/his insides.

The confession became a medicalized regulation of trans authenticity through the institutions of psychiatry and medicine. By placing the transsexual outside the boundaries of the hegemonic sex/gender binary, medical discourse constructed the transsexual as a site of transgression and then reinscription. Once a transsexual properly and truthfully (within medical regulations) confesses her disorder, she can obtain the appropriate procedures to “pass” as a “normal” man or woman. Significantly, for trans individuals, confessing one’s desire to transition to another sex must be regulated through

a psychiatrist and doctor. Connecting the confession with examination and personal history with the organization of a system of identifiable symptoms establishes the practice of confession as a scientifically acceptable method of observation. In short, a transsexual’s gender disorder becomes scientific knowledge if her/his symptoms conform to the criteria of the diagnosis.

But as Foucault asked, “How much does it cost the subject to be able to tell the truth about itself?” The price a trans individual pays when confessing her nonnormative gender identity to a medical professional often involves the internalization of the language of pathology in the medical model of transsexuality. Consequently, some transsexuals believe that transsexuality, or gender identity disorder, is indeed a mental illness. An individual is required to confess her/his desire to transition within the bounds of gender identity disorder as a means to gain access to sex reassignment technology, thereby inscribing the medical discourse as foundational and necessary. Additionally, she must deny her history as the opposite sex to become fully intelligible within hegemonic cultural norms. In other words, she authenticates her identity through disavowing her “wrong” gendered history, which is the price she must pay to fabricate a believable history and obtain acceptability in society.

Many transsexuals thus operate, knowingly or not, within the framework of the Cartesian dualism as a strategy to gain authenticity through confessing disorder with their gender identity. Henry Rubin conducted an ethnographic study with FTM transsexuals and discovered that his participants believe they have a core male identity that is

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50 Ibid, 65.
concealed by their female bodies. Therefore, they alter their bodies to match their core male identities as a means to make their true selves recognizable to society and themselves. This conviction assumes that bodies reveal the truth inside oneself and Rubin argues that these trans men evoke the normative notion that all men must have male bodies as a way to gain recognition of their true gender identities. He states, “This is nothing less than an ingenious reinvigoration of these hegemonic beliefs for the project of self-realization and social recognition.” While this reinvigoration of gender norms may be a way to gain social recognition, this mode of thinking depoliticizes trans issues by making nonnormative gender presentation a personal issue.

A counterdiscourse to confessing authenticity rearticulates transsexuals’ lives as political action by “reappropriate [ing]ting difference and reclaiming the power of the refigured and reinscribed body.” But generating a counterdiscourse is difficult because the transsexual is taught to disappear into the “normal” population as quickly as possible. Transsexuals must erase much of their histories and reconstruct a plausible past to gain acceptance through unquestionable recognition in society. This erasure works to maintain dichotomous gender norms and subjugate transsexual bodies, while also permitting an individual to be intelligible as a subject. But at the same time, this recognition restrains an individual to conforming to the norms. As discussed above, transsexuals are stuck in a paradox: a trans individual is constrained by normative ideals of recognition whether s/he chooses to stay preoperative or s/he chooses to obtain surgery

53 Ibid, 152.
54 Stone, 232.
and live postoperative. To disrupt this regime of normalization, and also, perhaps, offer a route to a more bearable and less paradoxical life, Stone asks transsexuals to own their pasts with all its complexities and ambiguities and to come out as transsexuals.

Coming out of the transsexual closet subverts the medicalized confession into a form of resistance through publicly asserting gender transgression, thereby becoming an alternative form of confession. Publicly claiming one’s trans identity de-essentializes the medical model of transsexuality by resisting the Cartesian dualism “inherent” in the hegemonic binary sex/gender system. Moreover, s/he opposes the violence afflicted on trans people through the medical system along with society in general by working to break down those systems that reinforce hegemonic sex/gender norms. An individual’s process of publicly “coming out” resignifies the confession, placing the emphasis on gender transgression, not reinscription.

Yet publicly “coming out” is not always a possibility for many transgender and transsexual people. First, to dispute the norms through which recognition is granted endangers one’s recognizability as a subject. Second, “coming out” can impede one’s ability to gain employment, find housing, and access medical treatment; one is subjugated into living a life in the margins of society. Third, the loss of loved ones can influence one’s decision to stay in the closet. Many transsexuals lose romantic relationships, children, friends, and other family members through the process of confessing one’s desire to live as a transsexual. For example, when Deirdre McCloskey, author of Crossing, came out of the closet at the age of 52, she had a wife and two children, whom she then lost during her transition from male to female.
Moreover, because the GID diagnosis requires a transsexual to desire to live full-time as the opposite sex, a trans individual cannot request any sort of sex-reassignment surgery or hormones to masculinize or feminize her/his appearance without fully transitioning to the opposite sex. Therefore, transgender individuals are placed in “the position of the haunting abject” of the GID diagnosis because GID conflates issues of gender nonconformity, gender identity, and emotional and/or physical suffering. Only “true” transsexuals can gain access to “gender-confirming health care.” According to the DSM-Ⅲ-TR, “Gender Identity Disorder can be distinguished from simple nonconformity to stereotypical sex-role behavior by the extent and pervasiveness of the cross-gender wishes, interests, and activities. … Rather, it represents a profound disturbance of the individual’s sense of identity with regard to maleness or femaleness.” Through the framework of Cartesian dualism in the DSM diagnosis, behaviors that diverge from normal, acceptable gender requirements are stigmatized and deemed clinically diagnosable. The possibility for a healthy, functional trans individual to

56 Sedgwick, Eve Kosofsky. “How to Bring Your Kids up Gay,” 20. Sedgwick discusses theorizing gender and sexuality as separate but also “intimately entangled axes of analysis” (20). Through separating these categories, she believes that effeminate boys are endanger of being left in the “position of the haunting abject.” She also says that effeminate boys become the haunting abject of “gay thought itself” (20).

57 Spade, Dean. Normal Life, 45n11. Spade uses the term “gender-confirming health care for trans people” throughout his book and states two main reasons. He says, “First, the same programs that exclude coverage of this care or deny this care for trans people often cover it for non-trans people, so the distinction is not about certain kinds of procedures or medications; it is about who is seeking them” (45n11). Second, he says he wants to avoid terms like “sex reassignment surgery” because they concentrate on a small part of the trans community. Much of the trans community request (and denied) mental health care, hormones, and/or other surgical procedures, but this various from individual to individual. I have used terms like “sex reassignment surgery” through this paper because I am discussing specific requirements for the DSM diagnosis. In my final section, I will use Spade’s term to discuss possibilities outside the medical model.


59 Lev, Arlene Istar. Transgender Emergence, 90.
receive treatment is foreclosed through this mental illness framework. In short, a transsexual cannot be deemed healthy, since the medical discourse continues to diagnose her/his suffering from a pathology of the mind.

In fact, a paradox is created because the diagnostic process requires transsexuals to be diagnosed as mentally ill within the bounds of GID. Yet these individuals are required to be healthy enough to comprehend the physical and emotional costs of treatment. As a result, transsexuals must police their own desires for treatment to show enough distress to necessitate help but not so much as to appear unreasonable or dangerous. A trans individual’s desires are thus already foreclosed through the structures of normalization embedded in the medico-scientific understanding of transsexuality and GID.

In sum, the process of transitioning is painful enough and once an individual can pass, they often do not want to out themselves and experience more pain. Moreover, many trans people are forcibly outed through legal battles and transphobic violence. Since transsexuals are constructed as an identity disorder in the *DSM*, the devastating violence and persecution often experienced through the process (and after) is blamed on the individual rather than society. The *DSM-IV* diagnosis briefly discusses ‘peer teasing and rejection’ and even acknowledges that children may refuse to go to school because of taunting or pressure to dress in clothing stereotypically appropriate to their assigned sex. But unfortunately, the next sentence places the blame on ‘the person’s own preoccupation with cross-gender wishes that often ‘interferes with ordinary activities’ and
ends up in situations of social isolation.° In other words, the criteria frames the taunting and rejection as a product of one’s own identity disorder, not as a result of the social norms embedded in the binary sex/gender system. As a result, many transsexuals associate “outness” as an identity label that causes unnecessary suffering and danger, and thereby decide to “pass” as “normal” women and men, which will be discussed in detail below.

**Recognizing Authenticity**

The contemporary classification of transsexuality depends on the Enlightenment framework that reduces all relationships to dichotomies, where the Cartesian dualism and the male/female binary shape the medico-scientific classification of transsexuality. The language of authenticity that valorizes the mind over the body is embedded in Cartesian dualism, which thereby inspires an entirely personal understanding of self-fulfillment while “making the various associations and communities in which the person enters purely instrumental in their significance.” An individual’s relationship to community becomes secondary to self-realization; and, in relation to Cartesian dualism, the individual is associated with the mind and society with the body. In the case of trans identity, therefore, connections to a supportive community that an individual may foster during transition are understood as extraneous. According to the medical model, once she discovers her “true self;” she is expected to cut ties from that community. Within the

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trans community, this disconnect further depoliticizes trans identity; therefore, transsexuality is a personal identity disorder that needs to be regulated in order to be a “normal” member of society. Sex-reassignment surgery is one example of how a trans person can blend into society.

As stated before, the necessity for surgery creates an additional paradox for trans individuals: the surgical procedures necessary for many trans individuals to live a bearable life also reinforce the biopolitical techniques of normalization that make a trans life unbearable in the first place. A bearable life not only involves feeling safe while walking down the street or finding permanent housing and job security, but becoming intelligible through the process of social recognition, which thereby makes an individual less vulnerable to violence, suicide, and discrimination. Challenging gender norms imperils an individual’s recognizability as a subject as well as risks exposure to more suffering and violence, while the regulatory power of the binary sex/gender system restricts an individual’s ability to unsettle gender norms. Moreover, being denied recognition is a form of subjection; and trans individuals begin gaining social recognition beyond their own psychic process in the psychiatrist and doctor’s office.

Even though an individual obtains social recognition by reiterating hegemonic norms, these norms are set as the ideal so that no one can actually live up to them. Dean Spade states, “The impossibility of matching the ideal types generates a lifetime of self- and external policing that keep us occupied with our personal reform efforts.” Hegemonic norms reinforce the notion that the individual must always be aware of her

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63 Spade, Dean. Normal Life, 105.
appearance and behaviors in relation to what is considered normal. Therefore, marginalized groups often police themselves not only in relation to centralized norms, but also to themselves and in opposition to other marginalized groups. By self-policing, a category homogenizes difference from within as a means to ensure everyone represents the same standards and politics, thereby essentializing what it means to belong to that category. These essentializing characteristics of identity categories are often expressed through the language of authenticity within the realm of identity politics.

Identity politics historically emerged in the U.S., post-Civil Rights movements of the 1960s, from identity categories in order to mobilize particularities of group oppression against systemic inequalities. The particularities of a groups’ oppression is often expressed through an essentialized identity, i.e., an inherent quality that connects individuals within a group. The language of authenticity shapes the essentializing characteristics of identity politics, which influence the politics within the trans community. Juana Rodriguez believes that identity politics conflate ideology, identity, and political practices, and the lived consequences of this conflation construct the political dualism of insider/outsider. Those individuals who cannot live up to the norms of the identity category are excluded from membership to the group and are marked as outsider. Rodriguez states, “[O]n a political level, recounting individual narratives within the private confines of identity-based groups is simply no longer sufficient as a means of effectively transforming the social conditions of our lives if we do not also reclaim a

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Rodriguez, Juana. *Queer Latinidad*, 44.
vocal public presence.” The medical discourse of transsexuality reinforces the subjectivity of one’s personal experience, which thereby further depoliticizes trans narratives. Moreover, trans narratives are often expressed in a normative way— either in a support group or in a therapist’s office as a means to gain access to the medical model of transsexuality.

Identity politics within the trans community often revolve around the issue of passing. An individual’s ability to be socially recognized and authenticated as a “normal” man or woman depends on one’s access to reassignment technologies, which typically becomes a fiscal issue over anything else. Obviously race, class, and location influence those who are able to be out as trans and those who find it necessary to stay in the closet as well as who can successfully pass. Katrina Roen states, “While recent academic and political articulations of transgenderism privilege crossing over passing, it is not uncommon for trans communities to operate with the opposite hierarchy, valuing passing and ostracizing those transpeople who do not seem to work hard enough at passing.” Because the medical model shapes the transsexual community’s notion of subjectivity, passing is of more importance than it is in the transgender community, which will be discussed in the next section. Moreover, because the transsexual’s authentic self resides in the mind, altering the body to match her/his core identity is the primary objective.

Passing thus constitutes success—to live successfully as the other sex is the ultimate goal of the medical understanding of transsexualism because societal norms state

65 Ibid.
66 Roen, Katrina. “‘Either/Or’ and ‘Both/Neither,’” 504.
that only one body per individual can be correct. Sandy Stone discusses the need to pass in the trans community and states, “Under the binary phallocratic founding myth by which Western bodies and subjects are authorized, only one body per gendered subject is ‘right’. All other bodies are wrong.” As a result, “passing” has been a central feature of what it means to be transsexual for the past 60 or so years. This ideal has been internalized in the transsexual consciousness and thereby affirmed “normal” as a defining aspect of transsexualism as a scientific classification. The body needs to tell the truth about one’s gendered inner core, and this inner core is dependent on a naturalized sex/gender system.

Therefore, trans individuals are subjugated to a binary, naturalized system of gender through the process of normalization couched within the rhetoric of passing. Dean Spade discusses the normalizing effects of medical discourse on the transgender community in “Mutilating Gender.” He maintains that “passing” becomes crucial the moment an individual enters a medical office because it is the medical professional who decides whether one can present her/himself in a realistic way. Consequently, the doctor determines if the individual can live within the gender norms of the other sex while a trans individual’s desire to transition is policed through medicalized systems of power. In other words, the disciplinary techniques that generate properly sexed bodies become visible when a trans individual enters a medical office. Moreover, a trans individual’s ability to gain recognition as a “true” transsexual within the medical framework depends

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67 Stone, 231.
on her/his ability to portray stereotypical behaviors of the opposite sex; stereotypical behavior is utilized to measure one’s mental health.

In “Transsexuals’ Narrative Construction of the ‘True Self’,” Douglas Mason-Schrock found that transsexuals considered childhood a time when their authentic desires had not yet been repressed by restrictive gender norms. They thereby used childhood stories, such as cross-dressing and sports participation, as evidence of transsexualism.68 Their stories reinforced gender stereotypes by claiming that only men are masculine and only women are feminine. The notion that childhood plays an essential role in the formation of a transsexual identity is, unsurprisingly, reflected in the DSM-IV-TR classification of “gender identity disorder.” The DSM-IV-TR entry of childhood ‘gender identity disorder’ (GID) describes symptoms of childhood cross-gender behavior in detail. Boys with GID enjoy playing house, watching television about their favorite female characters, and drawing pictures of princesses and pretty girls. Of course they avoid playing with trucks and have no interest in sports. Girls with GID hate dresses, desire short hair and wearing “boys” clothing, like to wrestle and play contact sports. Significantly, the “true-self” narrative from the support group that Mason-Schrock attended mirrors the language of the DSM. In short, this childhood narrative provides evidence of the “wrong body” trajectory as well as reaffirms one’s core gender identity.

Through consciously refusing to reiterate the standard criteria around his (childhood) gender identity, Spade illuminates the constructedness of the language

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68 Mason-Schrock attended eight transgender support group meetings over a period of 15 months. He also joined an e-mail list, read articles and magazines about transgender issues, and conducted 10 in-depth interviews from transsexuals he met at the support group.
inscribed in the medical model around (childhood) origin narratives. Within the medical model, trans individuals who are approved for hormones and sex-reassignment surgery reiterate the standard “transsexual narrative,” which becomes the “transsexual trajectory.”69 Furthermore, this “transsexual trajectory” supports the diagnostic criteria that generate a naturalized account of gender, which contends that non-transsexual individuals grow up without experiencing any gender confusion or experimentation. Spade states:

>This story isn’t believable, but because medicine produces it not through a description of the norm, but through a generalized account of the transgression, and instructs the doctor/parent/teacher to focus on the transgressive behavior, it establishes a surveillance and regulation effective for keeping both non-transsexuals and transsexuals in adherence to their roles.70

The medical discourse embedded in cultural understandings of transsexualism relies on preserving an ideal of two distinct gender categories that normally include everyone but occasionally get wrongly assigned and require correction to reinscribe the norm. In short, transsexuals are stuck in a double bind because they are either pathologized for sticking to gender norms or pathologized for not sticking to them. The final section will focus on those that resist the pathologizing discourse of the DSM.

**Claiming a Counterdiscourse**

Jennifer Terry discusses the concept of “deviant subjectivity,” which draws from Foucault’s notion of “reverse discourse.”71 Both concepts work to multiply discourse to

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70 Spade, Dean. “Mutilating Gender,” 321.
resist normalization. Terry asserts that ‘deviant subjectivity’ is “a process by which a position or identity-space is constructed discursively by sexology and medicine and strategically seized upon by its objects of study who, in their processes of self-inquiry, are at moments compliant and at other moments resistant to pejorative or pathologizing characterizations of them by doctors.”72 Individuals in deviant positions need, for reasons of survival, to have the capability to observe and recognize the regulations of the center and the margins. In other words, transgender subjectivity is constituted through the medical model of GID as well as trans resistance to those very discourses that have pathologized and policed trans autonomy. How does the pathologization of transsexuality influence the conditions of transgender subjectivity?

Given that transsexuality, as a psychiatric and medical taxonomy, is embedded in the discursive history of medico-scientific discourse, transsexuality cannot be understood as completely autonomous from the hegemonic, normative, and pathologizing history of medical science, as seen through the language of authenticity in the Cartesian dualism inscribed in the DSM. The DSM diagnosis enables individuals seeking to achieve autonomy through authenticity, yet this authenticity is already foreclosed through the discourses of pathology and disorder. In short, the DSM diagnosis enables and limits trans autonomy because, according to the medical model, a trans individual can pass as the opposite sex but s/he can never authentically embody that sex. Moreover, any

71 Terry, Jennifer. “Theorizing Deviant Historiography.” In The History of Sexuality. Foucault argues that a reverse discourse happened when “homosexuality began to speak in its own behalf, to demand that its legitimacy or ‘naturality’ be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified” (101).
72 Ibid, 59-60.
autonomy gained through the *DSM* diagnosis is limited because it individualizes trans identity through disconnecting gender trouble from social conditions. If GID (or soon to be called “Gender Dysphoria”) is removed from the *DSM*, the trans community can begin to claim autonomy from the psychiatric realm that has worked hard to pathologize them. But if the diagnosis is removed, many transgender people will most likely be denied “gender-confirming healthcare” because doctors will not be required to recognize trans desire for hormones and surgical procedures. Therefore, the trans community is stuck in a double bind: the trans community could benefit from the removal of GID from the *DSM*, yet they are the ones who have the most at stake in keeping it.

Trans activists have been protesting the normative and pathologizing language of transsexuality as early as the 1960s. They call for a counterdiscourse to the negating and normalizing effects of confessing the transsexual body in medical science. For example, at the same time gender clinics began to open in universities across the country, MTF transsexuals in the Tenderloin district of San Francisco formed the activist group COG (Conversion is Our Goal or Change: Our Goal) in 1967 that lasted for around two years. Although COG represented the “first wave” of trans activism, in which most MTF transsexuals felt that women should either marry or find conventional women’s work, 

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73 Many transgender and transsexual people are already denied access to medical assistance. In “The State of Transgender Rights in the United States of America,” Currah, Green, and Stryker discuss the discrimination transgender people experience when trying to obtain medical services. They state that many transgender people avoid going to doctors even for the most urgent situations because they are afraid of rejection or humiliation. They also state, “Transsexual people in particular have difficult relationships with the medical system because once they are diagnosed as transsexual, insurance companies discriminate against them by excluding them from coverage for the necessary treatments and procedures and for any complications or conditions that may arise from these treatments and procedures” (11).


75 For more information on COG, see Joanne Meyerowitz’s *How Sex Changed*, especially pages 230 – 232. She uses the terms “first wave” and “second wave” in relation to trans activism.
these trans women opened the door for the “second wave” of trans activism in the 1970s. The “second wave” consisted of more radical transsexuals who insisted on depathologizing transsexualism, cultivating agency outside the medical model, and lessening conventional post-operative gender norms.

By the late 1970s there was a temporary decline in trans activism. In the early 1970s, the trans political movement could no longer look to the gay and feminist communities for support. When homosexuality was removed from the DSM in 1973, the gay liberation movement and the trans communities no longer had a mutual concern in working to deal with how they were each regarded by the mental health system. Once the (radical) feminist movement centered on the “woman identified woman” and rediscovered a love for biological determinism, MTF transsexual feminists and lesbians were no longer welcomed. Additionally, butch lesbians were excluded from the new lesbian feminist communities because butches were “trying to imitate men.” This rejection actually worked to create the first visible FTM transsexual communities since many of those butch women became trans men.

Then in 1978, Janice Raymond published *The Transsexual Empire: The Making of the She-Male* and brought transphobia to a new level. For example, she states, “All transsexuals rape women’s bodies by reducing the real female form to an artifact, appropriating this body for themselves.”76 Raymond argues that MTF transsexuals are representatives of the patriarchal subjugation of women and the best way to deal with the

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76 Quoted in Susan Stryker. *Transgender History*. 106.
problem of transsexualism would be by “morally mandating it out of existence.” Her book served as a catalyst for a new wave of trans activism. In her book, Raymond specifically attacks Sandy Stone, who worked at Olivia Records, an all women recording company. Raymond accuses Stone of using her (of course Raymond uses ‘his’) “male” privilege to “cash in” and dominate lesbian feminist culture.

Sandy Stone left Olivia Records after the publication of Raymond’s book and eventually earned a Ph.D. at the History of Consciousness program at University of California Santa Cruz under Donna Haraway. In 1992, Stone wrote “The Empire Strikes Back: A Posttranssexual Manifesto” as a critique of the medical model of transsexualism as well as a direct response to Raymond. Stone says:

To deconstruct the necessity for passing implies that transsexuals must take responsibility for all of their history, to begin to rearticulate their lives not as a series of erasures in the service of a species of feminism conceived from within a traditional frame, but as a political action begun by reappropriating difference and reclaiming the power of the refigured and reinscribed body.

In other words, transsexuals need to come out and stop “passing” as men and women. Stone inspired the emerging transgender movement on both an intellectual and political level by calling for “posttranssexual” theorizing that could restructure the common narratives that rejected transsexuals as ill, mistaken, or appalling.

At the same time as queer became a way to describe someone at the margins of the gay and lesbian movement, transgender became a term to define someone who did not want to fully pass or deny his or her identity as a transsexual. According to Dallas

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Denny, Holly Boswell popularized the use of the term transgender through an article published in 1991 in both *Chryasalis Quarterly* and *Tapestry*.

Boswell suggested an “essential transgender essence,” i.e. identities that were not centered on gender stereotypes and norms. Perhaps it was no coincidence that she chose to use the terms “essential” and “essence” since trans identity has always been embedded in the language of authenticity. Boswell provided a way to talk about transsexualism without using the terms that clearly maintain pathology and support the supremacy of the medical industry.

Examples of employing transgender politics as a form of resistance in the 1990s are found in the short-lived “Transgender Nation,” (1992), a sub-group of “Queer Nation” founded by Anne Ogborn. Also, Riki Wilchins formed “Transexual Menace” in New York in 1993 as an education and outreach organization as well as a direct action group that held vigils outside courthouses where antitransgender crimes were being tried.

Magazines and newsletters, such as *TNT (Transsexual News Telegraph, 1991-2002)*, and *TransSisters: The Journal of Transsexual Feminism, (1993-Present)*, were published and distributed across the country. These publications, along with others, worked to resignify the hegemonic notion of confessing one’s gender through medical discourse.

The term “transgender” has continued to be utilized as a descriptive label within academic contexts as well as in the political realm for those individuals who do not fit neatly into the normative binary sex/gender system. According to Currah, Green, and Stryker, transgender has become a category that contains all forms of gender non-normativity, which consequently maintains the gender normativity of all other identity

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groups. Therefore, they use “transgender” as “a lens for examining the relationship between specific forms of oppression experienced by particular kinds of ‘transgendered’ people due to the specific kinds of gender atypicality that prejudices state and society against them, and to link those specific instances of oppression to systemic injustices within the operation of social power.”\textsuperscript{80} Contemporary notions of transgender politics (in urban areas) have worked to include all kinds of gender nonnormativity and provide a site to build resistance against institutions of power that subjugate the trans community.

For example, the magazine \textit{Original Plumbing} (2009-Present) focuses on the culture and sexuality of FTM trans men and examines a wide range of trans masculinities and identities.\textsuperscript{81} For another example, the Sylvia Rivera Law Project (SRLP), founded by Dean Spade, in New York City provides free legal assistance to any trans individual in need to legal representation.\textsuperscript{82} The SRLP focuses on people of color and poor people as a means to serve those individuals who are typically the most marginalized within the transgender community. The transgender politics shaping \textit{Original Plumbing} and the SRLP work to create a safe space for trans individuals to communicate with and educate each other.

Since the 1990s, the transgender community has disrupted the normative categories that construct cultural understandings of the sex/gender system. Additionally, transgender politics contest identity politics of assimilation—i.e. passing—through fighting to dismantle the institutions of biopower that reproduce the violence and

\textsuperscript{81} See \url{http://www.originalplumbing.com/} for more information.
\textsuperscript{82} See \url{http://srlp.org} for more information.
abjection associated with the societal norms shaping trans lives. In *Undoing Gender*, Judith Butler asks how we can “create a world in which those who understand their gender and their desire to be nonnormative can live and thrive not only without the treat of violence from the outside but without the pervasive sense of their own unreality, which can lead to suicide or a suicidal life.”83 Striving to free trans identity from the language of authenticity embedded in essentialized gender norms as well as fighting back against the oppression of a proper, unitary, and scientific discourse will continue to uncover an understanding of trans lives that exists outside of pathologization and dichotomous gender structures.

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83 Butler, Judith. *Undoing Gender*, 281.
References


Foucault, Michel. *The History of Sexuality Volume One: An Introduction*. New York:


