

Mutilating Gender

Dean Spade

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This essay examines the relationship between individuals seeking sex reassignment surgery (SRS) and the medical establishments with which they must contend in order to fulfill their goals. . . .

Throughout this essay, I draw on my own experience of attempting to find low-cost or free counseling in order to begin the process of getting a double mastectomy. The choice to use personal narrative in this piece comes from a belief that just such a combination of theoretical work about the relationships of trans people to medical establishments and gender norms and the experience of trans people is too rarely found. Riki Anne Wilchins describes how trans experience has been used by psychiatrists, cultural feminists, anthropologists, and sociologists “travel[ing] through our lives and problems like tourists . . . [p]icnicking on our identities . . . select[ing] the tastiest tidbits with which to illustrate a theory or push a book.” In most writing about trans people, our gender performance is put under a microscope to prove theories or build “expertise” while the gender performances of the authors remain unexamined and naturalized. I want to avoid even the appearance of participation in such a tradition, just as I want to use my own experience to illustrate how the requirements for diagnosis and treatment play out on individual bodies. The recent proliferation of academic and activist work on trans issues has created the impression in many people (mostly non-trans) that problems with access to services for trans people are being alleviated, and that the education of many specialists who provide services to trans people has made available sensitive therapeutic environments for trans people living in large metropolitan areas who can avail themselves of such services. My unsuccessful year-long quest for basic low-cost respectful counseling services in Los Angeles, which included seeking services at the Los Angeles Gender Center, the Los Angeles Gay and Lesbian Services Center, and Children’s Hospital Los Angeles is a testament to the problems that still remain. This failure suggests the larger problems with the production of the “transsexual” in medical practice, and with the diagnostic and treatment criteria that made it impossible for the professionals from whom I sought care to respectfully engage my request for gender-related body alteration.

I hope that the use of my experience in this paper will provide a grounding illustration of the regulatory effects of the current diagnosis-treatment scheme for GID and resist the traditional framing of transsexual experience which posits trans people as victims or villains, insane or fascinating. Instead, I hope to be part of a project already taken up by Riki Anne Wilchins, Kate Bornstein, Leslie Feinberg, and many others which opens a position for trans people as self-critical, feminist, intellectual subjects of knowledge rather than simply case studies.

I. GOVERNANCE: PASSING AS A TRANSSEXUAL

Here’s what I’m after: a surgically constructed male-appearing chest, no hormones (for now—maybe forever), no first-name change, any pronouns (except “it”) are okay, although when it comes to gendered generics I happen to really like “Uncle” better than “Aunt,” and definitely “Mr. Spade.” Hausman writes, “transsexuals must seek and obtain medical treatment in order to be recognized as transsexuals. Their subject position depends upon a necessary relation to the medical establishment and its discourses.” I’ve quickly learned that the converse is also true, in order to obtain the medical intervention I am seeking, I need to prove my membership in the category “transsexual”—prove that I have GID—to the proper authorities. Unfortunately, stating my true objectives is not convincing them.

II. THE TRANSEXUAL CHILDHOOD

"When did you first know you were different?" the counselor at the L.A. Free Clinic asked. "Well," I said, "I knew I was poor and on welfare, and that was different from lots of kids at school, and I had a single mom, which was really uncommon there, and we weren't Christian, which is terribly noticeable in the South. Then later I knew I was a foster child, and in high school, I knew I was a feminist and that caused me all kinds of trouble, so I guess I always knew I was different." His facial expression tells me this isn't what he wanted to hear, but why should I engage this idea that my gender performance has been my most important difference in my life? It hasn't, and I can't separate it from the class, race, and parentage variables through which it was mediated. Does this mean I'm not real enough for surgery?

I've worked hard to not engage the gay childhood narrative—I never talk about tomboyish behavior as an antecedent to my lesbian identity, I don't tell stories about cross-dressing or crushes on girls, and I intentionally fuck with the assumption of it by telling people how I used to be straight and have sex with boys like any sweet trashy rural girl and some of it was fun. I see these narratives as strategic, and I've always rejected the strategy that adopts some theory of innate sexuality and forecloses the possibility that anyone, gender-troubled childhood or not, could transgress sexual and gender norms at any time. I don't want to participate in an idea that only some people have to engage a struggle of learning gender norms in childhood either. So now, faced with these questions, how do I decide whether to look back on my life through the tranny childhood lens, tell the stories about being a boy for Halloween, not playing with dolls: What is the cost of participation in this selective recitation? What is the cost of not participating?

Symptoms of GID in the Diagnostic and Statistical Manual (DSM-IV) describe at length the symptom of childhood participation in stereotypically gender inappropriate behavior. Boys with GID "particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. . . . They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks." Girls with GID do not want to wear dresses, "prefer boys' clothing and short hair," are interested in "contact sports, [and] rough-and-tumble play." Despite the disclaimer in the diagnosis description that this is not to be confused with normal gender non-conformity found in tomboys and sissies, no real line is drawn between "normal" gender non-conformity and gender non-conformity which constitutes GID. The effect is two-fold. First, normative childhood gender is produced—normal kids do the opposite of what kids with GID are doing. Non-GID kids can be expected to: play with children of the own sex, play with gender appropriate toys (trucks for boys, dolls for girls), enjoy fictional characters of their own sex (girls, specifically, might have GID if they like Batman or Superman), play gender appropriate characters in games of "house," etc. Secondly, a regulatory mechanism is put into place. Because gender nonconformity is established as a basis for illness, parents now have a "mill of speech," speculation and diagnosis to feed their children's gender through should it cross the line. As Foucault describes, the invention of a category of deviation, the description of the "ill" behavior that need be resisted or cured, creates not a prohibitive silence about such behavior but an opportunity for increased surveillance and speculation, what he would call "informal-governance."

The Diagnostic Criteria for Gender Identity Disorder names, as a general category of symptom, "[a] strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)." This criterion suggests the possibility of a gender categorization not read through the cultural gender hierarchy. This requires an imagination of a child wanting to be a gender different from the one assigned to him without having that desire stem from a cultural understanding of gender difference defined by the "advantaging" of certain gender behavior and identities over others. To use an

illustrative example from the description of childhood GID symptoms, if a child assigned "female" wants to wear pants and hates dresses, and has been told that this is inappropriate for girls, is that decision free from a recognition of cultural advantages associated with gender? Since a diagnosis of GID does not require a child to state the desire to change genders, and the primary indicators are gender inappropriate tastes and behaviors, how can this be separated from cultural understandings of what constitutes gender difference and gender appropriateness? If we start from an understanding that gender behavior is learned, and that children are not born with some innate sense that girls should wear dresses and boys shouldn't like Barbie or anything pink, then how can a desire to transgress an assigned gender category be read outside of cultural meaning? Such a standard does, as Billings and Urban argue, privatize and depoliticize gender role distress. It creates a fictional transsexual who just knows in hir gut what man is and what woman is, and knows that sie is trapped in the wrong body. It produces a naturalized, innate gender difference outside power, a fictional binary that does not privilege one term.

The diagnostic criteria for GID produces a fiction of natural gender, in which normal, non-transsexual people grow up with minimal to no gender trouble or exploration, do not crossdress as children, do not play with the wrong-gendered kids, and do not like the wrong kinds of toys or characters. 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. In order to get authorization for body alteration, this childhood must be produced, and the GID diagnosis accepted, maintaining an idea of two discrete gender categories that normally contain everyone but occasionally are wrongly assigned, requiring correction to reestablish the norm.

It's always been fun to reject the gay childhood story, to tell people I "chose" lesbianism, or to over articulate a straight childhood narrative to suggest that lesbianism could happen to anyone. But not engaging a trans childhood narrative is terrifying—what if it means I'm not "real"? Even though I don't believe in real, it matters if other people see me as real—if not I'm a mutilator, an imitator, and worst of all, I can't access surgery.

Transsexual writer Claudine Griggs' book takes for granted that transsexuality is an illness, an unfortunate predicament, something fortunate, normal people don't have to go through. . . .

This is precisely the approach I want to avoid as I reject the narrative of a gender troubled childhood. My project would be to promote sex reassignment, gender alteration, temporary gender adventure, and the mutilation of gender categories, via surgery, hormones, clothing, political lobbying, civil disobedience, or any other means available. But that political commitment itself, if revealed to the gatekeepers of my surgery, disqualifies me. One therapist said to me, "You're really intellectualizing this, we need to get to the root of why you feel you should get your breasts removed, how long have you felt this way?" Does realness reside in the length of time a desire exists? Are women who seek breast enhancement required to answer these questions? Am I supposed to be able to separate my political convictions about gender, my knowledge of the violence of gender rigidity that has been a part of my life and the lives of everyone I care about, from my real "feelings" about what it means to occupy my gendered body? How could I begin to think about my chest without thinking about cultural advantage?

III. CHOOSING PERSPECTIVE: PASSING "FULL-TIME"

From what I've gathered in my various counseling sessions, in order to be deemed real I need to want to pass as male all the time, and not feel ambivalent about this. I need to be

willing to make the commitment to "full-time" maleness, or they can't be sure that I won't regret my surgery. The fact that I don't want to change my first name, that I haven't sought out the use of the pronoun "he," that I don't think that "lesbian" is the wrong word for me, or, worse yet, that I recognize that the use of any word for myself—lesbian, transperson, transgender butch, boy, mister, FTM fag, butch—has always been/will always be strategic is my undoing in their eyes. They are waiting for a better justification of my desire for surgery—something less intellectual, more real.

I'm supposed to be wholly joyous when I get called "sir" or "boy." How could I ever have such an uncomplicated relationship to that moment? Each time I'm sirred I know both that my look is doing what I want it to do, and that the reason people can assign male gender to me easily is because they don't believe women have short hair, and because, as Garber has asserted, the existence of maleness as the generic means that fewer visual clues of maleness are required to achieve male gender attribution. This "therapeutic" process demands of me that I toss out all my feminist misgivings about the ways that gender rigidity informs people's perception of me.

Perhaps the most overt requirement for transsexual diagnosis is the ability to inhabit and perform "successfully" the new gender category. Through my own interactions with medical professionals, accounts of other trans people, and medical scholarship on transsexuality, I have gathered that the favored indication of such "success" seems to be the gender attribution of non-trans people. Because the ability to be perceived by non-trans people as a non-trans person is valorized, normative expressions of gender within a singular category are mandated.

IV. MAYBE I'M NOT A TRANSSEXUAL

The counselor at the L.A. Free Clinic decided I wasn't transsexual during the first (and only) session. When I told him what I wanted, and how I was starting counseling because I was trying to get some letter that I could give to a surgeon so that they would alter my chest, he said, "You should just go get breast reduction." Of course, he didn't know that most cosmetic surgeons won't reduce breasts below a C-cup (I wouldn't even qualify for a reduction), and that breast reduction is a different procedure than the construction of a male-looking chest. I also suppose that he wasn't thinking about what happens to gender deviants when they end up in the hands of medical professionals who don't have experience with trans people.

Some surgeons have strong reactions to transsexual patients, and often, if the surgery is done in a teaching hospital, the surgeon turns out to be a resident or staff member who is offended by the procedure. "In one case, with which I am familiar," writes a doctor, "the patient's massive scars were probably the result of the surgeon's unconscious sadism and wish to scar the patient for 'going against nature.'"

To this counselor, my failure to conform to the transsexuality he was expecting required my immediate expulsion from that world of meaning at any cost. My desire couldn't be for SRS because I wasn't a transsexual, so it must be for cosmetic surgery, something normal people get.

All my attempts at counseling, and all those experiences of being eyed suspiciously when I suggested that I was trans, or told outright I was not by non-trans counselors, made me

expect that I would get a similar reception from trans people in activist or support contexts. This has not been the case. I've found that in trans contexts, a much broader conception of trans experience exists. The trans people I've met have, shockingly, believed what I say about my gender. Some have a self-narrative resembling the medical model of transsexuality, some do not. However, the people I've met share with me what my counselors do not: a commitment to gender self-determination and respect for all expressions of gender. Certainly not all trans people would identify with this principle, but I think it makes better sense as a basis for identity than the ability to pass "full-time" or the amount of cross-dressing one did as a child. Wilchins posits an idea of identity as "an effect of political activism instead of a cause." I see this notion reflected in trans activism, writing, and discussion, despite its absence in the medical institutions through which trans people must negotiate our identities.

Feinberg writes:

Once I figured out that "transgendered" was someone who transcended traditional stereotypes of "man" and "woman," I saw that I was such a person. I then began a quest for finding words that described myself, and discovered that while psychiatric jargon dominated the discourse, there were many other words, both older and newer, that addressed these issues. While I accepted the label of "transsexual" in order to obtain access to the hormones and chest surgery necessary to manifest my spirit in the material world, I have always had a profound disagreement with the definition of transsexualism as a psychiatric condition and transsexuals as disordered people.

V. TELLING STORIES: STRATEGIC DEPLOYMENT OF THE TRANSSEXUAL NARRATIVE

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 After attending only three discussion group meetings with other trans people, I am struck by the naiveté with which I approached the search for counseling to get my surgery-authorizing letters. No one at these groups seems to see therapy as the place where they voice their doubts about their transition, where they wrestle with the political implications of their changes, where they speak about fears of losing membership in various communities or in their families. No one trusts the doctors as the place to work things out. When I mention the places I've gone for help, places that are supposed to support queer and trans people, everyone nods knowingly, having heard countless stories like mine about these very places before. Some have suggestions of therapists who are better, but none cost less than \$50/hr. Mostly, though, people suggest different ways to get around the requirements. I get names of surgeons who do not always ask for the letters. Someone suggests that since I won't be on hormones, I can go in and pretend I'm a woman with a history of breast cancer in my family and that I want a double mastectomy to prevent it. I have these great, sad, conversations with these people who know all about what it means to lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want. I understand, now, that the place that is safe to talk about this is in here, with other people who understand the slipperiness of gender and the politics of transition, and who believe me without question when I say what I think I am and how that needs to look.

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VII. CONCLUSION

Personal narrative is always strategically employed. It is always mediated through cultural understandings, through ideology. It is always a function of selective memory and narration. Have I learned that I should lie to obtain surgery, as others have before me? Does that lesson require an acceptance that cannot successfully advocate on behalf of a different approach to my desire for transformation?

An examination of how medicine governs gender variant bodies through the regulation of body alteration by means of the invention of the illness of transsexuality brings up the question of whether illness is the appropriate interpretive model for gender variance. The benefits of such an understanding for trans people are noteworthy. As long as SRS remains a treatment for an illness, the possibility of Medicaid coverage for it remains viable. Similarly, courts examining the question of what qualified a transsexual to have legal membership in the new gender category have relied heavily on the medical model of transsexuality when they have decided favorably for transsexuals. A model premised on a disability- or disease-based understanding of deviant behavior is believed by many to be the best strategy for achieving tolerance by norm-adherent people for those not adhering to norms. Such arguments are present in the realm of illicit drug use and in the quest for biological origins of homosexuality just as they are in the portrayal of transsexuality as an illness or disability.

However, it is vital that the costs of such an approach also be considered. First, the medical approach to gender variance, and the creation of transsexuality, has resulted in a governance of trans bodies that restricts our ability to make gender transitions which do not yield membership in a normative gender role. The self-determination of trans people in crafting our gender expression is compromised by the rigidity of the diagnostic and treatment criteria. At the same time, this criteria and the version of transsexuality that it posits produce and reify a fiction of normal, healthy gender that works as a regulatory measure for the gender expression of all people. To adopt the medical understanding of transsexuality is to agree that SRS is the unfortunate treatment of an unfortunate condition, to accept that gender norm adherence is fortunate and healthy, and to undermine the threat to a dichotomous gender system which trans experience can pose. The reification of the violence of compulsory gender norm adherence, and the submission of trans bodies to a norm-producing medical discipline, is too high a price for a small hope of conditional tolerance.