THE SOCIO-MEDICAL CONSTRUCTION OF TRANSSEXUALISM

An interpretation and critique

Dwight B. Billings and Thomas Urban

There is hardly a more dramatic instance of contemporary professional authority than so-called 'sex-change' surgery. Physicians perform cosmetic surgery yet certify that their patients have undergone a change in sex. Courts acknowledge this claim by allowing transsexuals to be issued new birth certificates in most states. Our study of sex-change surgery [1]reveals that these physicians heal neither the body nor the mind, but perform a moral function instead. After conducting a surgical rite of passage, physicians are accorded moral authority to sponsor passage from one sexual status to another. Public acceptance of sex-change surgery attests both to the domination of daily life and consciousness by professional authority as well as the extent to which many forms of deviance are increasingly labeled 'illness' rather than 'sin' or 'crime'(Freidson, 1970). Furthermore, and in a curious way, the stress by 'phallocentric medicine' (Wilden, 1972: 278) on the presence or absence of a penis as the definitive insignia of gender challenges the politics of women's movement and the intellectual thrust of the behavioral sciences, which assert that anatomy need not define destiny. Sex-change surgery privatizes and depoliticises individual experiences of gender-role distress.

We show that transsexualism is a socially constructed reality which only exists in and through medical practice. The problem of transsexual patients does not lie 'in their minds', as sex-change proponent John Money (1972: 201) puts it. Money'' statement typifies medicine'' reification of

---

[1] ***We spent four years analyzing several hundred medical journal accounts of sex-change surgery and interviewing scores of physicians and patients in a variety of clinical settings throughout the United States. In addition, Thomas Urban was a participant observer for three years (1978-80) in a sex-change clinic.***

transsexualism as a psychological entity. In contrast, we believe transsexualism is a relational process sustained in medical practice and marketed in public testimony such as Money's (1972: 201) description of the 'warm glow' of sexual fulfillment available through surgery. The legitimization, rationalization, and commodification of sex-change operations have produced an identity category – transsexual—for a diverse group of sexual deviants and victims of severe gender-role distress.

THE SEARCH FOR THE TRUE TRANSSEXUAL

Naming the problem

The first reported sex-change operation took place in Germany in 1931 (Pauly, 1968) but the procedure was not widely known until Christine (George) Jorgensen's much-publicized surgery in Denmark in 1952. The desire to be a member of the opposite sex had previously been viewed in psychoanalytic literature as an undifferentiated perversion. In 1954, however, Us endocrinologist Harry Benjamin asserted that Jorgensen's claim that he was a woman trapped within a man's body was indicative of a unique illness distinct from tranvestism and homosexuality, perhaps conditioned by endocrine factors, and not amenable to psychotherapy. He named this non-psychopathic sexual disorder 'transsexualism'.[2]

Benjamin 's (1954; 1966; 1967a; 1971) discussions of diagnosis, etiology and treatment provoked hostile reactions from psychoanalysts (Greenberg, Rosenwald and Nielson, 1960; Gutheil, 1954; Lukianowicz, 1959; Northrup, 1959; Ostow, 1953) who charged that it is one thing to remove diseased tissue and quite another to amputate healthy organs because emotionally disturbed patients request it. An influential report in the *Journal of the American Medical Association* rejected the distinction between transsexualism on the one hand and transvestism and homosexuality on the other, and argued strongly against sex-change surgery:

---

[2] ***Pioneer sex researchers Magus Hirschfeld and Havelock Ellis described an asexual variety of transvestism in which males completely identify as females (Horton and Clarke, 1931). Benjamin (1954) only reasserted this distinction by calling attention to it with the term 'transsexual'. For doing so he is honored as the father of 'Benjaminian transsexualism', even though Cauldwell (1949a) first used the term.***

" Although our subjects share certain needs, wishes, and personality characteristics, it would be completely erroneous to conclude from these similarities that they represent a homogeneous group. The need for surgery that these persons share does not in itself represent a disease entity but rather a symptomatic expression of many complex and diverse factors. " (Worden and Marsh, 1955: 1297)

Professional opposition to sex-change surgery and disputes over its legality (Holloway, 1974; Hastings, 1966: 599) inhibited recognition of transsexualism as a disease for several years. In 1966, however, John Hopkins University physicians admitted performing experimental sex-reassignment surgery and claimed to be able to diagnose true Benjaminian transsexuals (Johns Hopkins University, 1969). A 1965 survey showed that only 3 per cent of US surgeons would take seriously a request for sex-change surgery, yet by the early 1970s such operations were becoming commonplace (Green, Stoller and MacAndrew, 1966). In 1966 Benjamin (1966: 105) complained that the subject 'was 'still largely unknown (except in the tabloids) and [was] still an almost unexplored field in medicine'; yet by 1970, the director of the gender identity clinic at the University of California at Los Angeles announced: 'For me, at this time, the critical question is no longer whether sex-reassignment for adults should be performed, but rather for whom' (Green, 1970: 270). As recognition of transsexuals as illness increased, physicians' perception of its incidence heightened. In 1953, Swedish physicians had described Christine Jorgensensen's case as an 'exceedingly rare syndrome' (Hamburger, Sturup and Dahl-Iversen, 1953). Today, US medicine recognizes transsexualism as a 'serious and not uncommon gender disorder of humans' (Edgerton, 1973b: 74)[3] The thousands of operations performed in the United States to date attest that medicine is indeed 'oriented to seeking out and finding illness, which is to say that it seeks to create social meanings of illness where that meaning or interpretation was lacking before' (Freidson, 1970: 252).

Medical exemplars and professional motivations

[3] ***Freedman, Green and Spitzer (1976: 61) refer to the discovery of transsexualism as a recent major advance in the behavioral sciences. They estimate one in 40,000 men are transsexuals.***

The treatment of hermaphrodites, persons born with the sexual organs of both sexes, set several precedents for sex-reassignment of transsexuals. Surgical techniques for reconstructing genital abnormalities and standards developed to determine the direction of hermaphroditic sex assignment were both applicable to transsexualism. Some physicians who treated hermaphrodites stressed chromosomal characteristics; surgeons generally stressed the nature of the external genitalia. From their study of 105 cases of hermaphroditism, Money, Hampson and Hampson (1957) proposed that up to the age of 2 ½, years, the external genitalia should be the principal determinant for sex assignment; in persons older than 2 ½, surgery should conform to the established direction of gender-role socialization. By reporting dramatic instances among hermaphrodites of chromosomal men who have been successfully socialized as women, and vice versa, they demonstrated the independence of biological sex and gender . Money, Hampson and Hampson (1955: 290) claimed , however, that gender 'is so well established in most children by the 2 ½ years that it is then too late to make a change of sex with impunity'[4] They acknowledged that sex-reassignment could be made in later years if hermaphrodites themselves felt some error had been made in their assigned sex – a concession that proved important for the treatment of transsexuals.

Money et al.'s claim that all the hermaphroditic children in their sample were 'successfully' reassigned from one sex to another before the age of 2 ½ provided the only empirical support for gender-role fixity. Only five chidden in their sample of 105 were reassigned after this age, though four were judged by unspecified criteria as 'unsatisfactory'. Anomalies were soon reported, though these studies are rarely cited in the transsexual literature (Berg, Nixon and MacMahon, 1963). Dewhurst and Gordon (1963) reported fifteen successful cases of reassignment among seventeen hermaphroditic children up to 18 years of age. Thus, there were at least as many cases in medical literature of patients successfully altering their gender-roles as there were cases of those who did not.

Psychiatrist Ira Pauly (1968), a proponent of sex-change, acknowledged that such anomalies cast some doubt on the otherwise considerable clinical evidence for gender-role fixity – a theory crucial to the

---

[4] ***Subsequently, Money Hampson and Hampson (1957) compared gender-role learning in humans to 'critical imprinting' in some animal species which, they argued, begins in the first year of life.***

argument that psychotherapy is ineffective for transsexuals (Benjamin, 1966). Pualy claimed, however, that psychiatrist Robert Stoller had clarified the apparent contradiction. Stoller (1964a; 1964b) re-directed attention from 'gender-role' to 'core gender identity', arguing that those rare individuals who appear to change identity' later in life do not really do so. Rather, he argued, they have always had a third (hermaphroditic) gender identity –'not male or female but both (or neither)' (Stoller, 1964b: 456). Apparent cases of reversals of early socialization were thus discounted.

Clinical experience with hermaphrodites thus established three points:

1. the refinement of surgical techniques for genital reconstruction;
2. the theory that gender-role learning is independent of physical anatomy and is fixed at an early age; and
3. the policy that, since self-identification is more important than external genitalia, 'rare requests' from adult hermaphrodites for sex-reassignment should be given 'serious evaluation' (Money, Hampson and Hampson, 1955).

Psychiatrists and plastic surgeons at John Hopkins University provided another precedent for sex-change operations with a series of studies of patients requesting cosmetic surgery. Here was an established field of medicine where doctors performed operations upon demand without medical justification. Yet Edgerton, Jacobson and Meyer (1960-1: 139), found that 16 per cent of their sample of patients demanding elective surgery were judged psychotic, 20 per cent neurotic and 35 per cent had personality trait disorders. Meyer et al. (1960: 194) found that of thirty patients studied, one was diagnosed psychotic, two were severely neurotic, eight had obsessive personalities and four were schizoid; fourteen others were judged as tending towards obsessional schizophrenia. Most patients rejected psychotherapy, however, as an alternative to surgery. The researchers concluded from post-operative interviews that 'psychological improvement' and patient satisfaction resulted from surgery. Even 'severely neurotic and technically psychotic patients' were judged to benefit from such operations (Edgerton, Jacobson and Meyer, 1960—1: 144).

With the publication of these findings, and those on hermaphrodites, the medical rationales for sex-change surgery were in place. Johns Hopkins University became the most prominent centre for the surgical treatment of

transsexualism in the United States in the 1970s. Psychologist formed the nucleus of the Johns Hopkins team.

Three factors motivated physicians to fight attempts to declare sex-change operations illegal:

1. The paramount role of the physician as healer was stressed (Benjamin, 1966: 116). Early defenses stressed patients' intense anguish and the duty of physicians 'to ease the existence of these fellow-men' (Hamburger, 1953: 373).
2. The opportunity for ground-breaking research in psychiatry was recognized. Robert Stoller (1973a: 215) referred to transsexuals as 'natural experiments' offering 'a keystone for understanding the development of masculinity and femininity in all people'.[5] Surgeons, too were interested in sharpening their skills. Several told us in interviews that they regard sex-change surgery as a technical *tour de force* which they undertook initially to prove to themselves that there was nothing they were surgically incapable of performing. Plastic surgeons, especially, found sex-change surgery strategically important for expanding their disciplinary jurisdiction.[6]
3. An over-abundance of surgeons in the United States has resulted in competition for patients and an increasing number of 'unnecessary' operations (Bunker, 1970), many of which are performed on women in the course of their sexual maturation and functioning (Corea, 1977). Although medicine is a 'market profession', it is not socially legitimized as a business enterprise (Larson, 1977). Nevertheless, sex-change surgery is profitable: reassignment operations alone cost around $10,000 in the

---

[5] ***Some experiments were not so 'natural', University of Minnesota researchers, for instance, were curious about the effects of high estrogen dosage and surgery on 'profound psychopaths'. Not surprisingly, they concluded that 'if there is one follow-up conclusion that can be made with assurance at this stage, it is one follow-up conclusion that can be made with assurance at this stage, it is that estrogen and sex-reassignment surgery do not alter the sociopathic transsexual' (Hastings, 1974).***

[6] ***Such operations 'represented a unique experience and challenge to perfect techniques heretofore restricted to the treatment of congenital malformations and traditionally the province of the urologist and gynecologist, rather than the plastic surgeons' (Money and Schwartz, 1969: 255). The desire for jurisdictional expansion and prestige among lower-status medical specialties—in this case, plastic surgery and psychiatry – is especially 'conducive to the "discovery" of a particular deviant label' as Pfohl (1977: 310) shows in the case of the 'discovery' of child abuse by pediatric radiologists.***

late 1970s. Related elective surgery, consultation fees and weekly estrogen treatments push the cost even higher.[7]

Legitimizing the search: etiology, diagnosis and treatment

News of Johns Hopkins University's program touched off a renewed wave of opposition within medicine in the late 1960s.[8] Psychoanalysts in private practice led the attack. Using a variety of analytic techniques to support their position that persons demanding castration were *ipso facto* mentally ill, they labeled transsexuals as 'all border-line psychotics' (Meerloo,1967: 263) or victims of 'paranoid schizophrenic psychosis' (Socarides, 1970: 346) or 'character neurosis' (Stinson, 1972: 246). They attacked surgery as non-therapeutic. If patients' requests represented' a surgical acting out of psychosis' (Volkan and Bhatti, 1973: 278), then surgeons were guilty of 'collaboration with psychosis' (Meerloo, 1967: 263) The *Journal of Nervous and Mental Disease* devoted an entire issue in 1968 to the topic and concluded that the issues of etiology, diagnosis and treatment were still unresolved and that the term 'transsexualism' itself had won premature acceptance in the literature. The report concluded: 'What [transsexualism] means in contradistinction to 'transvestite' or 'homosexual' is not clear' (Chubu and Mackie, 1968: 413). Such criticism threatened the professional security of sex-change physicians and raised the question of whether patients could consent to such operations, since psychotics cannot legally do so.

---

[7] ***Physicians' fees alone – apart from hospitalization – for 628 patients and 169 operations at Stanford University's-change clinic totaled $413,580.00. This figure excludes the cost of psychiatric counselling and other operations (e.g., rhinoplasty, augmentation mamoplasty and thyroid cartilage shaves) which patients usually demand. Some private practitioners have performed up to 1,000 sex-change operations. Restak (1980: 11) calls sex-change surgery a $10 million growth industry'.***

[8] ***Other university hospitals,, such as the University of Minnesota's, began surgical treatment at roughly the same time but avoided public disclosure (Hastings, 1969). In addition, a few operations were secretly performed in the 1950s at the University of California at San Francisco (Benjamin, 1966: 142). We have learned that Cook County Hospital in Chicago was performing sex-change operations as early as 1947, predating Jorgensen's famous European surgery by five years.***

In response, sex-change proponents legitimized surgical treatment by:

1. Constructing an etiological theory which stressed the non-psychopathic character of the illness; and
2. rationalizing diagnostic and treatment strategies.

Although some physicians asserted that biological predisposition's for transsexualism might yet be discovered, most stressed early socialization in their etiological accounts. Recalling the hermaphrodite literature, Money and Gaskin (1970-1: 251) spoke of the 'virtually ineradicable' effects of ambivalent gender-role learning at an early age. Stoller (1967:433) claimed that male transsexualism was the predictable outcome of a particular family situation involving 'too much contact with mother's body for too long and a father who is absent and so does not interrupt the process of feminization'. The result is a son so strongly identified with his mother that he not only *wishes* to be like her, but comes to believe that he *is* like her, despite incongruous genitals. Stoller conceptualized transsexualism as an identity issue – not a neurotic perversion – resulting 'from the same kinds of forces necessary for normal development' (1973b: 216). In contrast to neurotic perversions such as transvestism, Stoller contended that transsexualism wasn't a product of neurosis, i.e., of conflict and compromise any more than is the core masculinity in normal men or femininity in normal women' (1973b: 219).

Thus, physicians defended themselves against the charge of 'collaboration with psychosis' by claiming to resolve surgically their patients' bitter conflicts between self-image and body-image. Arguing that 'psychiatric name-calling' adds little to understanding (Baker and Green, 1970: 89), they replaced the language of perversions with a new language to describe patient demand for sex-change surgery. There demands were referred to as a 'single theme' (Hoopes, Knorr and Wolf, 1968), a 'principle theme' (Pauly, 1968), an '*idee fix*' (Money and Gaskin, 1970-1), an 'intensive desire' (Foorester and Swiller, 1972) and an 'intense conviction or fixed idea' (Sturup, 1976).[9]

---

[9] ***They attempted a further semantic shift by questioning the term 'delusional' arguing that the request for sex-changing surgery, given medical technology, is no more delusional than the request to go to the moon, given modern space technology (Knorr, Wolf and Meyer, 1969).***

Within this etiological framework, physicians were confident they could diagnose transsexualism accurately. While critics charged that 'transsexualism represents a wish, not a diagnosis' (Socarides, 1970), Baker and Green (1970: 90) asserted that 'transsexualism is a behavioral phenomenon unique unto itself. We believe that although it is related to other anomalies of psychosexual orientation and shares features in common with them, it can, nevertheless, be differentiated'. Male transsexualism, upon which attention was fixed,[10] was identified as a point on a clinical continuum along with effeminate homosexuality and transvestism. Although the boundaries 'are sometimes ill-defined' (Baker and Green, 1970: 90) and the 'transition zones are blurry' (Money and Gaskin, 1970-1: 254), Fisk (1973: 8) summarized the following behavioral guidelines for recognizing the ' true transsexual':

1. A life-long sense or feeling of being a member of the 'other sex';
2. the early and persistent behaviouristic phenomenon of cross-dressing, coupled with a strong emphasis upon a total lack of erotic feelings associated with cross-dressing; and
3. a disdain or repugnance for homosexual behavior.

Once physicians were satisfied that they were dealing with patients whose sanity was intact, and that they were not catering to perverse wishes for self-destruction, then the best indicator of transsexualism was the intensity of a patient's desire for surgery. They assumed such persistence would distinguish a male transsexual from an effeminate homosexual or a transvestite who -- while behaviorally similar – none the less 'values his penis and abhors the thought of its loss' (Baker and Green, 1970: 91). The lack of erotic motivation, along with evidence of a life-long identity pattern, were taken as further proof of transsexualism. Correspondingly, ideal treatment consisted of:

1. Careful psychiatric screening to assess personality stability and the fixity of gender identity;

---

[10] ***There was considerably less agreement on the etiology and diagnosis of female transsexualism, partly because there is no concept of female transvestism. Clinicians at the University of California at Los Angeles found female transsexuals harder to identify than male transsexuals (Stoller, 1972), while the Johns Hopkins University clinic reported the opposite (Money and Gaskin, 1970-1). An influential theory of female transsexualism was offered by Pauly (1969a)***

2. an extensive period of hormone treatment to develop secondary anatomical characteristics of the cross-sex;
3. at least one year of supervised cross-gender living to guarantee stability and commitment; and, finally,
4. surgery (Baker and Green, 1970; Edgerton, Knorr and Collison, 1972).

Physicians were urged to standardize patient management policies and a number of quantitative diagnostic instruments, such as Lindgren and Pauly's (1975) 'Body Identity Scale' were developed to rationalize patient selection.[11] Scientistic accounts of transsexual treatment largely succeeded in silencing critics, for, as Habermas (1979: 184) among others has demonstrated, 'the formal conditions of [scientistic] justification themselves obtain legitimating force' in the justification of norms and actions in modern culture.

A success story: selling transsexualism

The first physicians to 'discover' and treat transsexuals were totally unprepared for the experience (Ihlenfeld, 1973b: 64). Their 'inexperience and naivete' (Fisk, 1973) was not surprising since 'there [were] no textbooks to consult, no authorities to lean on and to quote' (Benjamin, 1966: 19). Often they were required to make decisions unrelated to their professional training. By the late 1960s, sex-change proponents began publicly to extol the benefits of sex-reassignment in books, journals, newspapers, magazines and world lecture tours. Although its role is rarely acknowledged in the truncated histories of transsexual treatment presented in medical journals, the Erikson Educational Foundation of Baton Rouge Louisiana, made three important contributions to the social movement to incorporate sex-change in medical jurisdiction:[12]

---

[11] ***The strategic political value of rationalization/standardization is also apparent. In 1977, at the Fifth International Gender Dysphoria Syndrome Symposium in Norfolk, Virginia, we heard a leading physician argue for a committee to prepare policy guidelines by saying: 'If we have such a committee we can hold the American Medical Association and the American College of Surgeons in abeyance.'***

[12] ***Freidson (1970: 254) has noted the contributions of such crusading lay interest groups to the professional construction of illness. These 'flamboyant moral entrepreneurs' function like advocacy organizations in movements to define social problems (Blumer, 1971; Spector and Kitsuse, 1977). They seek public support for the***

1 *Socialization*. The Erikson Educational Foundation brought transsexualism to the attention of the public and the medical symposia;
   - annually sponsoring international medical symposia;
   - helping to send physicians and behavioral scientists such as Leo around the world to discuss the new 'disease';
   - sponsoring workshops at medical schools, colleges and national meetings of professional associations;
   - disseminating information about transsexualism through films and pamphlets to physicians, psychologists, lawyers, police, clergy, and social workers.

Such efforts aroused public sympathy for transsexuals. In one of her daily 'Dear Abby' newspapers columns, Abigail Van Buren told a distressed wife who discovered her husband cross-dressing that he was a possible candidate for surgery who should consult the Erikeson Educational Foundation. She affirmed her belief in surgical reassignment, saying: 'I believe that knowledge, skill, and talent are divinely inspired and that those scientists, physicians, and surgeons whose combined efforts have made sex-change surgery possible, do so with God's guidance' (Van Buren, 1977:C-10. Similarly, Ann Landers (1979: B-5) wrote that 'those who want the surgery should have it'.

2 *Patient advocacy and services*.. The foundation created a National Transsexual Counselling Unit in conjunction with the San Francisco Police Department and issued identification papers to transsexuals otherwise subject to police harassment.[13]The foundation obtained funding for individual sex-change operations from private insurance carries, city and state welfare agencies and vocational rehabilitation programmes. It established a national referral network for patients, which identified over 250 sympathetic, competent doctors. From 1968 to 1976 it circulated a newsletter to more than 20,000 subscribers which cited and summarized medical and scientific reports on transsexualism.

---

application of the label of illness to behaviors (such as excessive drinking) not otherwise defined as illness, e.g., alcoholism (Conrad, 1975)..

[13] The foundation convinced the Pennsylvania Health Department to issue authorization permits for pre-surgical cross-dressing and it lobbied successfully throughout the United States for new birth certificates for post-operative patients.

3 *Grants*. The foundation made grants through the Harry Benjamin Foundation to individual researchers and to several gender clinics, including the one at Johns Hopkins University.

Physicians often complain that transsexual patients are unrealistic about the benefits of surgery. Many 'harbor unrealistic expectations for an immediately blissful life, exciting and romance-filled' (Green, 1970). In other contexts (e.g., arguing their patients' competence to give informed consent) physicians defend their patients' senses of reality, but here they acknowledge that 'rarely does such a patient initiate a realistic discussion about the obvious problems that follow surgery: legal, social, economic, and emotional. The fact that there is pain connected with the surgery takes some patients rather by surprise' (Hastings, 1974: 337).

Physicians fail to comprehend that medical claims themselves are one source of such dreams and misunderstandings. Benjamin (1966) claimed an astonishing success rate for reassignment surgery. Only one of the fifty-one patients he examined after surgery was judged 'unsatisfactory'. He wrote glowing accounts of these 'twice-born' patients: 'To compare the Johnny I knew with the Joanne of today is like comparing a dreary day of rain and mist with a beautiful spring morning, or a funeral march with a victory song' (1966: 153). Similarly, readers of the *Erikson Education Foundation Newsletter (*Erikson Educational Foundation, 1969: !) learned of anonymous transsexuals for whom 'new life is brimming over with hope and happiness'. Physicians offered men more than just the chance to be rid of their dreaded male insignia – they were promised the experience of female sexuality. A representative of the University of Virginia gender clinic told the *National Enquirer (*1979: 1) that 'following a sex-change operation, the new female is able to function normally with the exception of having babies'. Money (1972: 204) claimed that the owner of an 'artificial vagina' from Johns Hopkins University 'enjoys sexual intercourse, experiencing a pervasive warm glow of erotic feeling and in some instances, a peak of climatic feeling that corresponds to the orgasm of former days'. Human experiences such as sexual fulfillment and gender-role comfort were thus transformed into luxury commodities available at high prices from US physicians; victims of aberrant gender-role conditioning and other sexual deviants were induced to seek gratification in a commodified world of 'artificial vaginas' and fleshly, man-made penises.

Physicians now admit that '"transsexualism" was apparently made so appealing that doctors report patients saying, "I want to be a transsexual"' (Person and Ovesey, 1974a: 17) reviewed 121 post-operative cases and concluded unequivocally that 'improved social and emotional adjustments is at least 10 times more likely than an unsatisfactory outcome'.[14] Ihlenfeld's (1973a) evaluation of 277 post-operative patients was only three pages long; Gandy's (1973) study of seventy-four patients consisted of two pages and a table. All the reports were superficial.[15] Relying entirely on the lesson of cognitive dissonance research which suggests that post-operative patients could ill afford to be critical of such a profound alteration as genital amputation.[16]

Follow-up evaluations and the discovery of 'the con'

Early follow-up studies, which minimized complications and stressed post-operative adjustment, were important for the legitimization of sex-change operations. Gradually, however, a number of disquieting items surfaced in the medical literature, including what appears to be a 'polysurgical attitude' among post-operative transsexuals demanding repeated forms of cosmetic surgery (Pauly, 1969b: 47) and many surgical complications. In 1977, the Stanford University gender clinic, thought by many professionals to perform the finest sex-change surgery in the country, reported that their two-stage female-to-male conversion took an average of 3.5operations and that half of their male-to female conversions involved complications (Norburg and Laub, 1977). Post-operative complications reported in medical journals include: breast cancer in hormonally-treated males; the need for surgical reduction of bloated limbs resulting from hormones; repeated construction of vaginal

---

[14] ***Compare also Baker and Green (1970). Edgerton, Knorr and Collison (1970), Hoenig, Kenna Youd (1971), Money and Gaskin (1970-1), and Randell (1969).***

[15] ***In the most extensive review of follow-up literature to date, Tiefer and Zitrin(1977) report that of ten unpublished and nineteen published reports, twenty-four were 'preliminary', 'anecdotal', or 'brief'. Of the five studies rated 'excellent', only two were by US physicians – with a combined sample of thirty-eight patients – despite the fact that thousands of operations have been performed in the United States.***

[16] ***Thus, one patient with a 'terrible sense of foreboding' immediately after surgery, when asked whether he had done the wrong thing, responded: 'But if I did, well, it's done and I have to find some way to adjust to it' (quoted in Money and Wolff, 1973: 248). See also Stoller and Newman (1971: 26).***

openings; infections of the urinary system and rectum; haemorrhaging; loss of skin grafts; post-operative suicides and suicide attempts; persistent post-operative depression, psychosis, and phobia; sexual dysfunctions; and pre- and post- operative prostitution, often necessitated by the high cost of treatment. Some sex-change patients threatened 'to shoot the genitals of the surgeon with a shot gun' (Laub and Fisk, 1972☺; others filed legal suits, euphemistically referred to by Money (1972: 208) as 'a psychopathically litigious disposition'.[17]

As the frequency and range of complications became known, physicians were shocked by a bizarre revelation: transsexuals had routinely and systematically lied. Since transsexualism is initially self-diagnosed and because there no organic indications of the 'disease', physicians are dependent upon the accuracy and honesty of patients' statements for diagnosis as well as for their understanding of the illness. Deception became so commonplace that Stoller (1973a: 536) complained: 'Those of us faced with the task of diagnosing transsexualism have an additional burden these days, for most patients who request sex-reassignment are in complete command of the literature and know the answers before the questions are asked.' The psychiatrist's task was to judge how well patients' self-reported life histories fit the criteria for transsexualism established in the medical literature. Since the reputable clinics treated only 'textbook' cases of transsexualism, patients desiring surgery, for whatever personal reasons, had no other recourse but to meet this evaluation standard. The construction of an appropriate biography became necessary. Physicians reinforced this demand by rewarding compliance with surgery and punishing honesty with an unfavorable evaluation. The result was a social process we call 'the con'.

An elaborated and well-formed patient grapevine, indirectly facilitated by the Erikson Educational Foundation's patient services, conveyed tips on each clinic's evaluative criteria and on 'passing'.

Unlike the old medical saw that claims the last time you see a textbook case of anything is when you close the textbook, we began to see patients that appeared to be nearly identical – both from a subjective and

[17] ***Compare Hastings (1974), Levine, Shaiova and Mihailovic (1975), Markland (1973), Meyer and Hoopes (1974), Randell(1971) and Tiefer and Zitrin (1977) for reports on complications.***

historical point of view.... Soon it became conspicuously and disturbingly apparent that far too many patients presented a pat, almost rehearsed history, and seemingly were well versed in precisely what they should or should not say or reveal. Only later did we learn that there did and does exist a very effective grape-vine.

(Fisk, 1973:8)

In many instances, the con involved outright deception. For example, a physician warned the Fifth International Gender Dysphoria Symposium in 1977 to watch out for a male-to-female post-operative transsexual posing as the mother of young, male candidates in order to corroborate their early socialization accounts of ambivalent gender cues and over-mothering. More often, the process was less direct. Fisk (1973: 9) acknowledges 'the phenomenon of retrospectively 'amending" one's subjective history. Here, the patient quite subtly alters, shades, rationalizes, denies, represses, forgets, etc.., in a compelling rush to embrace the diagnosis of transsexualism.' Many patients were as familiar with the medical literature as physicians were.[18].

As early as 1968, Kubie and Mackie (1968: 435) observed that patients demanding surgery 'tailor their views of themselves and their personal histories to prevailing "scientific" fashions'. Kubie and Mackie warned other physicians that such persons 'must present themselves as textbook examples of 'transsexuals" if they are to persuade any team of physicians to change them'. This advice went largely unheeded until, gradually, in follow-up conversations, some model patients admitted having shaped biographical accounts to exclude discrediting information, including homosexual and erotic, heterosexual pasts. One patient revealed: 'when I assumed the feminine role, I really researched and studied the part, and in essence, I have *conned you and otherwise charmed you* into believing in me' (Roth, 1973: 101, emphasis added).[19]

---

[18] ***In addition to bibliographies and summaries of technical literature published in the Erikson Education Foundation Newsletter and Benjamin's (1966), Martino (1977) and Morris (1974)***

[19] ***Physicians' efforts to be open and sympathetic to their patients, despite their need for reliable information, facilitated 'the con'. Edgerton, knorr and Collison (1970) advised their colleageues: 'It is not difficult for the surgeon to establish a good relationship with transsexual patients – but to do so, he must deal with the patient as a member of the psychological sex chosen by the patient.'***

Jon Meyer (1973: 35), director of Johns Hopkins University's gender clinic, complained that 'the label "transsexual" has come to cover such a 'multitude of sins"'. Meyer (1974) acknowledged that among the patients who had requested and sometimes received surgery at Johns Hopkins were sadists, homosexuals, schizoids, masochists, homosexual prostitutes and psychotic depressives. Stranford University physicians, too, admitted that among the patients they had operated on were transvestites, homosexuals and psychotic -- all previously viewed as distinct from transsexuals (Fisk, 1973).

The politics of re-naming

In the light of patient revelations, proponents of sex-change surgery were dangerously close to the accusations made by psychoanalytic critics – collaboration with psychosis. Fisk (1973: 8) proposed a solution. Instead of questioning the conceptual, clinical and diagnostic substructure of the 'disease', he simply replaced the term 'transsexual' with 'gender dysphoria syndrome', now a standard disease term.[20] This seemingly inconsequential shift in nomenclature had profound implication for medical practice. A wide variety of applicants for sex-change surgery, once unacceptable under Benjamin's classification, became legitimate candidates.

With transsexualism largely denuded of its diagnostic boundaries, physicians de-emphasized the technicalities of diagnostic differentiation and stressed behavioral criteria instead. As the Standford University team put it: 'Indeed, for prognosis, it is probable that the diagnostic category is of much less importance than the patient's pre-operative performance in a one-to-three year therapeutic trial of living in the gender of his choice'(laub and Fisk, 1974: 401). Ironically, such trials are no longer necessary, since sex-change surgery is now widely available in the United States upon demand. One physician who had performed approximately 100 sex-change operations in private practice told us that he diagnosed male-to-female transsexuals by bullying them: 'The "girls" cry; the gays get aggressive.' He also asked his female receptionist to

[20] ***Person and Ovesey (1974a; 1974b) attempted a similar renaming by referring to Benjaminian transsexualism as 'primary transsexualism'. Other patients, who lacked the non-erotic or life-long attributes, were labelled 'secondary transsexual'.***

interview candidates, since 'a woman always knows a woman', In 1978, this physician had not yet heard the term 'gender dysphoria'. Such practices have led some early advocates of surgery to decry the 'carnival-like atmosphere' in many medical settings (Stoller, 1973b). In the long run, with much of the conceptual foundation of the disease undermined, the true transsexual appears to be simply one who does not regret the surgery. At a conference we observed in 1977, Richard Green, who in 1970 had described transsexualism as 'a unique behavioral phenomenon is' (Baker and Green, 1970), jokingly said: 'I guess, like love, transsexualism is never having to say, "I'm sorry"'.

Our own participant observation in a prominent gender clinic confirms that diagnosis in the post-Benjamin era remains a subtle negotiation process between patient and physicians, in which the patient's troubles are defined, legitimized and regulated as illness. The ways in which patients prove their gender and physicians' cognitive frameworks for evaluating these claims are both grounded in commonsense knowledge of how gender is ordinarily communicated in everyday life. Physicians admitted to us that they are still groping in the dark: 'We just don't know. This whole thing is experimental', said one physician. We found that admission to surgery depended less on formal, rational, or fixed criteria than on the common sense of clinicians. Physicians scrutinized patients' accounts to discover their motivations. Extensive and costly screening procedures designed to test commitment were subverted by patients schooled in withholding damming evidence, such as histories of drug abuse, arrests and inconsistent sexual behavior. We observed patients using a special vocabulary of excuses and justifications to satisfy physicians who insisted on ritualized expressions such as 'I always played with dolls as a child'. The following dialogue illustrates the coaching we observed in interviews:

Physician: 'You said you always felt like a girl – what is that?'
Patient: [long pause] 'I don't know.'
Physician: 'Sexual attraction? Played with girls' toys?'

Despite physicians' belief that the semantic shift to 'gender dysphoria syndrome' was effective in 'allowing and encouraging our patients to be honest, open, and candid, with the result that our overall evaluations quickly became truly meaningful' (Fisk, 1973: 10), patient screening and interviewing still function as patient socialization. Diagnosis is linked to

routine everyday gender typifications (Goffman, 1977). More than anything else, physical appearance enables patients to control screening interviews; successful cross-dressing often truncates the screening process. When patients appear at a clinic convincingly cross-dressed verbal slips or doubtful accounts are set right by covering accounts – or are simple glossed over because physical appearance confirms the gender claimed. On the other hand, discrepant appearances are taken as alarming signs. One physician told us: L 'We're not taking Puerto Ricans any more; they don't look like transsexuals. They look like fags.'

Among the transsexual patients we interviewed were ministers who embraced the label 'transsexual' to avoid being labeled 'homosexual'; sexual deviants driven by criminal laws against cross-dressing , or by rejecting parents and spouses, to the shelter of the 'therapeutic state' (Kittrie, 1973); and enterprising male prostitutes cashing in on the profitable market for transsexual prostitutes which thrives in some large cities.[21] The following statement from a patient we interview whose lover was also a post-operative male-to-female reveals how inadequately the medical image of the stable, life-long transsexual fits some patients' experiences and motivations:

I thought I was a homosexual at one time; then I got married and had a child so I figured I was a heterosexual; then because of cross-dressing I thought I was a transvestite. Now [post-operative] I see myself as bisexual.

IMPLICATIONS FOR CRITICAL THEORY

Forms of illness are always more than biological disease; they are also metaphors, bearing existential, moral and social meanings (Sontag 1978). According to Taussig (1980): 3), 'the signs and symptoms of disease as much as the technologies of healing, are not 'things-in-themselves", are not only biological and physical, but are also signs of social relations disguised as natural things, concealing their roots in human reciprocity' .Even with negotiated illnesses which often lack a basis in biology, the

[21] ***See Meyer (1974) for a discussion of the diversity of sex-change as an attempt by certain men to benefit from and co-opt women's newly-won privileges which result from feminist consciousness and struggle.***

reified disease language of natural science obscures their social origins (Holzner and Marx, 1979: 137). Disease-talk is about things, not social interaction. Patients whose subjective histories are subsumed under the unifying rhetoric of transsexualism win operations but no language adequate to express the disparate and diverse desires which lead them to body mutilation. These remain private, inchoate, unspeakable[22]

Critical theorists describe the ideal therapy situation as a paradigm of non-distorted communication(Habermas,1968: 214). Rather than 'treat human beings as the quasi-natural objects of description'. the goal of communication is patients' self-reflection and emancipation from the reified pseudo-language of neurotic symptoms (Apel, 1977: 310).

The real task of therapy calls for an archaeology of the implicit in such away that the processes by which social relations are mapped into diseases are brought to light, de-reified, and in doing so liberate the potential for dealing with antagonistic contradictions and breaking the chains of oppression.

(Taussig, 1980: 7)

According to this view, therapy promises either to provide patients with sufficient self-understanding to criticize society and struggle politically against the crippling effects of social institutions or to provide new fetishes and easily commodifiable solutions to personal troubles (Kovel, 1976-7).

Transsexual therapy, legitimized by the terminology of disease, pushes patients towards an alluring world of artificial vaginas and penises rather than towards self-understanding and sexual politics. Sexual fulfillment and gender-role comfort are portrayed as commodities, available through medicine. Just as mass consumer culture, whose values are illusive, offers commodities whose 'staged appearance' are removed from the mundane world of their production (Scneider, 1975: 213), surgically constructed vaginas are abstracted from the pain and trauma of operating rooms and recovery wards.

---

[22] ***See Janice Raymond (1980) for an opposing critique of sex-change as an attempt by certain men to benefit from and co-opt women's newly-won privileges which result from feminist consciousness and struggle***

Critical theorists claim that the illusions of consumerism can be as pathological for individuals as the neuroses and psychoses symptomatic of the earlier period of capitalist industrial production (Lasch, 1978). Today, in late-capitalist consumer culture, frenzied rituals of buying contradict the puritanical self-denial characteristic of the nineteenth century. We express our identity as much as by the things we buy as the work we do . Commodities promise escape from alienation, and the fulfillment of our needs. Critics compare the temporary solace of consumer spending with the transitory euphoria of a drug-induced trance (Schneider, 1975: 222). Similarly, transsexuals are in danger of becoming surgical junkies as they strive for an idealized sexuality via surgical commodities. This is what physicians refer to as a 'poly-surgical attitude' among post-operative patients (Pauly, 1969a). Male-to-female patients especially are caught up an escalating series of cosmetic operations – including genital amputation – to more closely approximate ideal female form. They routinely demand breast implants and operations to reduce the size of the Adam's apple. Edgerton (1974) reports that 30 per cent of his patients also sought rhinoplasty (nose reconstruction); others demand injections of Teflon to modulate vocal pitch and silicon to alter the contours of face, lips, hips and thighs. Surgeons reduce the thickness of ankles and calves and shorten limbs. In their desperation to pass, male-to –female patients try to effect a commodified image of femininity seen in television advertising. In so doing, many patients are themselves transformed into commodities, resorting to prostitution to pay their medical bills.[23]

While it is difficult to asses the ultimate worth of consumer products, we can try to discern the false promises implicit in their appeal. In the absence of adequate follow-up research, it is impossible to assess the lasting value of sex-change surgery, though recent studies suggest an almost invariable erosion of the transsexual fantasy following an initial 'phase of elation' lasting two to five years after surgery (Meyer and Hoopes, 1974).Johns Hopkins University physicians stopped performing sex-change operations in 1979 on the grounds that the patients they operated on were no better off than a sample of transsexual patients who

---

[23] ***For the correlation between financial dependency during reassignment and prostitution, see Hasting (1974), Levine, Shaiova and Mihailovic (1975), Meyer (1974) and Norburg and Laub (1977).***

received psychotherapy but not surgery (Meyer and Reter, 1979). Other prominent clinics, however, continue to perform surgery (Hunt and Hampson, 1980).

The following excerpt from a letter written by one transsexual who underwent surgery expresses the disappointment and anguish of some patients:

No surgery can possibly produce anything that resembles a female vagina. The operation is a theft. [The surgically remodeled tissue] is nothing but an open wound. It needs dilation to keep it open and if dilated too much become useless for intercourse, Such an open wound lacks protective membranes and bleeds under pressure....A piece of phallus with an open wound below and a ring of scrotum hanging is all it is.... Who calls that an artificial vagina is nothing but a bandit looking for ignorant and credulous people to exploit them.

(quoted in Socarides, 1975: 130)

The evidence suggests that Meyer and Hoopes were correct when they wrote that,

in a thousand subtle ways, the reassignee has the bitter experience that he is not -- and never will be -- a real girl but is, at best, a convincing simulated female. Such an adjustment cannot compensate for the tragedy of having lost all chance to be male and of having, in the final analysis, no way to be really female.

(Meyer and Hoopes, 1974: 450)

THE POLITICS OF SEX-REASSIGNMENT

Taussig (1980) shows that 'behind every disease theory in our society lurks an organizing realm of moral concerns'. In this paper we have examined both physicians' and patients' motives for sex-change surgery. We conclude that at the level of ideology, sex-change surgery not only reflects and extends late-capitalist logic's of reification and

commodification, but simultaneously plays an implicit role in contemporary sexual politics.

The recognition that, in this day and age, the fulfillment of human desires is less a matter of public discussion than a technical accomplishment of social administration (Habermas, 1973: 253) applies equally to sex-changes. Medicine brushes aside the politics of gender to welcome suffering patients – many fleeing harassment for sexual deviance[24] -- into pseudo-tolerant gender identity clinics. Yet, these clinics are implicitly political and, indirectly, intolerant.

With reproduction and sexual functioning falling under medical jurisdiction, physicians have played crucial roles in maintaining gender organization (Ehrenreich and English, 1973). In providing a rite of passage between sexual identities, sex-change surgery implicitly reaffirms traditional male and female roles. Despite the mute testimony of confused and ambivalent patients to the range of gender experience, individuals unable or unwilling to confirm to the sex-roles ascribed to them at birth are carved up on the operating table to gain acceptance to the opposite sex-role.[25].

Critical theorists contend that, in the United States, hegemonic ideology absorbs and domesticates conflicting definitions of reality (Gitlin, 1979: 263). But rather than support contemporary movements aimed at reorganizing gender and parenting roles and repudiating the either/or logic of gender development (Chodorow, 1978: 1979; Ehrensaft, 1980), sex--change proponents support sex-reassignment surgery. By

---

[24] For physicians reports of harassed patients, see Benjamin (1971:77), Edgerton, Knorr and Collison (1970: 43), Meyer and Hoopes (1974:450) and Randell (1971:157)

[25] Physicians remarks on the prevention of transsexualism make the political implications of sex-change overt: deviations from traditional roles are potentially harmful to children. Benjamin (1971: 76) warns that male children's curiosity about female clothing 'should never be made light of by parents and Richard Green (1969: 33) warns of sissy behavior during childhood' and of 'playing house"'. Accepting Stoller's theory of the dominating mother as the principle agent of transsexual socialization, Green contends that 'goals of family therapy are for husband and wife to gain some perspective on the second-class status of husband and on the significance of their unbalanced roles in shaping their son's personality'. Similarly, Newman and Stoller (1971: 301) report success in effecting a 'therapeutically induced Oedipus complex' on a 'very feminine boy' by encouraging the child to assert his male identity by first beating a doll and then expressing aggression toward his mother and sister.

substituting medical terminology for political discourse, the medical profession has indirectly tamed and transformed a potential wildcat strike at the gender factory.[26]

Dwight B. Billings is Professor of Sociology at the University of Kentucky. He is a specialist in the critical theory tradition in sociology and engages in historical and comparative studies of social inequality in the United States.

Thomas Urban is Professor and Chair of Sociology at Teiko Post University, USA His resarch at Yale University led to an unpublished monograph on 'sex changfe' clinics. He is the author of the two-volume *Anti-Primitivism and the /decline of the /west (*1993)

---

[26] ***Said one politically aware transsexual quoted by Feinbloom (1976: 159): 'As long as society insists on requiring everyone to fit in a strict two-gender system, the whole transsexual thing will always be a game, to hide what I've been or what I want to be. If the women's movement is so into freeing up the definitions of gender, why not start with us***