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EDITORS

TRANSgendEr

RiGHTS

"A cutting-edge book full of new information and ideas."
—Patrick Califia
In recent years there have been debates about the status of the DSM diagnosis of gender identity disorder and, in particular, whether there are good reasons to keep the diagnosis on the books, or whether there are no longer very many good reasons. On the one hand, those within the GLBQT community who want to keep the diagnosis argue that it offers certification for a condition and facilitates access to medical and technological means for transitioning. Moreover, some insurance companies will absorb some of the high costs of sex change only if they first can establish that the change is “medically necessitated.” It’s important, for these reasons, not to understand sex change surgery or hormonal usage as “elective surgery.” Although one might want to say that it is a choice, even a choice of a dramatic and profound kind, it has to, for the purpose of the insurance allocation, be a medically conditioned choice. We can surely think for quite some time on what a medically conditioned choice actually is, but for this argument it’s important to distinguish between a choice conditioned by a diagnosis and one that is not. In the latter case, the choice to transition can include some or all of the following: the choice to live as another gender, to take hormonal surgery, to find and declare a name, to secure new legal status for one’s gender, and to undergo surgery. If it is determined by psychological or medical professionals to be necessitated, that is, if it is determined that not undergoing this transition produces distress, maladaptation, and other forms of suffering, then it would seem to follow that the choice to transition is conceived as one that is embraced and condoned by medical professionals who have the person’s ultimate well-being at issue. The “diagnosis” can operate in several ways, but one way it can and does operate, especially in the hands of those who are transphobic, is as an instrument of pathologization. To be diagnosed with gender identity disorder is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all. As a result, some activist psychiatrists and trans people have argued that the diagnosis should be eliminated altogether, that transsexuality is not a disorder, and ought not to be conceived of as one, and that trans people ought to be understood as engaged in a practice of self-determination, an exercise of autonomy. Thus, on the one hand, the diagnosis continues to be valued because it facilitates an economically feasible way of transitioning. On the other hand, the diagnosis is adamantly opposed because it continues to pathologize as a mental disorder what ought to be understood instead as one among many human possibilities of determining one’s gender for oneself.

One can see from the above sketch that is, for the sake of opening this chapter, cast in terms that are perhaps too simple, that there is a tension in this debate between those who are, for the purposes of the debate, trying to gain entitlement and financial assistance and those who seek to ground the practice of transsexuality in autonomy. We might well hesitate at once and ask whether these two views are actually in opposition to one another. After all, one might argue, and people surely have, that the way that the diagnosis facilitates certain entitlements, to insurance benefits, to medical treatment, and to legal status, actually works in the service of what we might call trans-autonomy. After all, if I want to transition, I may well need the diagnosis to help me achieve my goal, and achieving my goal is precisely an exercise of my autonomy. Indeed, we can argue that no one achieves autonomy without the assistance or support of a community, especially if one is making a brave and difficult choice such as transitioning. But then we have to ask whether the diagnosis is unambiguously part of the “support” that individuals need in order to exercise self-determination with respect to gender. After all, the diagnosis makes many assumptions that undercut trans-autonomy. It subscribes to forms of psychological assessment that assume that the diagnosed person is affected by forces he or she does not understand; it assumes that there is delusion or dysphoria in such people; it assumes that certain gender norms have not been properly embodied and that an error and a failure have taken place; it makes assumptions about fathers and mothers, and what normal family life is and should have been; it assumes the language of correction, adaptation, and normalization; it seeks to uphold the gender norms of the world as it is currently constituted and tends to pathologize any effort to produce gender in ways that fail to conform to existing norms (or to a certain dominant fantasy of
what existing norms actually are). It is also a diagnosis, we have to remember, that has been given to people against their will, and it is a diagnosis that has effectively broken the will of many people, especially queer and trans youth.

So it would seem that the debate is a complex one, and that, in a way, those who want to keep the diagnosis want to do so because it helps them achieve their aims and, in that sense, realize their autonomy. And those who want to do away with the diagnosis want to do so because it might make for a world in which they might be regarded and treated in nonpathological ways, therefore enhancing their autonomy in important ways. On the face of it, it would seem that there are two different approaches to autonomy, but here is where it seems important to note that this is not only a philosophical problem to be answered in the abstract. To understand the difference between these views, we have to ask how the diagnosis is actually lived. What does it mean to live with it? Does it help some people to live, to achieve a life that feels worth living? And does it also hinder some people from living, make them feel in a stigmatized position and, in some cases, contribute to a suicidal conclusion? On the one hand, we ought not to underestimate the benefits that the diagnosis has brought, especially to trans people of limited economic means who, without the assistance of medical insurance, could not have achieved their goals. On the other hand, we ought not to underestimate the pathologizing force of the diagnosis, especially on young people who may not have the critical resources to resist its pathologizing force. In these cases, the diagnosis can be debilitating, if not murderous. And sometimes it murders the soul, and sometimes it becomes a contributing factor in suicide. So the stakes of this debate are high, since it would seem, in the end, to be a matter of life and death, and for some the diagnosis seems to mean life, and for others, the diagnosis seems to mean death. For others, too, it may well seem to be an ambivalent blessing or, indeed, an ambivalent curse.

To understand how these two understandable positions have emerged, let’s consider first what the diagnosis consists of in the United States and understand something of its history and present usages. A “diagnosis” of gender disorder has to conform to the way that the DSM-IV defines gender dysphoria. The last revision to that set of definitions was instituted in 1994. For a diagnosis to be complete, however, psychological tests are needed along with “letters” from therapists providing a diagnosis and vouching that the individual in question can live and thrive in the new sexed identity. The 1994 definition is the result of several revisions, and probably needs to be understood as well in light of the American Psychiatric Association’s decision in 1973 to get rid of the “diagnosis” of homosexuality as a disorder and its 1987 decision to delete “ego dystonic homosexuality,” a remaining vestige from the earlier definition. Some have argued that the gender identity disorder diagnosis took over some of the work that the earlier homosexuality diagnosis performed, and that GID became an indirect way of diagnosing homosexuality as a gender identity problem. In this way, the GID continued the APA’s tradition of homophobia, but in a less explicit way. In fact, conservative groups that seek to “correct” homosexuality, such as the National Association of Research and Therapy of Homosexuality, argue that if you can identify GID in a child, there’s a 75 percent chance that you can predict homosexuality in that person as an adult, a result that, for them, is a clear abnormality and tragedy. Thus the diagnosis of GID is in most cases a diagnosis of homosexuality, and the disorder attached to the diagnosis implies that homosexuality remains a disorder as well.

The very way that groups such as these conceptualize the relationship between GID and homosexuality is problematic. If we are to understand GID as based on the perception of enduring gendered traits of the opposite sex, that is, boys with “feminine” attributes and girls with “masculine” attributes, then the assumption remains that boy traits will lead to a desire for women, and girl traits will lead to a desire for men. In both of these cases, heterosexual desire is presumed, where presumably opposites attract. But this is to argue, effectively, that homosexuality is to be understood as gender inversion and that the “sexual” part remains heterosexual, although inverted. It is apparently rare, according to this conceptualization, that boy traits in a boy lead to desire for other boys and that girl traits in a girl lead to desire for other girls. So the 75 percent of those diagnosed with GID are considered homosexual only if we understand homosexuality on the model of gender inversion, and sexuality on the model of heterosexual desire. Boys are still always desiring girls, and girls are still always desiring boys. If 25 percent of those diagnosed with GID do not become homosexual, that would seem to mean that they do not conform to the gender inversion model. But because the gender inversion model can only understand sexuality as heterosexuality, it would seem that the remaining 25 percent would be homosexual, that is, nonconforming to the model of homosexuality as inverted heterosexuality. Thus, we could argue, somewhat facetiously, that 100 percent of those diagnosed with GID turn out to be homosexual!

Although the joke is irresistible to me only because it would so alarm the National Association of Research and Therapy of Homosexuality, it is important to consider, more seriously, how the map of sexuality and gender is radically misdescribed by those who think within these terms. Indeed, the correlations between gender identity and sexual orientation are murky at best: we cannot predict on the basis of what gender a person is what kind of gender
identity that person will have, and what direction(s) of desire he or she will ultimately entertain and pursue. Although John Money and other so-called transpositionalists think that sexual orientation tends to follow from gender identity, it would be a huge mistake to assume that gender identity causes sexual orientation or that sexuality references in some necessary way a prior gender identity. As I’ll try to show, even if one could accept as unproblematic what “feminine” traits are, and what “masculine” traits are, it would not follow that the “feminine” is attracted to the masculine, and the “masculine” to the feminine. That would only follow if we used an exclusively heterosexual matrix to understand desire. And actually, that matrix would misrepresent some of the queer crossings in heterosexuality, when for instance a feminized heterosexual man wants a feminized woman, in order that the two might well be “girls together.” Or when female heterosexual women want their boys to be both girls and boys for them. The same queer crossings happen in lesbian and gay life, when butch on butch produces a specifically lesbian mode of male homosexuality. And bisexuality, as I’ve said before, can’t be reducible to two heterosexual desires, understood as a feminine side wanting a masculine object, or a masculine side wanting a feminine one. Those crossings are as complex as anything that happens within heterosexuality or homosexuality. These kinds of crossings happen more often than is generally noted, and it makes a mockery of the transpositionalist claim that gender identity is a predictor of sexual orientation. Indeed, sometimes it is the very disjunction between gender identity and sexual orientation—the disorientation of the transpositionalist model itself—that constitutes for some people what is most erotic and exciting.

The way that the disorder has been taken up by researchers with homophobic aims presupposes the tacit thesis that homosexuality is the damage that will follow from such a change, but it is most important to argue that it is not a disorder and that there is a whole range of complex relations to cross-gendered life; some of them may involve dressing in another gender, some of them may involve living in another gender, some of them may involve hormones, and surgery, and most of them involve one or more of the above. Sometimes this implies a change in so-called object choice, but sometimes not. One can become a transman and want boys (and become a male homosexual), or one can become a transman and want girls (and become a heterosexual), or one can become a transman and undergo a set of shifts in sexual orientation that constitute a very specific life history and narrative. That narrative is not capturable by a category, or it may be capturable by a category only for a time. Life histories are histories of becoming, and categories can sometimes act to freeze that process. Shifts in sexual persuasion can be in response to particular partners, so that lives, trans or not, don’t always emerge as coherently heterosexual or homosexual, and the very meaning and lived experience of bisexuality can also shift through time, forming a particular history that reflects certain kinds of experiences rather than others.

The diagnosis of gender dysphoria requires that a life takes on a more or less definite shape over time; a life can only be diagnosed if it meets the test of time. One has to show that one has wanted for a long time to live life as the other gender; it also requires that one prove that one has a practical and livable plan to live life for a long time as the other gender. The diagnosis, in this way, wants to establish that gender is a relatively permanent phenomenon. It won’t do, for instance, to walk into a clinic and say that it was only after you read a book by Kate Bornstein that you realized what you wanted to do, but that it wasn’t really conscious for you until that time. It can’t be that cultural life changed, that words were written and exchanged, that you went to events and to clubs, and saw that certain ways of living were really possible and desirable, and something about your own possibilities became clear to you in ways that they had not been before. You would be ill-advised to say that you believe that the norms that govern what is a recognizable and livable life are changeable, and that within your lifetime, new cultural efforts were made to broaden those norms, so that people like yourself might well live within supportive communities as a transsexual, and that it was precisely this shift in the public norms, and the presence of supportive communities, that allowed you to feel that transitioning has become for you possible and desirable. In this sense, you cannot explicitly subscribe to a view that changes in gendered experience follow on changes in social norms, since that would not suffice to satisfy the Harry Benjamin standard rules for the care of gender identity disorder. Indeed, those rules presume, as does the GID, that we all more or less "know" already what the norms for gender—"masculine" and "feminine"—are, and that all we really need to do is figure out whether they are being embodied in this instance or some other. But what if those terms no longer do the descriptive work that we need them to do? What if that only operates in unwieldy ways to describe the experience of gender that someone has? And if the norms for care and the measures for the diagnosis assume that we are permanently constituted in one way or another, what happens to gender as a mode of becoming? Are we stopped in time, made more regular and coherent than we necessarily want to be, when we submit to the norms in order to achieve the entitles one needs, and the status one desires?
Although there are strong criticisms to be made of the diagnosis—and I will detail some of them below when I turn to the text itself—it would nevertheless be wrong to call for its eradication without first putting into place a set of structures through which transitioning can be paid for and legal status attained. In other words, if the diagnosis is now the instrument through which benefits and status can be achieved, it cannot be simply disposed of without finding other, durable ways to achieve those same results.

One obvious response to this dilemma is to argue that one should approach the diagnosis strategically. One could then reject the truth-claims that the diagnosis makes, that is, reject the description it offers of transsexuality but nevertheless make use of the diagnosis as a pure instrument, a vehicle for achieving one’s goals. One would, then, ironically or facetiously, or halfheartedly submit to the diagnosis, even as one inwardly maintains that there is nothing “pathological” about the desire to transition and the resolve to realize that desire. But here we have to ask whether submitting to the diagnosis does not involve, more or less consciously, a certain subjection to the diagnosis such that one does end up internalizing some aspect of the diagnosis, conceiving of oneself as mentally ill or “failing” in normality, or both, even as one seeks to take a purely instrumental attitude toward these terms.

The more important point in support of this last argument has to do with children and young adults, since when we ask who it is who would be able to sustain a purely instrumental relation to the diagnosis, it tends to be shrewd and savvy adults, ones who have other discourses available for understanding who they are and want to be. But are children and teens always capable of effecting the distance necessary to sustain a purely instrumental approach to being subjected to a diagnosis?

Richard Isay gives as the primary reason to get rid of the diagnosis altogether its effect on children. The diagnosis itself, he writes, “may cause emotional damage by injuring the self-esteem of a child who has no mental disorder.” Isay, a doctor, accepts the claim that many young gay boys prefer so-called feminine behavior as children, playing with their mother’s clothes, refusing rough-and-tumble activities, but he argues that the problem here is not with the traits but with “parental admonitions... aimed at modifying this behavior [which] deleteriously affect[s] these boys’ self-regard.” His solution is for parents to learn to be supportive of what he calls “gender atypical traits.” Isay’s contribution is important in many respects, but one clear contribution it makes is that it calls for reconceptualizing the phenomenon that refuses pathologizing language: he refuses to elevate typical gender attributes to a standard of psychological normality or to relegate atypical traits to abnormality. Instead, he substitutes the language of typicality for normality altogether. Physicians who argue against Isay not only insist that the disorder is a disorder, and that the presentation of persistently atypical gender traits in children is a “psychopathology,” but they couch this insistence on pathologization with a paternalistic concern for the afflicted, citing how the diagnosis is necessary for insurance benefits and other entitlements. Indeed, they exploit the clear and indisputable need that poor, working-class, and middle-class trans-aspirants have for medical insurance and legal support to argue not only in favor of keeping the diagnosis on the books but in favor of their view that this is a pathology that must be corrected. So even if the diagnosis is approached as an instrument or vehicle for accomplishing the end goal of transitioning, the diagnosis can still (1) instill a sense of mental disorder on those whom it diagnoses, (2) entrench the power of the diagnosis to conceptualize transsexuality as a pathology, and (3) be used as a rationale by those who are in well-funded research institutes whose aim it is to keep transsexuality within the sphere of mental pathology.

Some other solutions have been proposed that seek to ameliorate the pathological effects of the diagnosis by taking it out of the hands of the mental health profession altogether. Jacob Hale argues that psychologists and psychiatrists should not mediate this matter; the question of whether and how to gain access to medical and technological resources should be a matter between client and medical doctor exclusively. His view is that one goes to the doctor for other kinds of reconstructive surgeries or on other occasions where taking hormones may prove felicitous, and no one asks you a host of questions about your earliest fantasies or childhood practices of play. The certification of stable mental health is not required for breast reduction or menopausal ingestion of estrogen. The required intervention of a mental health professional on the occasion in which one wants to transition inserts a paternalistic structure into the process and undermines the very autonomy that is the basis for the claim of entitlement to begin with. A therapist is asked to worry about whether you will be able, psychologically, to integrate into an established social world characterized by large-scale conformity to accepted gender norms, but the therapist is not asked to say whether you are brave enough or have enough community support to live a transgendered life when the threat of violence and discrimination against you will be heightened. The therapist is not asked whether your way of living gender will help to produce a world of fewer constrictions on gender, and whether you are up to that important task. The therapist is asked to predict whether your choice will lead to postoperative regret, and here your desire is examined for its persistence and tenacity, but little attention is given to what happens to one’s persistent and tenacious desires when the social world, and the diagnosis itself, demeans them as psychic disorders.
I began this chapter by suggesting that the view one takes on keeping or opposing the diagnosis depends in part on how one conceives the conditions for autonomy. From Isay, we see an argument that claims that the diagnosis not only undermines the autonomy of children but mistakes their autonomy for pathology. In the argument that Hale offers, we see that the diagnosis itself takes on a different meaning if mental health professionals no longer use it. The question remains, though, whether medical practitioners with no particular background in mental health will nevertheless use mental health criteria to make decisions that could be no less favorable than those made by mental health practitioners. If Hale is arguing, though, that it ought to be shifted to medical doctors as part of a drive to redefine the diagnosis so that it no longer contains mental health criteria in it, then he is also proposing a new diagnosis or no diagnosis, since the DSM-IV rendition cannot be voided of its mental health criteria. To answer the question of whether the shift to medical doctors would be propitious, we would have to ask whether the inclinations of medical practitioners are generally to be trusted with this responsibility, or whether the world of progressive therapists offers a better chance for humane and successful passage through the process of diagnosis. Although I do not have a sociologically grounded answer to this question, I consider that it has to be pursued before one can judge the appropriateness of Hale’s recommendation. The great benefit of his view is that it treats the patient as a client who is exercising consumer autonomy within the medical domain. That autonomy is assumed, and it is also posited as the ultimate goal and meaning of transitioning itself.

But this raises the question of how autonomy ought to be conceived in this debate, and whether revisions in the diagnosis itself might provide a way around the apparent stand-off between those who wish to have the diagnosis deleted and those who wish to keep it for the instrumental value it provides, especially for those in financial need. There are two different conceptions of autonomy at work in this debate. The view that opposes the diagnosis altogether tends to be individualist, if not libertarian, and the views that argue in favor of keeping the diagnosis tend to acknowledge that there are material conditions for the exercise of liberty. The view that worries that the diagnosis may well be internalized or damaging suggests that the psychological conditions for autonomy can be undermined, and have been undermined, and that youth are at higher risk for this compromised and damaged sense of self.

Autonomy, liberty, and freedom are all related terms, and they also imply certain kinds of legal protections and entitlements. After all, the U.S. Constitution guarantees the pursuit of liberty, and it could be argued that restrictive conditions imposed on transsexual and transgendered individuals to exercise a liberty proper to that identity and practice are discriminatory. Paradoxically, the insurance companies demean the notion of liberty when they distinguish, say, between mastectomies that are “medically necessitated” and those that constitute “elective surgery.” The former are conceived as operations that no one readily chooses, that are imposed on individuals by medical circumstance, usually cancer. But even that conceptualization misrepresents the kinds of choices that informed patients make about how to approach cancer, where possible treatments include radiation, chemotherapy, arimidex, lumpectomy, partial and full mastectomy. Women will make different choices about treatment depending on how they feel about their breasts and the prospects of further cancer, and the range of choices made is significantly broad. Some women will struggle to keep their breasts no matter what; others let them go without much difficulty. Some will choose reconstruction and make some choices about prospective breasts, and others choose not to.

A rather butch lesbian in San Francisco recently had cancer in one breast and decided, in consultation with her doctor, to have a full mastectomy. She thought it was a good idea to have the other breast removed as well, since she wanted to minimize the chances of a recurrence. This choice was made easier for her because she had no strong emotional attachment to her breasts: they did not form an important part of her gendered or sexual self-understanding. Whereas her insurance company agreed to pay for the first mastectomy, they worried that the second breast was “elective surgery” and that, if they paid for that, it would be setting a precedent for covering elective transsexual surgery. The insurance company thus wanted to limit both consumer autonomy in medical decision making (understanding the woman as someone who wanted for medical reasons to have the second breast removed) and to dismiss autonomy as the basis for a transsexual operation (understanding the woman as a possible transitioner). At the same time, a friend of mine recovering from a mastectomy sought to understand what possibilities existed for her for reconstructive surgery. She was referred by her doctor to transsexual clients who could introduce her to various technologies and the relative aesthetic merits of those options. Although I’m not aware of coalitions of breast-cancer survivors and transsexuals, I can see how a movement could easily emerge whose main demand would be to petition insurance companies to recognize the role of autonomy in producing and maintaining primary and secondary sex characteristics. All this seems less strange, I would suggest, when we understand cosmetic surgery on a continuum with all the other practices that humans engage in to maintain and cultivate primary- and secondary-sex characteristics for cultural and social reasons. I gather that men who want penile augmentation or women who want breast augmentation and
reduction are not sent to psychiatrists for certification. It is, of course, interesting to consider in light of current gender norms why a woman who wants breast reduction requires no psychological certification, but a man who wants penile reduction may well. There is no presumption of mental malfunctioning for women who take estrogen or men who take Viagra. This is because, I presume, they are operating within the norm to the extent that they are seeking to enhance the "natural," making readjustments within acceptable norms, and sometimes even confirming and strengthening traditional gender norms.

The butch, nearly trans, person who wanted her cancerous and noncancerous breasts removed understood that the only way she could gain the benefits of a mastectomy was to get cancer in her other breast or to subject her own gender desires to medical and psychiatric review. Although she didn't consider herself trans, she understood that she could present as trans in order to qualify for the GID and insurance benefits. Sometimes reconstructive breast surgery is covered by medical insurance, even if done for elective reasons, but mastectomy is not included as elective surgeries covered by insurance. In the world of insurance, it appears to make sense that a woman might want less breast, but no sense that she would want no breast. Wanting no breast puts into question whether she still wants to be a woman. It is as if the butch's desire to have the breast removed is not quite plausible as a healthy option unless it is the sign of a gender disorder or some other medical urgency.

But why is it that we do accept these other choices as choices, regardless of what we take their social meanings to be? Society doesn't consider itself to have a right to stop a woman from enlarging or diminishing her breasts, and we don't consider penile enhancement to be a problem, unless it is being done by an illegitimate doctor who botches the results, as it sometimes sadly is. No one gets sent to a psychiatrist because they announce their plans to cut or grow their hair or to go on a diet, unless one is at risk for anorexia, and yet these practices are part of the daily habits of cultivating secondary-sex characteristics, if we expand that category to mean all the various bodily indicators or "cues" of sex. If the bodily traits "indicate" sex, then sex is not quite the same as the means by which it is indicated. Sex is made understandable through the signs that indicate how it should be read or understood. These bodily indicators are the cultural means by which the sexed body is read. They are themselves bodily, and they operate as signs, so there is no easy way to distinguish between what is "materially" true and what is "culturally" true about a sexed body. I don't mean to suggest that purely cultural signs produce a material body, but only that the body does not become sexually readable without those signs, and that those signs are irreducibly cultural and material at once.

So what are the versions of autonomy at work in these various approaches to the DSM diagnosis of gender identity disorder? And how might we conceive of autonomy in such a way that we might find a way of thinking through the reasonable disagreements that have emerged on whether to preserve or eradicate the diagnosis? Although it is obvious that not all individuals diagnosed with GID are or wish to become transsexual, they are nevertheless affected by the use of the diagnosis to further the aims of transsexuals, since to use the diagnosis is to strengthen its status as a useful instrument. This is no reason not to use it, but it does imply a certain risk, and certain implications. A strengthened diagnosis can have effects that its users do not intend or condone. And though it may well serve an individual's important needs to secure status and funding for a transition, it may well be used by the medical and psychiatric establishments to extend their pathologizing influences on populations of transsexuals, trans youth, and lesbian, bi, and gay youth as well. From the point of view of the individual, the diagnosis can be regarded as an instrument by which to further one's self-expression and self-determination; indeed, it can be counted among the fundamental instruments one needs to make a transition that makes life livable and that provides the grounds for one's flourishing as an embodied subject. On the other hand, the instrument takes on a life of its own, and it can work to make life harder for those who suffer by being pathologized and who lose certain rights and liberties, including child custody, employment, and housing, by virtue of the stigma attached to the diagnosis or, more precisely, by virtue of the stigma that the diagnosis strengthens and furthers. Whereas it would seem best to live in a world in which there was no such stigma, and no such diagnosis, we do not yet live in such a world; and the profound suspicion about the mental health of those who transgress gender norms structures the majority of psychological discourses and institutions, medical approaches to gender, and legal and financial institutions that regulate questions of status and possibilities for financial assistance and medical benefits.

There is an important argument to be made from the perspective of freedom, and yet it is important to remember that the specific forms that freedom takes depend on the social conditions and social institutions that govern human options at this time. Those who claim that transsexuality is, and should be, a matter of choice, an exercise of freedom, are surely right, and they are right as well to point out that the various obstacles posed by the psychological and psychiatric professions are paternalistic forms of power by which a basic human freedom is being suppressed. Underlying some of these positions is a libertarian approach to sex transformation. Richard Green, the president of the Harry Benjamin International Gender Dysphoria Association,
and a strong advocate for transsexual rights, including the rights of transsexual parents, cites John Stuart Mill, arguing on behalf of this issue as a matter of personal freedom and of privacy. He writes that Mill "argued forcefully that adults should be able to do with their bodies as they wish providing that it did not bring harm to another. Therefore, if the third gender, the transsexual, or the would-be limb amputee can continue to shoulder social responsibilities post-surgery, then the surgical requests are not society's business." Although Green makes this claim, one he himself calls "philosophical," he notes that it comes into conflict with the question of who will pay, and whether society has an obligation to pay for a procedure being defended as a matter of personal liberty.

I don't find many people writing in this area, except from within the discourse of the Christian Right, whose response to GID is to embrace it wholeheartedly and say, "Don't take this diagnosis away from me! Pathologize me, please!" There are, surely, many psychiatrists and psychologists who insist on GID as a pathology. And there is a well-funded and impossibly prolific professor of neuropsychiatry and behavioral science at the University of South Carolina, George Rekers, who combines a polemical political conservatism with an effort to intensify and extend the use of this diagnosis. His main concern seems to be about boys, boys becoming men, and men becoming strong fathers in the context of heterosexual marriage. He also traces the rise of GID to the breakdown of the family, the loss of strong father figures for boys, and the subsequent "disturbance" that it is said to cause. His manifest concern about the emergence of homosexuality in boys is clear from his discussion as well, citing as he does the 1994 DSM conclusion that 75 percent of GID youth turn out to be homosexual as adults. Rekers has published loads of studies strewn with "data" presented within the context of empirical research protocols. Although intensely polemical, he understands himself as a scientist and an empiricist, and he attributes ideological bias to his opponents. He writes that "in a generation confused by radical ideologies on male and female roles, we need solid research on men and women who are well adjusted examples of a secure male identity and a secure female identity." His "solid research" is intended to show the benefits of distinguishing clearly between gender norms and their pathologies "for family life and the larger culture." In this vein, Rekers also notes that "preliminary findings have been published in the literature which report on the positive therapeutic effects of religious conversion for curing transsexualism...and on the positive therapeutic effect of a church ministry to repentant homosexuals." He seems to be relatively unconcerned with girls, which impresses me as entirely symptomatic of his preoccupation with patriarchal authority and his inability to see the threat that women of all kinds might pose to the presumptions he makes about male power. The fate of masculinity absorbs this study because masculinity, a fragile and fallible construct, needs the social support of marriage and stable family life in order to find its right path. Indeed, masculinity by itself tends to falter, in his view, and needs to be housed and propped up by various social supports, suggesting that masculinity is itself a function of these social organizations and has no intrinsic meaning outside them. In any case, there are people like Rekers who make an adamant and highly polemical case, not only for retaining the diagnosis but for strengthening it, and they give highly conservative political reasons for strengthening the diagnosis so that the structures that support normalcy can be strengthened.

Ironically, it is these very structures that support normalcy that compel the need for the diagnosis to begin with, including its benefits for those who need it in order to effect a transition. It's with some irony, then, that those who suffer under the diagnosis also find that there is not much hope for doing without it. The fact is, that under current conditions, a number of people have reason to worry about the consequences of having their diagnosis taken away or failing to establish eligibility for the diagnosis. Perhaps the rich will be able to shell out the tens of thousands of dollars that an FTM transformation entails, including double mastectomy and a very good phallopastoplasty, but most people, especially poor and working-class trannies, will not be able to foot the bill. At least in the United States where socialized medicine is largely understood as a communist plot, it won't be an option to have the state or insurance companies pay for these procedures without first establishing that there are serious and enduring medical and psychiatric reasons for doing so. A conflict has to be established; there has to be enormous suffering; there has to be persistent ideation of oneself in the other gender; there has to be a trial period of cross-dressing throughout the day to see if adaptation can be predicted; there have to be therapy sessions, and letters attesting to the balanced state of one's mind. In other words, one must be subjected to a regulatory apparatus, as Foucault would have called it, in order to get to the point where something like an exercise in freedom becomes possible. One has to submit to labels and names, to incursions, to invasions, one has to be gauged against measures of normalcy, and one has to pass the test. So sometimes what this means is that one needs to become very savvy about these standards and know how to present oneself in such a way that one comes across as a plausible candidate. And sometimes therapists find themselves in a bind, being asked to supply a letter for someone they want to help, but abhorring the very fact that they have to write this letter, in the language of diagnosis, in order to help produce the life that their client wants to have. In a sense, the regulatory discourse surrounding...
the diagnosis takes on a life of its own; it may not actually describe the patient who uses the language to get what he or she wants; it may not reflect the beliefs of the therapist who nevertheless signs her name to the diagnosis and passes it along. Approaching the diagnosis strategically involves a series of individuals not quite believing what they say, signing on to language that does not represent the reality it is or should be. The price of using the diagnosis to get what one wants is that one cannot use language to say what one really thinks is true. One pays for one’s freedom, as it were, by sacrificing one’s claim to use language truthfully. In other words, one purchases one sort of freedom only by giving up another.

So perhaps this brings us closer to understanding the quandary of autonomy that the diagnosis introduces and the specific problem of how freedom is to be understood as conditioned and articulated through specific social means. The only way to secure the means by which to start this transformation is by learning how to present yourself in a discourse that is not yours, a discourse that effaces you in the act of representing you, a discourse that denies the language you might want to use to describe who you are, how you get here, and what you want from this life, denies all this at the same time that it holds out the promise, if not the blackmail, that you will get this life, you stand a chance of getting your life, the body and the gender you want, if you agree to falsify yourself and, in so doing, support and ratify the power of this diagnosis over many more people in the future.

If one comes out in favor of choice, and against diagnosis, it would seem that one has to deal with the enormous financial consequences of this decision for those who cannot pay for the resources at hand and whose insurance, if there is insurance, will not honor this choice as one that is to be included as a covered elective treatment. And even when local laws are passed, offering insurance to city workers who seek such treatments, as is the case now in San Francisco, there are still diagnostic tests to pass, so choice is clearly bought at a price, sometimes at the price of truth itself.

The way things are set up, if we want to support the poor and the uninsured in this area, it would seem that we have to support efforts to extend insurance coverage, and to work within the diagnostic categories accepted by the AMA and the APA, codified in the DSM-IV. The call to have matters of gender identity depathologized and for elective surgery and hormone treatment to be covered as a legitimate set of elective procedures seems bound to fail, only because most medical, insurance, and legal practitioners are committed to supporting access to sex change technologies only if we are talking about a disorder. Arguments to the effect that there is an overwhelming and legitimate human demand here are bound to prove inadequate. Examples of the kinds of justifications that ideally would make sense and should have a claim on insurance companies include: this transition will allow someone to realize certain human possibilities that will help this life to flourish, or this will allow someone to emerge from fear and shame and paralysis into a situation of enhanced self-esteem and the ability to form close ties with others, or this transition will help alleviate a source of enormous suffering or give reality to a fundamental human desire to assume a bodily form that expresses a fundamental sense of selfhood. Though some gender identity clinics, like the one at the University of Minnesota run by William Bockting, do make such arguments, and do provide supportive therapeutic contexts for people disposed to make a choice on this issue, whether it be to live as transgendered or transsexual, whether to be third sex, whether to consider the process as one of a becoming whose end is not in sight, and may never be. But even that clinic has to supply materials to insurance companies that comply with DSM-IV.

The exercise of freedom that is performed through a strategic approach to the diagnosis involves one in a measure of unfreedom, since the diagnosis itself demeans the self-determining capacities of those it diagnoses, but whose self-determinations, paradoxically, it sometimes furthers. When the diagnosis can be used strategically, and when it undermines its own presumption that the individual diagnosed is afflicted with a condition over which no choice can be exercised, the use of the diagnosis can subvert the aims of the diagnosis. On the other hand, to pass the test, one must submit to the language of the diagnosis. Although the stated aim of the diagnosis is it wants to know whether an individual can successfully conform to living according to the norms of another gender, it seems that the real test that the GID poses is whether one can conform to the language of the diagnosis. In other words, it may not be a matter of whether one can conform to the norms that govern life as another gender, but whether one can conform to the psychological discourse that stipulates what these norms are.

Let’s take a look at that language. The GID section of the DSM starts by making clear that there are two parts of this diagnosis. The first is that “there must be strong and persistent cross-gender identification.” This would be difficult to ascertain, I would think, since identifications do not always appear as such: they can remain aspects of hidden fantasy, or parts of dreams, or inchoate structures of behavior. But the DSM asks us to be a bit more positivist in our approach to identification, assuming that we can read off of behavior what identifications are at work in any given person’s psychic life. Cross-gender identification is defined as “the desire to be” the other sex, “or
true, although bio-women, those in drag, transgendered, and transwomen share certain risks on the street, especially if any of them is perceived as a prostitute. Similarly, one might say, it is generally more culturally advantageous to be a man if you want to be taken seriously in a philosophy seminar. This seems to be true, but some men are at no advantage at all, if they cannot talk the talk, and being a man is no sufficient condition for being able to talk that talk. So I wonder whether it is possible to consider becoming one sex or the other without considering the cultural advantage it might afford, since the cultural advantage it might afford will be the advantage it affords to someone who has certain kinds of desires, who wants to be in a position to take advantage of certain cultural opportunities. If GID insists that the desire to be another sex or the insistence that one is the other sex has to be evaluated without reference to cultural advantage, it may be that GID misunderstands some of the cultural forces that go into making and sustaining certain desires of this sort. And then GID would also have to respond to the epistemological question of whether sex can be perceived at all outside the cultural matrix of power relations in which relative advantage and disadvantage would be part of that matrix.

The diagnosis also requires that there be “persistent discomfort” about one’s assigned sex or “inappropriateness,” and here is where the discourse of “not getting it right” comes in. The assumption is that there is an appropriate sense that people can and do have, a sense that this gender is appropriate for me, to me. And that there is a comfort that I would have, could have, and that it could be had if it were the right norm. In an important sense, the diagnosis assumes that gender norms are relatively fixed and that the problem is making sure that you find the right one, the one that will allow you to feel appropriate where you are, comfortable in the gender that you are. There must be evidence of “distress”—yes, certainly, distress. And if there is not “distress,” then there should be “impairment.” Here it makes sense to ask where all this comes from: the distress and the impairment, the not being able to function well at the workplace or in handling certain daily chores. The diagnosis presumes that one feels distress and discomfort and inappropriateness because one is in the wrong gender, and that conforming to a different gender norm, if viable for the person in question, will make one feel much better. But the diagnosis does not ask whether there is a problem with the gender norms that it takes as fixed and intransigent, whether these norms produce distress and discomfort, whether they impede one’s ability to function, whether they generate sources of suffering for some people or for many people, and what the conditions are in which they provide a sense of comfort, or belonging, or, even, become the site for realizing certain human possibilities that let a person feel possibility, futurity, life, and well-being.
The diagnosis seeks to establish criteria by which a cross-gendered person might be identified, but the diagnosis, in articulating criteria, articulates a rigid version of gender norms. It offers the following account of gender norms (the emphases are mine) in the language of simple description: “In boys, cross-gendered identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls’ or women’s clothes or may improvise such items from available materials when genuine materials are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts.” The description seems to be based on a history of collected and summarized observations; someone has seen boys doing this and reported it, and others have done the same, and those reports are collected, and generalizations are derived from the observable data. But who is observing, and through what grid of observation? This we do not know. And though we are told that in boys this identification is “marked” by a preoccupation with “traditionally feminine activities,” we are not told in what this mark consists. And it seems important, since the “mark” will be what selects the observation as evidence for the thesis at hand. In fact, what follows from this claim seems to undermine the claim itself, since what the boys are said to do is to engage in a series of substitutions and improvisations. We are told that they may have a preference for dressing in girls’ or women’s clothes, but we’re not told whether the preference manifests itself in actually dressing in them. We are left with a vague notion of “preference” that could simply describe a supposed mental state, or internal disposition, or it may be inferred by practice. This last seems open to interpretation. But what we are told is that one practice they do engage in is improvisation, taking items that are available and making them work as feminine clothing. Feminine clothing is called “genuine clothing,” which leaves us to conclude that the materials with which these boys are improvising is less than genuine, other than genuine, if not ingenuine and “false.” “Towels, aprons, and scarves are often used to represent long hair or skirts.” So there is a certain imaginary play, and a capacity to transfigure one item into another through improvisation and substitution. In other words, there is an art practice at work here, one that would be difficult to name, simply, as the simple act of conforming to a norm. Something is being made, something is being made from something else, something is being tried out. And if it is an improvisation, it is not fully scripted in advance.

Although the description goes on to insist on the fascination of these boys with “stereotypical female-type dolls”—and “Barbie” is mentioned by name—and “female fantasy figures” also seem prominent, we are not really given an account of the place that dolls and fantasy have in formulating gender identification. For a given gender to be a site of fascination or, indeed, for a so-called stereotype to be a source of fascination may well involve several kinds of relations to the stereotype. It may be that the stereotype is fascinating because it is overdetermined, that it has become the site for a number of conflicting desires. But the DSM assumes that the doll you play with is the one you want to be. But maybe you want to be her friend, her rival, her lover. Maybe you want all this at once. Maybe you do some switching with her. Maybe playing with the doll, too, is a scene of improvisation that articulates a complex set of dispositions, and that something else is going on in this play besides a simple act of conforming to a norm. Perhaps the norm is itself being played, explored, even busted. We would need to take play as a more complex phenomenon than does the DSM if we were to begin to pose and pursue these kinds of questions.

The way you can tell that girls are having cross-gendered identification according to the DSM-IV is that they argue with their parents about wearing certain kinds of clothes. They prefer boys’ clothing and short hair, apparently, and they have mainly boy friends, express a desire to become a boy, but also, oddly, “they are often misidentified by strangers as boys.” I am trying to think through how it could be that evidence of one’s cross-gendered identification is confirmed by being identified as a boy by a stranger. It would seem that random social assignment functions as evidence, as if the stranger knows something about the psychological makeup of that girl, or as if the girl has solicited that interpellation from the stranger. The DSM goes on to say that the girl “may ask to be called by a boy’s name.” But even there, it seems, she is first addressed as a boy and, only after being addressed, wants to take on a name that will confirm the rightness of the address itself. Here again, the very language that the DSM provides seems to undercut its own arguments, since it wants to be able to claim cross-gendered identification as part of gender identity disorder, and so as a psychological problem that can be addressed through treatment. It imagines that each individual has a relation to its “assigned sex” and that this relation is either one of discomfort and distress or a sense of comfort and being at peace. But even this notion of “assigned sex”—sex “assigned” at birth—implies that sex is socially produced and relayed, and that it comes to us not merely as a private reflection that each of us makes about ourselves but as a critical interrogation that each of us makes of a social category assigned to us, that exceeds us in its generality and power, but which also, consequentially, instances itself at the site of our bodies. It is interesting that the DSM seeks to establish gender as a set of more or less fixed and conventional norms, even as it keeps giving us evidence to the contrary, almost as if it is at cross-purposes with its own aims. Just as the boys who were im-
provising and substituting were doing something other than conforming to preestablished norms, so the girls seem to be understanding something about social assignment, about what might happen if someone starts to address you as a boy, and what that might make possible. I'm not sure that the girl who seizes on this stray and felicitous interpulsion is giving evidence to a preestablished “disorder” of any kind, but noting that the very means by which sex comes to be, through assignment, opens up possibilities for reassignment that excite her sense of agency, play, and possibility. Just as the boys who are playing with scarves as if they were something else are already versing themselves in the world of props and improvisation, so the girls, seizing on the possibility of being called by another name, are exploring the possibilities of naming themselves in the context of that social world. They are not simply giving evidence to internal states but performing certain kinds of actions, and even engaging practices, practices that turn out to be essential to the making of gender itself.

The DSM offers a certain discourse of compassion, as many psychiatrists do, suggesting that to live with such a disorder is a cause of distress and unhappiness. The DSM has its own antipoetry on this subject: “In young children, distress is manifested by the stated unhappiness about their assigned sex.” And here it seems that the only unhappiness is one created by an internal desire, not by the fact that there is no social support for such children, that the adults to whom they express their unhappiness are diagnosing and pathologizing them, that the norm of gender frames the conversation in which the expression of unhappiness takes place. At the same time that the DSM understands itself as diagnosing a distress that then becomes a candidate for alleviation as a result of the diagnosis, it also understands that “social pressure” can lead to “extreme isolation for such a child.” The DSM does not talk about suicide, even though we know that the cruelty of adolescent peer pressure on transgendered youth can lead to suicide. The DSM does not talk about risks of death, generally, or murder, something that happened only miles from my home in California last week when a transgendered boy arrived at a teen party in a dress, and his body was found dead from beating and strangulation in the Sierra foothills. Apparently, the “distress” that comes from living in a world in which suicide and death by violence remain real issues is not part of the diagnosis of GID. So consider that the DSM remarks, after a brief discussion of the euphemistically called “peer teasing and rejection,” that “children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex.” Here the language of the text seems to understand that there may be an impairment of ordinary functioning caused by the pressure of social norms. But then, in the next sentence, it domesticates the distress caused by social norms, by claiming that it is the person’s own preoccupation with cross-gender wishes that often “interferes with ordinary activities” and ends up in situations of social isolation. In a way, the fact of social violence against transgendered youth is euphemized as teasing and pressure, and then the distress caused by that is recast as an internal problem, a sign of preoccupation, self-involvement, which seems to follow from the wishes themselves. Indeed, is the “isolation” noted here real, or are the communities of support eclipsed from the observation? And when there is isolation, is it, therefore, a sign of a pathology? Or is it, for some, the cost of expressing certain kinds of desires in public?

What is most worrisome, however, is how the diagnosis works as its own social pressure, causing distress, establishing wishes as pathological, intensifying the regulation and control of those who express them in institutional settings. Indeed, one has to ask whether the diagnosis of transgendered youth does not act precisely as peer pressure, as an elevated form of teasing, as a euphemized form of social violence. And if we conclude that it does act in such a way, standing for gender norms, seeking to produce adaptation to existing norms, then how do we return to the vexed issue of what the diagnosis also offers? If part of what the diagnosis offers is a form of social recognition, and if that is the form that social recognition takes, and if it is only through this kind of social recognition that third parties, including medical insurance, will be willing to pay for the medical and technological changes that are sometimes desired, is it really possible to do away with the diagnosis altogether? In a way, the dilemma with which we are faced in the end has to do with the terms by which social recognition is constrained. Since even if we are tempted by the civil libertarian position in which this is understood as a personal right, the fact is that personal rights are only protected by, and can only be exercised through social and political means; to assert a right is not the same as being empowered to exercise it. And in this case, the only recognizable right at hand is the “right to be treated for a disorder and to take advantage of medical and legal benefits that seek its rectification.” One exercises this right only by submitting to a pathologizing discourse, and, in submitting to the discourse, one also gains a certain power, a certain freedom.

It is possible to say, necessary to say, that the diagnosis leads the way to the alleviation of suffering, and it is possible, necessary, to say that the diagnosis intensifies the very suffering that requires alleviation. Under present and entrenched social conditions in which gender norms are still articulated in conventional ways, and departures from the norm regarded as suspect, this is the paradox that autonomy is in. Of course, it is possible to move to a country where the state will pay for sex reassignment surgery, to apply to a
"transgender fund" that a broader community supplies to help those who cannot pay the high costs, or indeed to apply for a "grant" to individuals that covers "cosmetic surgery." And the movement for trans people to become the therapists and diagnosticians has and will surely help matters. These are all ways around the bind, until the bind goes away. But if the bind is to go away for the long run, the norms that govern how we understand the relation between gender identity and mental health would have to change radically, so that economic and legal institutions would recognize how essential becoming a gender is to one's very sense of personhood, one's sense of well-being, one's possibility to flourish as a bodily being. Until that time, freedom will require unfreedom, and autonomy is implicated in subjection. If the social world must change for autonomy to become possible, then individual choice will prove to have meaning only in the context of a more radical social change.

Notes

1. See Richard Friedman, "Gender Identity," Psychiatric News, January 1, 1998. This viewpoint, however, is one that accepts that the diagnosis does describe a pathology, so his view is not that the diagnosis should be kept only for instrumental reasons.

2. See Robert Pela, "Boys in the Dollhouse, Girls with Toy Trucks," The Advocate, November 11, 1997. He argues that "the American Psychiatric Association has invented mental health categories—specifically, gender identity disorder—that are meant to pathologize homosexuality and to continue the abuse of gay youth." He also cites Shannon Minter to the effect that "GID is just another way to express homophobia." See also Katherine Rachlin, "Transgender Individuals' Experiences of Psychotherapy" (paper presented at the American Psychological Association meetings, August 2001), http://www.symposion.com/ijt/ijtv06no01_03.htm. She notes that "individuals may resent having to spend time and money for psychological services in order to obtain medical services. They may also have fears concerning speaking to someone who holds the power to grant or deny them access to the interventions they feel they need. This fear and resentment creates a dynamic between therapist and client which may have an impact on the process and outcome of treatment." See also Anne Vitale, "The Therapist versus the Client: How the Conflict Started and Some Thoughts on How to Resolve It" in Transgender Care, ed. Gianni E. Israel, Donald E. Tarver II, and Diane Shaffer (Philadelphia: Temple University Press, 1997), 251–55. Kate Bornstein offers a searing critique of therapy: "Here's how this one works: we're taught that we are literally sick, that we have an illness that can be diagnosed and maybe cured. As a result of the medicalization of our condition, transsexuals must see therapists in order to receive the medical seal of approval required to proceed with any gender reassignment surgery. Now, once we get to the doctor, we're told we'll be cured if we become members of one gender or another. We're not told to divulge our transsexual status, except in select cases requiring intimacy. Isn't that amazing? Transsexuals presenting themselves for therapy in this culture are channeled through a system that labels them as having a disease (transsexuality) for which the therapy is to lie, hide, or otherwise remain silent. Transsexuality is the only condition for which the therapy is to lie" (Gender Outlaw: On Men, Women, and the Rest of Us [New York: Routledge, 1994], 62).

3. It is important to note that transsexualism was first diagnosed in 1980 in the DSM-III. In the DSM-IV, published in 1994, transsexualism does not appear, but is treated instead under the rubric of gender identity disorder, termed "GID" throughout this chapter as shorthand. The diagnosis as it currently stands requires that applicants for transsexual surgery and treatment show "evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is the other sex." Second, "this cross-identification must not be merely the desire for any perceived cultural advantages of being the other sex," but "there must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex." The diagnosis is "not made if the individual has a concurrent physical intersex condition," and "to make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning." For more information, see Trans-health.com 4, no. 1 (spring 2002); see the same online journal, volume 1, number 1 (summer 2001) for an important critique titled "The Medicalization of Transgenderism," a five-part work by Whitney Barnes (published in successive issues) that thoroughly and trenchantly covers pertinent issues related to the diagnostic category.

4. For a discussion on changes of nomenclature within the history of the diagnosis to differentiate those who are considered to be "gender dysphoric" from the start from those who arrive at this conclusion in time, see "The Development of a Nomenclature" in the Harry Benjamin International Gender Dysphoria Association's The Standards of Care for Gender Identity Disorders, 6th ed. (Düsseldorf: Symposium Publishing, 2001).


6. Friedman, "Gender Identity."

7. Jacob Hale, "Medical Ethics and Transsexuality" (paper presented at the Seventeenth Harry Benjamin International Gender Dysphoria Association Symposium, Galveston, Texas, October 31–November 4, 2001), http://www.symposion.com/ijt/hbida/2001/69_hale.htm. See also Richard Green's queries in the lecture cited below. "Should sex change be available on demand? That was hardly the issue in 1969, as the nearly insurmountable hurdle then was professionally endorsed reassignment. If gender patients can procure surgeons who do not require psychiatric or psychological referral, research should address outcome for those who are professionally referred versus the self-referred. Then an ethical issue could be, if success is less (or failure greater) among the self-referred, should otherwise competent adults have that autonomy of self-determination?" Later he asks, "Should there be a limit to a person's autonomy over body?" Green also applauds the fact that some transgendered individuals have now entered into the profession, so that they are the ones making the diagnosis and also electing the medical benefits.

8. For a discussion of the etiology of the diagnosis that covers recent psychological findings about postoperative regret and sex reassignment surgery's "success rates," see P. T. Cohen-Kettenis and L. J. G. Gooren, "Transsexualism: A Review of