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Changing Models of Transsexualism

Dallas Denny, MA

SUMMARY. The second half of the twentieth century saw the development within the psychological and medical communities of a transsexual model and procedures for identifying, describing, and treating individuals who sought sex reassignment. This model viewed transsexualism as a form of mental illness characterized by a pervasive and ongoing wish to be a member of the other sex. The model prescribes a set of medical and social procedures called sex reassignment, whereby an individual "changed sex." The 1990s saw the rise of a new model which explained transsexualism as a natural form of human variability. This model, which continues to gain prominence, views sex reassignment as but one of a variety of acceptable life choices for transsexual individuals, and recognizes the need and right of nontranssexual transgendered people to make similar choices. This paper discusses both models and touches on the social and treatment implications of the rise of the transgender model. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]

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Transsexualism was defined in the mid-20th century as a condition in which an individual wishes to manifest the primary and secondary sex characteristics of the non-natal sex and live as a member of that sex, and modifies his or her body with hormones and surgery to achieve that end (Benjamin, 1966; American Psychiatric Association, 1980). The 1990s, however, brought an increasing awareness among researchers and clinicians that genital sex reassignment surgery (SRS) is not uniformly desired or sought by all persons who dress and behave as members of the other sex on a full-time basis. This new paradigm (Denny, 1995) originating from transgendered people themselves (see especially Prince, 1973, and Boswell, 1991), provided an alternative to the model of transsexualism which had held sway since the 1960s (see Benjamin, 1966; Green and Money, 1969). The initial model held that transsexuals were "trapped in the wrong body," experiencing a psychic pain that could be alleviated only by body transformation. The new model views gender as a continuum rather than a male/female dichotomy (Bornstein, 1994; Rothblatt, 1994) and calls for individualized gender trajectories, which may or may not include hormonal therapy and sex reassignment surgery.

By the mid-1990s, the term transgender[ed] was widely used to describe all persons whose identities, behavior, or dress varied from traditional gender norms—not only transsexuals, transgenderists, crossdressers, and drag queens, but also those who challenged clothing or occupational norms, even gay men and lesbians, who transgress the norms of sexual attraction (cf Bornstein, 1994). Today, the transgender model is reflected not only in the lay and professional literatures, but in the *DSM IV* (American Psychiatric Association, 1994), in which the diagnostic category Transsexualism was replaced with the more general Gender Identity Disorder (GID); and in the proceedings of the Harry Benjamin International Gender Dysphoria Association,¹ which named its electronic periodical, *The International Journal of Transgenderism*.

DEVELOPMENT OF THE TRANSSEXUAL MODEL

In his seminal work *The Transsexual Phenomenon* (1966), Harry Benjamin, who had worked with hundreds of men and women desperate to change their sex, defined a syndrome he called *transsexualism*. Transsexuals were those men and women who were psychologically and socially a poor fit in their assigned sex, and who wished to belong to the other sex. Perhaps the defining characteristic was misery. Transsexuals were desperately unhappy in their skins. Some of these individuals, Benjamin argued, could be given a measure of relief by providing the medical treatment needed to enable them to live as members of the non-natal sex.

Also in 1966, a gender program was established at Johns Hopkins University. Three years later, Green and Money published a text with chapters representing the wide range of disciplines the Hopkins program used to help transsexuals with the physical, psychological, and social aspects of the process the authors called "sex reassignment." Other clinics soon opened in the U.S., following the multidisciplinary Hopkins model.

The transsexual model was primarily a medical one; it held that transsexualism was a form of mental illness. It was variously argued that the desire to change sex was caused by repressed or denied homosexuality (Socarides, 1969), perversion (Wiedeman, 1953), masochism (Wiedeman, 1953), neurosis (Ostow, 1953), psychosis (Baastrup, 1966), character or personality disorder (Spensley and Barter, 1971), brain trauma (Blumer, 1969), or an attempt by the [male] medical establishment to render females obsolete (Raymond, 1979). Theories of causation ranged from individual psychopathology to family pathology to prenatal, perinatal, or postnatal hormone disturbances or chromosomal aberrations (see Hoenig, 1985 for a review).

Yet the transsexual model provided a medical rationale for procedures which alleviated the suffering of transsexuals. The proponents argued, reasonably, that since no other treatment had been shown effective, sex reassignment should be considered—but only in the most serious and persistent cases: ". . . my principal argument was that we doctors should be as conservative as possible in advising sex-reassignment surgery or in performing such an irrevocable operation . . ." (Benjamin, 1969, p. 6).

The treatment was palliative. The individual would not be cured, but merely rendered able to participate more fully in life's rich banquet (see Green, 1969, p. 471).

Over the years, psychiatrists have tried repeatedly to treat these people without surgery, and the conclusion is inescapable that psychotherapy has not so far solved the problem. The patients have no motivation for psychotherapy and do not want to change back to their biological sex . . . If the mind cannot be changed to fit the body, then perhaps we should consider changing the body to fit the mind. (John E. Hoopes, quoted in Green and Money, 1969, p. 268)

The opponents of sex reassignment argued that the proper way to deal with a diseased mind was to treat the brain; to do otherwise constituted collaboration with the mental illness: "The difficulty of getting the patient into psychiatric treatment should not lead us to compliance with the patient's demands, which are based on his sexual perversion" (Wiedeman, 1953, responding to Hamburger et al.'s [1953] announcement of the sex reassignment of Christine Jorgensen).

ADVANTAGES OF THE TRANSSEXUAL MODEL

The transsexual model provided a theoretical framework for sex reassignment in an earlier era. It protected transsexuals, who now had a medical problem rather than a moral problem, and it gave professionals a logical reason for treating and studying gender-variant persons: they were doing their duty as healers. Under the auspices of the model, thousands of transsexuals who had previously had nowhere to turn found help.

The medically-based transsexual model brought professionals together to form a community. It made previously unavailable sex reassignment technologies available to transsexuals. The model stimulated much research and the publication of dozens of books and hundreds of articles in professional journals. Without it, there would have been no gender clinics, and the thousands of transsexuals who attended the clinics in the 1960s and 1970s would have been forced to choose between going without treatment or seeking out problematic and often dangerous black market hormones and surgeries.

DISADVANTAGES OF THE TRANSSEXUAL MODEL

Most of the professionals writing in the 1960s and 1970s realized sex reassignment was an extreme treatment which paid homage to bipolar gender norms. Pauly (1969) wrote “. . . we must discard the biblical polarity of the male-female, masculine-feminine dichotomy, and reorient our thinking along a scale of subtle nuances of behavior.”

Unfortunately, society was not yet ready to acknowledge that gender comes in shades of grey. Both transsexuals and the professionals who treated them had little choice but to function as best they could within the confines of a world that saw gender as black-and-white, male or female. The transsexual model was well suited for the times.

The model provided the theoretical framework necessary to provide medical treatment to transsexuals, but at a price: the treatment it prescribed—sex reassignment—was predicated on the notion that there were but two genders, and was thus relatively inflexible. Sex reassignment converted males into females and females into males; applicants were either accepted for sex reassignment or turned away; there was no middle ground.

Because treatment was predicated on the notion that the individual was changing sex, most gender clinics rejected those who didn't want SRS as “nontranssexual” (cf Newman and Stoller, 1974). Those accepted into the gender programs often had to fulfill elaborate requirements in order to obtain hormonal therapy and SRS (see Lothstein, 1983, pp. 87-91).

The treatment programs aggressively enforced binary male/female gender norms; those deemed appropriate for sex reassignment were expected and of-

ten required to behave and dress in ways that reflected the most extreme masculine and feminine presentations (Bolin, 1988; Denny, 1992). Sometimes, emphasis was placed not only on the ability to successfully pass as a member of the other gender, but on youth and sexual attractiveness:

A clinician during a panel session on transsexualism said he was more convinced of the femaleness of a male-to-female transsexual if she was particularly beautiful and was capable of evoking in him those feelings that beautiful women generally do. Another clinician told us that he uses his own sexual interest as a criterion for deciding whether a transsexual is really the gender she/he claims. (Kessler and McKenna, 1978, p. 113)

Most who were rejected for surgery looked like men trying unsuccessfully to imitate women. (Stone, 1977)

Under the transsexual model, the clinics attempted to turn out well-adjusted, attractive, heterosexual graduates. Applicants were rejected for a variety of reasons, including age, sexual orientation, marital status, occupational choice, and projected appearance in the new gender role (Denny, 1992). Even in the mid-1990s, gender programs around the world were turning down applicants for sex reassignment for such reasons (Petersen and Dickey, 1995).

Not surprisingly, transsexuals learned to tell stories consistent with the expectations of their caregivers:

It took a surprisingly long time—several years—for the researchers to realize that the reason the candidates' behavioral profiles matched Benjamin's so well was that the candidates, too, had read Benjamin's book, which was passed from hand to hand within the transsexual community, and they were only too happy to provide the behavior that led to acceptance for surgery. (Stone, 1991)

The preoperative individual recognizes the importance of fulfilling caretaker expectations in order to receive a favorable recommendation for surgery, and this may be the single most important factor responsible for the prevalent mental-health medical conceptions of transsexualism. *Transsexuals feel that they cannot reveal information at odds with caretaker expectations without suffering adverse consequences.* They freely admitted to lying to their caretakers about sexual orientation and other issues.

Although caretakers are often aware that transsexuals will present information carefully manipulated to ensure surgery. . . they have only to scrutinize several of their most prominent diagnostic markers available in the literature to realize the reason for the deceit. If caretakers would divorce themselves from these widely held beliefs, they would probably receive more honest information. (Bolin, 1988, p. 63)

It was an unfortunate fact that treatment under the model punished transsexuals for telling the truth. It also placed them at risk for abuse from professionals who controlled access to hormones and SRS. Transsexuals have long complained about this. The literature documents the excesses of the gender programs, some of which required their transsexual clients to divorce, change their names, quit their jobs, dress and behave in stereotypically masculine or feminine ways, and agree to participate in follow-up studies by offering the promise of hormonal therapy and SRS. Stone (1977, p. 142) wrote "All transsexual patients receiving hormone therapy at the clinic were asked to submit to a semi-structured interview, including a medical history, and a problem-specific physical examination. *Participation in the study was mandatory if the patients wished to continue to receive hormone therapy at the clinic*" (emphasis added; see also Denny, 1992).

THE TRANSGENDER MODEL

In 1973, Virginia Prince published an essay questioning the inevitability of SRS for those who lived as members of the non-natal sex. She wrote:

We have sexual identity clinics in which people are examined, selected, screened, and finally have surgery performed on them . . . It seems a very sad thing to me that a great many individuals have to go to the expense, pain, danger, and everything else when they could achieve a gender change without any of it. (Prince, 1973, p. 21)

In 1991, Boswell provided a theoretical framework for Prince's lived experience:

. . . in the vast majority of instances, we are not so much "gender conflicted" as we are at odds—even at war—with our culture. It is our culture that imposes the polarization of gender according to biology. It is our culture that has brainwashed us, and our families and friends, who might otherwise be able to love us and embrace our diversity as desirable and natural—something to be celebrated. (Boswell, 1991, p. 30)

Under the transgender model proposed by Boswell, transsexualism and other forms of gender variance are viewed not as mental disorders, but rather as natural forms of human variability.² Almost everyone in the United States deviates from John Wayne/Marilyn Monroe gender norms in some way or another, and those who do often face difficulties because of it. In the broadest sense of the term, gay men, lesbians, and everyone who challenges sexual, sar-

torial, behavioral, or occupational norms can be said to be to some extent transgendered (cf Signorile, 1996).

The transgender model changed the locus of pathology; if there is pathology, it might more properly be attributed to the society rather than the gender-variant individual. Those who are most visibly different are at risk for discrimination, hostility, and violence from an intolerant culture, and often from their schools, churches, police and other government officials, and even family members (Wilchins et al., 1997; see also the Remembering Our Dead website at www.gender.org/remember). Because of discrimination, many transgendered people are not able to get jobs, or, if they have them, keep them (Green and Brinkin, 1994). Marginalization can force occupational and other life choices with dire consequences for health and safety—for instance, some transgendered and transsexual women turn to sex work because they are unable to get or keep jobs due to discrimination and because there is a steady demand for transgendered sex workers. When one is faced with homelessness, denied even the most menial of jobs, sex work can sometimes provide an alternative way to pay the rent.³

The transgender model holds that this societal mistreatment can result in psychological difficulties, including shame and guilt and resulting self-destructive behaviors, including abuse of alcohol and other drugs, eating disorders, and self-injurious behavior; dissociative conditions; personality and behavior disorders; and mood disturbances. Accounts under the older transsexual model tended to assume such problems were symptoms of or co-existent with the “syndrome” of transsexualism, discounting or more often never even considering that they might be reactions to societal discrimination and abuse.

At first discussed only in the pages of community newsletters and magazines, the transgender model quickly found acceptance in gay and lesbian and academic circles. By the mid-1990s, the term was appearing widely in newspapers, magazines and books. A new generation of helping professionals was on the scene, questioning the orthodoxies of the transsexual model (Israel and Tarver, 1998). The model was also proving useful in promoting political, legal, and social acceptance of gender-variant people (Currah, Minter, and Green, 2000).

The transgender model appeals to many who had hesitated to call themselves transsexuals or crossdressers, including gay men and lesbians who recognize their gender variance (Signorile, 1996). The gay and lesbian community, which has had a longstanding love-hate relationship with transgendered people (Brewster, 1969; Denny, 1994), has become more welcoming, and transgender has been added to the name or mission statements of even the most recalcitrant GLB organizations (Human Rights Campaign, 2001). The model also appeals

to academics, and the name transgender has been added to the titles of texts and conferences.

DISADVANTAGES OF THE TRANSGENDER MODEL

The transgender model weakens some arguments which have been successfully used to justify hormonal therapy and sex reassignment surgery. If transsexuals and other transgendered persons are not mentally ill, there is no psychiatric justification for hormonal therapy and SRS. If these technologies are not being used to provide relief for a psychiatric condition, they can be viewed as cosmetic or even frivolous in nature.

It should be noted, however, that the suffering of transsexuals is real enough, and the dissatisfaction of transsexuals with their bodies and gender of assignment has been well documented from Benjamin (1966) to present. Dozens of studies have shown sex reassignment to be effective in both male-to-female and female-to-male transsexuals (see Blanchard and Sheridan, 1990). The lone study showing "no objective advantage" to male-to-female sex reassignment (Meyer and Reter, 1979) was seriously methodologically flawed (Blanchard and Sheridan, 1990) and possibly fraudulent (Ogas, 1994).

The transgender model tends to render transsexuals invisible. While many transgendered people are comfortable fitting somewhere in the space between the two commonly acknowledged genders, transsexuals have no doubts about the gender to which they belong. They unambiguously identify with the non-natal gender. They are not necessarily comfortable in the middle spaces, and many of them find little in common with transgenderists and crossdressers and others of ambiguous gender. Transsexuals often claim they are pressured to take "the middle road" by peers and helping professionals, and may be ridiculed because of their identities as members of the non-natal sex.

This has resulted in an ideological division within the transgender community with special implications for legal protections: should nondiscrimination and hate-crime protections be extended only to those who change sex, or to those with ambiguous or alternating gender presentations?

The transgender model also threatens some existing legal protections. If a political entity offers protection from discrimination based on a perceived disability (transsexualism), what happens when that disability is destabilized? Transgender civil rights activists have asked this and similar questions. While protections based on nondiscrimination may prove to be more long-lasting, some activists believe it is beneficial to pursue legal protections on the basis of disability (see MacKenzie and Nangeroni, 2002).

THE EFFECT OF THE TRANSGENDER MODEL

Opponents of sex reassignment have been troubled by the apparent increase in the numbers of men and women who have sought and obtained sex reassignment in recent years (see McHugh, 1992). There are no national statistics on sex reassignment procedures, but certainly more and more transsexuals and other transgendered people seem to be coming forward, as evidenced by increased attendance at conferences and support groups. There are a number of possible reasons for this. First, the transgender model lets gender-variant men and women view themselves as healthy and can relieve their burden of guilt and shame, helping them to come out rather than remain invisible to demographers (Denny, 1997). Second, the model appeals to nontranssexual gender-variant people. Many individuals who formerly identified as gay or lesbian, and especially genderqueer youth find it appealing.

The transgender model doesn't require the individual to be attractive or to pass as a member of the other gender and makes no restrictions based on sexual orientation, marital status, or occupation—nor does it require appearance and dress that is stereotypically male or female. Androgyny is not only acceptable, but often seen as desirable (Boswell, 1991).

In the transgender model, access to feminizing or masculinizing medical treatment is not limited to only those who seek treatment at formal gender programs; the various technologies of sex reassignment, previously available only to a few individuals after a rigorous screening process, are now available to almost anyone who desires it. Those who desire to change their bodies are not forced into a pre-arranged course that inevitably culminates in sex reassignment surgery. They can pick and choose among medical technologies, altering their bodies no more or no less than they need or wish.

The transgender model has opened a middle ground that was not possible under the model it replaced. Before about 1990, transgendered persons were expected to declare themselves to be crossdressers, who were not expected to seek sex reassignment; or transsexuals, who *were* expected to and who came under pressure from peers when they didn't (see Bolin, 1988). This situation had changed dramatically by the mid-1990s, when the same researcher found that individuals were encouraged to interpret and express their gender variance in individual ways (Bolin, 1994). Gender-variant people now self-identify in often idiosyncratic ways, many of which do not lead to hormonal therapy and SRS. Respondents to a survey by Denny and Roberts (1997) used more than 40 terms when describing themselves. Cromwell, Green and Denny's (2001) findings were similar.

The transgender model highlights some of the culturally bound assumptions of early critics of transsexualism and sex reassignment, and in so doing renders them obsolete or ineffective. For instance, if there is no mental illness,

sex reassignment cannot be viewed as collaboration with mental illness (Wiedeman, 1953); since many transgendered people deliberately blend gender (Devor, 1989) and post-transition transsexuals nowadays tend to dress and look much like any other group of men and women (Bolin, 1994), transsexuals can no longer be accused of having and expressing stereotyped notions of manhood and womanhood (Raymond, 1979), for they are no longer expected by medical professionals to dress and behave in a stereotypic manner. The older literature must also be re-examined in light of the social pressures now known to be inherent in the treatment setting, particularly characterizations such as the following:

[Transsexuals as a class] were depressed, isolated, withdrawn, schizoid individuals with profound dependency conflicts. Furthermore, they were immature, narcissistic, egocentric and potentially explosive, while their attempts to obtain [professional assistance] were demanding, manipulative, controlling, coercive, and paranoid. (Lothstein, 1979, quoted in Stone, 1991)

A modern reading raises questions as to whether the behavior characterized by Lothstein above was actually an artifact of the treatment setting.

While it is not without disadvantages, the transgender model has allowed theoretical constructions which were not possible under the older model. The transsexual model held, for instance, that there is but one type of female gender variance (see Pauly, 1992, for a discussion). Devor's (1993) data challenged this orthodoxy, and in 1997 she presented a multifactorial model of female gender variance. Without the overarching framework of the transgender model, Devor's model might never have been developed.⁴

IMPLICATIONS FOR PSYCHIATRY

The transgender model, now ten years old, has had a significant effect on interactions between transgendered persons and mental health professionals. The expectations of both caregivers and clients, and the therapy hour itself, have been affected. There is a world of difference when both the therapist and the patient believe the patient to be mentally ill and in crisis, and when both the therapist and the client believe the client to be healthy and self-actualized and contemplating a life-altering decision. There is, moreover, considerable difference between the mutual belief that the purpose of therapy is to determine whether the patient is or is not a candidate for sex reassignment and the mutual belief that the purpose of therapy is to help the client make sense of and life plans about his or her feelings about gender. In other words, even if one is transsexual, one is not required or expected to alter one's body and change

gender roles—although that is certainly an option. Whether for religious reasons, out of consideration for family, or because of economic considerations, many of today's transsexuals remain in whole or in part in their original gender roles.

Today's client is likely to be educated about transgender issues, to know his or her options, and to have a broad-based support system. The therapist can and should provide factual information, help the client understand the available options, and make necessary referrals. This can prove difficult to a therapist unfamiliar with the transgender model. To the uninitiated, contemporary self-definitions may be bewildering, and the therapist may be unwilling to authorize medical procedures for a client who does not fit the "all-or-none" model of transsexualism. Similarly, a client who interprets his or her experience by way of the transsexual model may be unaware of or unwilling to acknowledge options other than sex reassignment culminating in genital surgery.

Psychiatrists and other caregivers should be careful not to confuse their personal beliefs about gender with the clinical needs of the patients they are treating. Therapists should know that despite nonsurgical lifestyle options now open to transgendered people, transsexuals tend to view SRS as the treatment of choice.⁵

Gender programs in the U.S. now offer support to all transgendered people and educate their clients about non-surgical alternatives; the Program in Human Sexuality took an early lead in this (Bockting and Coleman, 1992a; Bockting, 1997). New treatment models have been developed, in particular the transgender model used at the University of Minnesota, a well-patient model at the Comprehensive Gender Services Program of the University of Michigan Health System (Cole, 1997; Samons, 1998), and a community empowerment model used by the Gender Identity Project at the Gay and Lesbian Community Services Center of New York (Warren, Blumenstein and Walker, 1998).

The treatment literature has also come under the influence of the transgender model. Of note are works by Cole et al. (2000), Bockting and Coleman (1992b), Denny (1998), and Israel and Tarver (1998), all of whom use terminology quite different from the earlier literature. Texts by authors who have been influenced by the transgender model (Brown and Rounsley, 1996; Ettner, 1996, 1999) are easily contrasted to works by authors who have not (Ramsey, 1996; Lothstein, 1983).

A paradigm change is a scientific revolution of sorts (Kuhn, 1962), and those who are fortunate enough to be around when one occurs stand to learn a grand deal. Far from upsetting the apple cart, the rise of the transgender model has provided new opportunities for researchers and clinicians and transsexuals alike.

NOTES

1. Usually referred by the acronym, HBIGDA. Formed in the late 1960s and named after the physician who defined the syndrome of transsexualism, HBIGDA is a professional organization for those who are associated in a professional capacity with gender-variant people. HBIGDA's Standards of Care, first published in 1979, are revised periodically. For its first 20 years, HBIGDA was concerned exclusively with transsexualism, but by the late 1990s had broadened its focus to encompass nontranssexual transgendered people. The International Journal of Transgenderism is available online at www.symposion.com/ijt.

2. History and anthropological studies seem to support this; gender-variant roles are documented in many tribal societies, and Western culture has hundreds of examples of historical figures whose behavior and dress varied greatly from the norms of the place and time (see especially Bullough and Bullough, 1993; Herdt, 1994; Taylor, 1996).

3. Transgendered and transsexual sex workers are at high risk for HIV/AIDS. Studies in several cities have revealed high levels of HIV seropositivity among transgendered sex workers (see Xavier, 2001a, for a review and Xavier, 2001b, for a discussion of implications for health care policy).

4. Female-to-male transsexuals, once considered rare (Pauly, 1969), and rendered virtually invisible under the transsexual model (see Cromwell, 1999 for a discussion), have become more visible under the transgender model (Green and Wilchins, 1996) and have garnered much press (Bloom, 1994).

5. The transgender model has opened new possibilities for nontranssexual gender-variant people, but transsexuals aren't necessarily interested in new interpretations of manhood and womanhood or exploring a gender middle-ground. They don't wish for more freedom in their natal sex roles, but to be members of the other sex.

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