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Sex, Lies, and the NHS: Relocating Trans

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The UK position

In 2004, internal government papers made it clear that in the UK, transsexualism 'is *not* a mental illness. It is a condition considered *in itself* to be free of other pathology (though transsexual people can suffer depression or illness like anyone else)', [1] [2] reiterated by formal, public guidance to the NHS that 'It cannot be overemphasized that being trans is not a mental illness.'[3]

Eight years later, in 2012, government was asked, both in Commons and Lords, why the NHS continued to operate an automatic, mandatory, unconsented referral of trans people to two years of psychiatric assessment, given that it was not a mental health issue. [4] [5] Those questions were followed up in a House of Lords debate [6] in December 2014, and government continued to provide no real response to them. In the meantime, between 2012 and 2014, the European Commission, [7] Amnesty International, [8] and the European Union Agency for Fundamental Rights[9] each published major reports, calling for the depsychopathologisation of trans people, and highlighting the enormous social injustice consequent on this medical status, and encouraged by the European Parliament, the World Health Organisation announced that it was removing transsexualism from the mental illness section of the *International Classification of Diseases* [ICD].[10]

Remarkably, then, trans people face a number of obvious inequities, all of which breach the Equality Act (2010), the Human Rights Act and the European Convention on Human Rights. For example, every other woman in the UK has the right to receive HRT from her GP without question, whereas GPs may simply refuse HRT to trans women without any reason. This is direct discrimination. If a woman wants bilateral mastectomy as Risk Reducing Surgery, because she has a family history of breast cancer, she is required to have one interview with a clinical psychologist and then proceeds directly to surgery. If a man or non-binary person wants the same procedure because they are trans, they are required to spend years in psychiatric assessment, and in the end the surgeon may make a separate psychiatric diagnosis and decide not to proceed. This is direct discrimination. Finally, of course, no other UK citizen is compelled to attend psychiatric treatment unless they have a mental illness, whereas all trans people are not only conscripted into psychiatry without their consent, as a kind of unofficial sectioning, but suffer this outside the *Deprivation of Liberty Safeguards (2009)*. This is not only direct discrimination but also wholly unconstitutional.

How did this happen?

Manufacturing trans as a psychopathology

Let me begin by making a distinction between sex, gender, and sexuality. While sex is a matter of biology (female, male, intersex), and sexuality one of love (gay, straight, bisexual), gender is a matter of cultural norms that categorize activities and artefacts as masculine, feminine, or transgressive.[11] These are three historically separate ideas, rooted in three different disciplines: science, the arts, and cultural studies. Medicine muddles these three terms, with serious consequences for the public. For example, between 1885 and 1967, medicine confused male homosexuality — a matter of love — with mental illness, a matter of biology. A cultural antipathy was turned by law into a crime, and medicine adroitly manufactured ordinary human feeling into a psychopathology. A similar story is that of the single mothers detained in asylums up to 1967[12] as '"feebleminded" females' with 'irresponsible sexual proclivities and bad moral judgement'. [13] Psychiatric treatment regimes included chemical castration for men, and aversion therapy, electro-convulsive therapy, and forcible confinement for everyone, accompanied by a grooming process through which so-called 'patients' were persuaded that their psychiatrist-abuser was their saviour. These 'therapies' were medical fantasy, concealing legalized hate crime. Explicitly, they were eugenic in nature, since, like male homosexuality, '"feebleminded" females' provided a 'threat to a country's biological worth and integrity'.[14]

Second-wave feminism redressed this confusion of categories by exploring the way in which a deterministic, biological, sexed, male–female dyad was played out as a culturally essentialist, gendered, masculine–feminine binary. This stream of research, founded on de Beauvoir's critique of male-centred ideologies that located women as the 'second sex',[15] underlined the difference between biological sex and cultural constructions of gender.

Medicine's definition of gender, however, formulated in1955[16] by Dr John Money and his colleagues at the Johns Hopkins Hospital in Baltimore, ignored feminism's careful distinction between sex and gender, biology and culture: Money conflated them and then made them synonymous in his very influential works. This collapsing of male, female, and intersex with masculine, feminine, and transgressive, in medical discourse, had the effect of erasing gender performance,[17] so that the cultural values associated with masculinity — strength, drive, discipline — could be expressed only by men, while values associated with the cultural category 'feminine' — patience, caring, gentleness — could only be associated with women. So, UCLA's Gender Identity Research Clinic founded in 1962, Dr Robert Stoller and Dr Richard Green:

> won its professional reputation for its attempts to get "sissy" boys (and occasionally "tomboy" girls) to behave in masculine (or, in the case of girls, feminine) ways. Stoller and Green hoped to instill traditional gender roles in children with the explicit goal of preventing transsexuality (and also transvestism and homosexuality) in adults. [18]

In an implicitly eugenic discourse, intersexed people were made automatically transgressive, and thus became as problematic culturally as they were regarded medically, attracting both clinical and cultural terminology such as 'indeterminate' and 'ambiguous', which rendered them inauthentic, and promoted their eradication.[19] In clinical practice, children who were born symptomatically intersexed — that is, exhibiting immediate physical evidence of their intersex — were routinely allocated a

male or female sex and given sex reassignment surgery [SRS] accordingly, without the option of allowing them to grow, develop, and make their own decision. Surgeons' duty of care to the individual was elided by a collective social panic about 'ambiguous' genitalia. Further, those insistent reassertions of male/masculine, female/feminine binaries effectively defined the category of 'transsexualism' and so-called 'transsexuals'.

By 1968 'transsexualism' appeared as a separate heading in the American Medical Association's *Index Medicus* [20] and three broad etiological positions had emerged. Endocrinologists, such as Harry Benjamin, identified a somatic, neurophysiological, *in utero* etiology[21] while psychoanalysts such as Robert Stoller believed it stemmed from 'damaging psychodynamic processes in early childhood'[22], and at John Hopkins University John Money and his colleagues advocated 'a behaviourist model . . . similar to imprinting, in which young animals reacted to specific environmental stimuli that permanently structured their later social behaviour'.[23] Leaving his relationship with Stoller, Green joined Money to consolidate the behaviourist view by blaming the parents:

> Richard Green and John Money saw part of the "successful rearing of a child" as "orienting him, from birth, to his biologically and culturally acceptable gender role" and, to that end, advocated "a relationship between husband and wife exemplifying these respective roles."[24]

Patients became epistemological hostages to diagnosis as an independent entity. Their views were irrelevant – indeed, their whole beings were irrelevant except insofar as their bodies, degraded by objectification, might support one side of the argument or another.

This simplistic certainty found its most sinister expression in what has become known as the 'John/ Joan' case. In the same year as the UK decriminalized both male homosexuality and the elective termination of pregnancy, in 1967, a baby boy was accidentally penectomized during a minor surgical procedure.[25] His parents were advised by John Money, that their boy should be given sex reassignment surgery [SRS] and raised as a girl, and that his medical history should be kept a secret from him. Money carried out longitudinal monitoring of the boy's process of forcible acculturation, and in 1972 published findings showing that the procedure had been a success. He claimed to have 'proved' that gender was a matter of nurture, not of nature.[26] Because Money was a television personality and pop-psychology writer, his findings were widely distributed on both sides of the Atlantic by scientific and popular media.[27] Cultural studies was in its infancy as a discipline, and so no-one appeared to notice that Money was both right and wrong: right that gender is a matter of cultural norms, defined and expressed by nurture, and devastatingly wrong in that he was not dealing with a case of gender, but one of sex. Twenty-five years later, in 1997, Dr Milton Diamond, professor of anatomy and reproductive biology at the University of Hawaii, discovered that Money had falsified the results of his experiment. The boy, David Reimer, had been deeply distressed by his parents forcing him to feign 'female' behaviour when Money visited[28] and reassigned back to male when he finally learned his medical history.

Money, Green, and Stoller had proved that psychiatry could coerce children and adults into simulating specific behaviour by applying enough pressure, while

elsewhere, people who evaded that punitive treatment had a remarkably high level of satisfaction with the outcomes of medical and surgical intervention The psychiatric camp, therefore, needed to discredit surgical intervention, a task carried out in 1979 by Meyer and Reter[29], two psychiatrists who published a follow-up study on patients who had had surgical reconstruction at Johns Hopkins Gender Identity Clinic. Their study supported the efficacy of surgical intervention and the lack of regret afterwards,[30] but it added a heteronormative scoring system, in which people who got entered "gender-appropriate" marriage or cohabitation after SRS, or got better jobs, were scored up, while those who didn't, were scored down. On this basis, having roled sex, sexuality, and gender into one, they concluded that sex reassignment surgery, "confers no objective advantage in terms of social rehabilitation."[31] Critics of Meyer and Reter's methodology[32] were disregarded in a blatant turf-war between psychiatry and endocrinology, which psychiatry had now won, simply by falsifying the evidence.

Consequently, in 1979, Johns Hopkins ended its surgical programme – a move followed by other centres in the USA – and in1980, 'transsexualism' appeared as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [DSM].[33] It was a logical step from a flawed premise. If sex/gender/ sexuality was a matter of nurture, as psychiatry had 'proved', then behaviour outside the male-female binary was curable through psychiatric intervention. In a remarkable display of social anxiety and Freudian heteronormativity, in both the USA and the UK, people newly defined as 'transsexuals', inherited the violent and useless 'therapies' that had been used formerly on single mothers and gay men. People were, and are, obliged to survive a brutal and ineffective psychiatric regime, that could and does last for years, to gain the medicines, therapies, and surgeries, which continues to provides the only effective treatment for this somatic condition.

Regulatory responses

In the UK, in 1970, a landmark legal case concerning aristocratic inheritance by a trans woman, April Ashley, provided evidence from five medical authorities, three of which said that trans people were intersexed, and two of which said that they were psychiatrically disturbed.[34] The judgment preferred the minority medical view, determining that trans people were 'individuals with abnormal psychological attitudes in sexual matters',[35] so that a trans woman 'is properly classified as a male homosexual', and defining in detail the typical patient narrative associated with that psychiatric illness.[36] This medical definition had immediate legal consequences, stripping trans people of their civil identities, human rights, and employment rights, and initiating the eugenic project that is still in process today.[37] The Registrar General closed the facility for correcting birth certificates consequent on sex reassignment,[38] so that trans people could no longer have their Birth Certificates corrected, or marry, or adopt. Irrespective of how long they had been employed or how good a job they did, they could be and usually were dismissed instantly their status was known, and if they were then unable to pay their parking fines, their custodial sentence would be served in the wrong sex prison, where they would have their medical treatment cut off and where they were routinely raped by other inmates and prison officers alike. Additionally, psychiatrists required married people to divorce before they would approve surgery, while at the same time requiring evidence that patients were emotionally stable and gainfully employed, as a precondition of treatment. The only

option for UK medical treatment became brutal psychiatric intervention as a precursor to compulsory sterilisation. Legal exclusion accompanied social abjection and medical neglect. No support was forthcoming from other minority groups. These three enduring conditions – compulsory sterilisation, legal exclusion, and social abjection –delineate the UK's treatment of 'transsexuals' since 1970, as a eugenic project.

In 1996, UK trans activism produced the first legal decision in the world in favour of a trans person[39] and during the following decades redressed some of the legal inequities consequent on psychopathologisation. Meanwhile, the evidence for a neuroendocrinological etiology accumulated, [40] producing the shift in thinking reflected by government's policy change in 2004, while the legal bone of contention – *primo geniture* and aristocratic inheritance – ended in 2013.[41]

However, the 'typical patient narrative' fabricated by psychiatry for a courtroom in 1970, is still used as the basis for NHS Standards of Care, supported by a 'revolving door' system of self-interested psychiatrists, who manufacture additional evidence, based on that invalid narrative – just as 'scientific evidence' was manufactured by medicine to abject gay men and single mothers. Effectively, patients are still coerced by psychiatry into providing a pre-set narrative in order to get access to vital medicines and surgeries, in a system of 'forced confession', redolent of conversion therapy, that is as artificial as it is unethical. Further, psychiatry's enforced male-female binary, elides non-binary people. Finally, unequal civil identity – a Gender Identity Certificate instead of a Birth Certificate, echoing Partnership Ceremonies in the days before equal marriage – and directly discriminatory medical treatment underline the ongoing consequences of medicine's confusion of sex, sexuality, and gender. The eugenic project continues. Meanwhile, what etiological evidence there is indicates that Harry Benjamin's hypothesis was right, and that patients experience a congenital neuroendocrinological condition – essentially an intersex condition. What is absolutely clear is that psychiatry has no material part to play in this somatic condition: it cannot prescribe chemicals to redress an imbalance in brain chemistry, and psychotherapy is no more effective in treatment than it ever has been in 'curing' lesbians and gay men.

There seems to be a 'cultural complex' at play, a set of attitudes that 'tend to be repetitive, autonomous, resist consciousness and collect experience that confirms their historical point of view',[42] that means psychiatry expects trans people to accept bizarre and unequal treatment without question. This is astonishing, given the ethnographic turn in medicine in the last two decades,[43] and given the massive, vociferous evidence and representations from trans people, trans organisations, and national and international agencies, all calling for psychiatry to withdraw from treating trans people, not least so that money is spent on people with real needs for psychiatric care rather than on a psychiatric fantasy. Clearly, NHS treatment has not been able to keep pace with changes in government policy, scientific knowledge, social attitudes, academic research, or UK legislation, and it is thus unsurprising that a major legal case is in preparation, to end enforced psychiatric intervention. What is sought is the same system of consent and choice that operates for all other UK citizens, to provide for trans people that inviolable right to human dignity that is a fundamental principle of equality.

[1] Government Policy concerning Transsexual People, http://www.dca.gov.uk/constitution/transsex/policy.htm [accessed 16 February 2014].
[2] Research Paper 04/15, *The Gender Recognition Bill* [HL]: Bill 56 of 2003-04, House of Commons Library, 17 February 2004, p. 8.
[3] Department of Health, *Trans: A Practical Guide for the NHS* (London: DH, 2008), p. 11.
[4] House of Lords Hansard Written Answers for 19 January 2012, Column WA150.
[5] House of Commons Hansard Written Answers for 12 Nov 2012, Column 66W.
[6] House of Lords Hansard, Health: Lesbian, Bisexual and Trans Women Question for Short Debate, 3 December 2014, Column 1384-1396.
[7] Silvan Agius and Christa Tobler, *Trans and intersex people: Discrimination on the grounds of sex, gender identity and gender expression* (Luxembourg: European Union, 2012).
[8] Amnesty International, *The State Decides Who I am: Lack of Legal Gender Recognition for Transgender People in Europe* (London: Amnesty International, 2014).
[9] FRA: European Union Agency for Fundamental Rights, *Being Trans in the European Union: Comparative analysis of EU LGBT survey data* (Luxembourg: Publications Office of the European Union, 2014).
[10] FRA, p. 81.
[11] I am presenting a deliberately essentialized viewpoint, both because medicine, the law, and the media operate through essentialist discourses, and to make quite clear the abjection these meta-narratives produce in UK society. Acknowledging the power and incisiveness of contemporary discourse on gender, especially the work of Judith Butler, my position here is closer to Irigaray's assertion that 'citizenship is thus no longer characterized by the accumulation of possessions protected by a civil law. It is a function of being born, actually and not abstractly'. Luce Irigaray, *I love to you,* trans. by Alison Martin (London: Routledge, 1996) p. 53.
[12] An account of how 'degenerate' women were put into or kept in asylums in the early twentieth century is provided by Mark Jackson, '"A menace to the good of Society": Class, Fertility, and the Feeble-Minded in Edwardian Society', in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. by Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004). See also Louise Hide, *Gender and Class in English Asylums, 1890-1914* (London: Palgrave Macmillan, 2014).
[13] Alexander Mina Stern, 'Gender and Sexuality: A Global Tour and Compass', *The Oxford Handbook of the History of Eugenics*, edited by Alison Bashford and Philippa Levine (Oxford: OUP, 2010), pp. 173-191, p. 177.
[14] Ibid., p. 177.
[15] Simone de Beauvoir, *Le Deuxième Sexe* (Paris: Gallimard, 1949).
[16] John Money, Joan G. Hampson, and John L. Hampson, 'Hermaphroditism: Recommendations Concerning Assignment of Sex, Change of Sex, and Psychologic Management', *Bulletins of the Johns Hopkins Hospital* 97 (1955), 284–300.
[17] For example, Judith Butler, *Gender Trouble* (London: Routledge, 1990); Judith Butler, *Undoing Gender* (London: Routledge, 2004); Judith Butler, *Gender Performance,* YouTube http://www.youtube.com/watch?v=fndkPPJBi1U [accessed 25 February 2014].
[18] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (London: Harvard University Press, 2002), pp. 126.
[19] Elizabeth Reis, *Bodies in Doubt: An American History of Intersex* (Baltimore: Johns Hopkins University Press, 2009).
[20] American Medical Association, *Index Medicus* (Chicago: AMA, 1968).
[21] Ibid., p. 106.
[22] Ibid., p. 116.
[23] Ibid., pp. 114-115.
[24] Ibid., p. 125.
[25] A detailed account is provided by John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a* Girl (London: Quartet, 2000).

[26] John Money and Anke A. Ehrhardt, *Man and Woman, Boy and Girl: The Differentiation and Dimorphism of Gender Identity from Conception to Maturity* (Baltimore: Johns Hopkins Press, 1972).
[27] For example, John Money and Patricia Tucker, *Sexual Signatures: On Being a Man or a Woman* (Boston: Little, Brown, 1975) was issued by Abacus as a paperback in the UK in 1977, in Barcelona in 1978, and in Tokyo in 1979.
[28] M Diamond and H K Sigmundson, 'Sex reassignment at birth. Long term review and clinical implications', *Archives of Pediatrics and Adolescent Medicine*, 1997 151: 298-304.
[29] Jon K. Meyer and Donna J. Reter, 'Sex Reassignment: Follow-up', *Archives of General Psychiatry* 36 (August 1979), 1013-1015.
[30] Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (London: Harvard University Press, 2002), p. 267.
[31] Ibid., p. 267-8.
[32] For example, Michael Fleming, Carol Steinman, and Gene Bocknek, 'Methodological Problems in Assessing Sex-Reassignment Surgery: A Reply to Meyer and Reter', *Archives of Sexual Behavior*, 9:5 (1980), 451-6.
[33] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington: APA, 1980).
[34] Ormrod, J. *Corbett* v *Corbett*, *All England Law Reports*, vol 2 (London: HMSO, 1970). 'But there is a difference of opinion whether cases in which the chromosomal, the gonadal and the genital sex are congruent, but psychological or hormonal factors are abnormal, should be classified as cases of inter-sex. Dr Randell said that, in terms of sex determination, he would not give much weight to such psychological factors as transsexualism if the chromosomes, the gonads and the genitalia were all of one sex. Professor Dewhurst's views are similar. Dr Armstrong and Professor Roth, on the other hand, would classify transsexuals as cases of inter-sex. Professor Mills, as an endocrinologist, takes a rather different view. In his opinion, patients in whom the balance between male and female hormones is abnormal should be regarded as cases of inter-sex, and he considers that there is sufficient evidence to justify the view that the respondent is an example of this condition.'
[35] *Corbett* v *Corbett*.
[36] *Corbett* v *Corbett*. 'They give a history, dating back to early childhood, of seeing themselves as members of the opposite sex which persists in spite of their being brought up normally in their own sex. This goes on until they come to think of themselves as females imprisoned in male bodies, or vice versa, and leads to intense resentment of, and dislike for, their own sexual organs which constantly remind them of their biological sex. They are said to be 'selective historians', tending to stress events which fit in with their ideas and to suppress those which do not. Some transsexual men live, dress and work regularly as females and pass more or less unnoticed. They become adept at make-up and knowledgeable about using oestrogen, the female sex hormone, to promote the development of female-like breasts, and at dealing with such masculine attributes as facial and pubic hair. As a result of the publicity which has been given from time to time to so-called 'sex-change operations', many of them go to extreme lengths to importune doctors to perform such operations on them. The difficulties under which these people inevitably live result in various psychological conditions such as extreme anxiety and obsessional states. They do not appear to respond favourably to any known form of psychological treatment and, consequently, some serious-minded and responsible doctors are inclining to the view that such operations may provide the only way of relieving the psychological distress. Dr Randell has recommended surgical treatment in about 35 cases, mostly restricted to castration and amputation of the penis, but in a few carefully selected cases he and Professor Dewhurst and the plastic surgeon who is working with them have undertaken vagino-plasty as well, that is the construction of a so-called artificial vagina. The purpose of these operations is, of course, to help to relieve the patient's symptoms and to assist in the management of their disorder; it is not to change their patient's sex, and, in fact, they require their patients before operation to sign a form of consent which is in these terms: 'I ... of ... do consent to undergo the removal of the male genital organs and fashioning of an artificial vagina as explained to me by ... (surgeon). I understand it will not

alter my male sex and that it is being done to prevent deterioration in my mental health. ... (Signature of Patient)'

[37] Three enduring conditions – compulsory sterilisation, legal exclusion, and social abjection – delineate eugenic projects, emphasised in this case by an absence of epidemiological records.

[38] Well-recorded examples of birth certificate corrections after SRS are Roberta Cowell and Michael Dillon: see Richard Ekins and Dave King, *Blending Genders* (London: Routledge, 1996), p. 81.

[39] *P v S and Cornwall County Council*, Case C-13/94 [1996] IRLR 347, ECJ.

[40] For example, Gender Identity Research and Education Society (GIRES), 'Atypical Gender Development – A Review', *International Journal of Transgender Studies*, vol 9, no. 1, 2006, pp. 29-44, p. 35.

[41] The *Succession to the Crown Act* (2013) allowed equal male and female succession to the British throne, from 22 April 2013 onwards, and on 13 May 2013 the *Daily Telegraph* printed a letter signed by 200 British aristocrats whose titles can still only be passed to a male heir. They said 'we believe if gender equality can be granted to the Royal Family, it is only logical and just that it be granted to all families [...] As the Labour peer Lord Dubs has said: "There should not be gender discrimination in Britain, full stop."' *Daily Telegraph*, 'Gender Equality for Peeresses', 13 May 2013, http://www.telegraph.co.uk/comment/letters/10052344/Gender-equality-for-peeresses.html [accessed 21 February 2014].

[42] Thomas Singer, 'The Cultural Complex and Archetypal Defenses of the Group Spirit', *The Cultural Complex: Contemporary Jungian Perspectives on Psyche and Society* (London: Routledge, 2004), p. 21.

[43] For example, Deborah Lupton, *Medicine as Culture* (London: Sage, 1993); Trisha Greenhalgh and Brian Hurwitz, eds. *Narrative Based Medicine* (London: BMJ, 1998); Martin Evans and Ilora G Finlay, eds. *Medical Humanities* (London: BMJ, 2001); David Greaves, *The Healing Tradition* (Abingdon: Radcliffe, 2004); Robert Pool and Wenzel Geissler, *Medical Anthropology* (Maidenhead: OUP, 2005); Roland Littlewood, ed. *On Knowing and Not Knowing in the Anthropology of Medicine* (Walnut Creek: Left Coast Press, 2007); Peter L. Rudnytsky and Rita Charon, eds. *Psychoanalysis and Narrative Medicine* (Albany: SUNY Press, 2008); John Gabbay and Andrée Le May, *Practice-Based Evidence for Healthcare* (Abingdon: Routledge, 2011).