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ABSTRACT
This essay investigates a divergence between medical and autobiographical accounts of transexuality. By analyzing a letter to the editor in the journal Aesthetic Plastic Surgery that defends trans patients as a “special case” (Selvaggi and Giordano, 2014), I examine how medicine produces trans patients as a separate category of patients. The differential treatment paths of trans and nontrans people who pursue “gender-enhancing” medical interventions demonstrate a double standard that undermines claims to act in the best interest of the patient. Using the evidence of trans men’s accounts of themselves as well as research into the experiences of trans people from across the United Kingdom, Australia, and North America, I critique the medical management of transexuality and call on clinicians to rethink the treatment practices of trans medicine.

Introduction
This essay explores how transexuality¹ and trans patients are constituted as problems within clinical practices. Drawing on the recent theorizations of reality, patients, diseases, and problems from Science and Technology Studies (STS), I examine how clinical practices act in the making of trans realities, foreclosing particular iterations of what transexuality could be (Mol, 1999, 2002, 2008; Mol and Law, 2002; Law, 2004; Barad, 2007). By analyzing a letter to the editor in the journal Aesthetic Plastic Surgery that defends trans patients as a “special case” (Selvaggi and Giordano, 2014), I examine how medical logic produces trans patients as a category distinct from nontrans people who access the same procedures. I argue that how clinicians constitute transexuality and trans patients in specific ways disallows a range of other trans onto-epistemo-logies.² Selvaggi and Giordano (2014) argue that trans people are necessarily an “inherently complex,” separate category of patients because their motivations are different and the purposes of surgery are different. I use this example as a way to show how clinical practices propel a circular logic that occludes certain trans realities and forecloses particular trans possibilities. How are problems (and patients) being produced through the very systems designed to treat them?

Although there has been a recent flurry of psychoanalytic writing about work with trans patients (Hansbury, 2011; Saketopoulou, 2011; Suchet, 2011), surprisingly little has been written in these accounts about the role of “psychiatric approval” that trans people must acquire if they wish to pursue medically supervised interventions (hormones and/or surgeries). This essay focuses on the role of psychiatric assessment and the involvement of “mental health professionals” in the treatment practices of trans medicine. I argue that the systems designed to treat trans patients reiterate a specific trans ontology and trajectory of treatment that may not be suitable or appropriate for some people. This occurs via a number of

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¹I use trans (adjective, adverb) in the broadest sense and transexuality as its noun form, recognizing its limitations. It is important to note that not all trans people desire or seek medical services for a variety of reasons, and some people who seek these services self-describe in other ways.

²”Onto-epistem-ology” is a Baradian compound noun that describes how ways of being are entangled with and inseparable from theories of knowledge (Barad, 2007, p. 89).
assumptions, or axioms, including that trans people always desire “to pass” as nontrans and that this will be possible (Latham, in press-a). Assumptions like this are based on a (nontrans) paradigm of binary sex-gender normativity that does not reflect how many trans people experience their bodies and lives. As Goldner (2011) points out, “The psychoanalysis of gender … has become suspect when it comes to trans. Analytic deconstruction too easily drifts into a search for psychopathology, which makes the search for meaning unsafe” (p. 167). By drawing on a number of published studies on trans people’s experiences of clinical treatment across the United Kingdom, North America, and Australia as well as the way trans men recount these events in their autobiographies, it becomes clear that many people experience clinical treatment practices as unhelpful, indeed painful, damaging, or traumatic.3

By challenging the treatment path available to trans people, I emphasize the need to take account of the specificity of trans people as individuals in clinical encounters (and access to medical interventions), arguing that current clinical practices not only limit and foreclose many trans possibilities but are often experienced as detrimental to that very category of patients their purpose it is to help. What makes this pressing is that these practices limit the very possibility of a supportive and encouraging clinical environment.

**Ontological politics**

Following Latour and Woolgar (1979), Law (2004) emphasizes that it is not possible to separate out the making of realities from the making of statements about those realities (discourses, research) and the doing of practices. This way of thinking mirrors that of Barad (2007), who argues that phenomena materialize through the apparatus with which we see, measure, and understand them. Law suggests reality is “not independent of the apparatuses that produce reports of reality” (2004, p. 31) and argues that commonsense realism is based on the following assumptions: (a) reality is “out there” (beyond ourselves), (b) reality is independent (of our actions and perceptions, for the most part), (c) reality is anterior (precedes us), (d) reality is definite (the world is specific, certain, and definable), (e) reality is singular (the same everywhere), and (f) reality is coherent (pp. 18–42). Against this view, Law argues that *methods make realities*.

This way of thinking about reality is important in this context because medical writing about transexuality and trans patients, like Selvaggi and Giordano’s (2014) letter, demonstrates that medical epistemology and processes of treatment take the notion of transexuality (or “gender dysphoria”) as anterior to, and independent of, clinical encounters. That is, transexuality is understood (and produced) to be an independent, stable, and definite “disorder” that *precedes* clinical encounters. This way of thinking obscures how transexuality emerges within those very practices of treatment. It also works to make transexuality (and trans people’s experiences of gender) *singular* (the same everywhere). This occludes the different, complex, and individual realities of trans people’s lives. We can position ourselves to better understand the realities of trans medical encounters, interventions, and lives, and therefore practice more appropriate care, if we account for transexuality as emergent. What is especially important about examining medical texts and practices in this way is, as Stryker (2008) explains, that

medical practitioners and institutions have the social power to determine what is considered sick or healthy, normal or pathological, sane or insane—and thus, often, to transform potentially neutral forms of human difference into unjust and oppressive social hierarchies [p. 36].

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3This essay forms part of a larger project investigating trans men’s sexual, clinical, and bodily realities. As such I draw on the accounts of trans men. Although trans women’s experiences will differ and deserve to be examined in their own terms, undoubtedly there are similarities in their experiences of treatment (see, e.g., Stone, 1991; Cummings, 1993; Bornstein, 1994; Stryker, 1994, 2006; Wilchins, 1997; Prosser, 1998; McKinnon, 2013). The evidence presented in this essay is not intended to be exhaustive or emblematic. Its aim is to point out that even if only *some* people have described their experiences in these ways, they deserve to be taken seriously.
Following Law (and Barad), if we take practices, statements and realities as entangled and co-constituting, then we need to ask some more questions.

If practices make realities, then *practices are political* because they make some potentialities possible and others impossible, even unimaginable. Mol (1999) calls this “ontological politics.” Mol suggests the following questions be used to analyze how phenomena materialize in particular ways in certain situations:

- *Where* are the options?
- *What* is at stake?
- *Are* there really options?
- *How* should we choose? [Mol, 1999, p. 79].

Implicit in Mol’s theory of ontological politics is, as Fraser (2010) notes, “the assumption that realities are always open to making and remaking” (p. 233). How might we open up medical practices and make more trans realities possible?

**Practicing trans politics**

Researchers are makers of realities. We are not passive observers of facts “out there”; we forge facts into shapes that suit our purposes. Accordingly, I remain skeptical of “facts” about transexuality and trans people, as most of what we “know” is produced by nontrans people, especially doctors (see Cromwell, 1999, pp. 19–30; Stryker, 2006). The work of this essay is part of a larger authoethnographic project that examines how transexuality is produced in medical literature (Latham, *in press-a*), clinical treatment practices (Latham, *in press-b*), and trans men’s autobiographies and other narratives about themselves (Latham, 2016). This essay attempts to intervene in order to reshape practices of trans medicine and broaden the field of trans possibilities. One of the principal concerns of this project is: *How* can trans people, like me, be taken seriously as “self-critical, feminist, intellectual subjects of knowledge rather than simply case studies” (Spade, 2006, p. 317)? This question is one of the founding enterprises of trans-gender studies (see especially Riddell, 1980; Stone 1991; Bornstein, 1994; Stryker, 1994; Halberstam, 1998a). Yet some 25 years of scholarship (and other activism) later, we find ourselves grappling still with how this can be accomplished. Asserting our life stories in our own terms via publishing autobiographies and what I term “auto-trans studies” (Latham, *in press-b*) are two of the prominent ways to do this. I wanted to try something else—something “trans” in a quite different way—“transdisciplinarity.”

During research into medical representations and treatment guidelines of trans medicine, I came across an article in the journal *Aesthetic Plastic Surgery*, which describes four principles of medicine (patient autonomy and informed consent, beneficence, nonmalfeasance, and justice) and discusses how each relates to ethical issues in cosmetic surgery (Sterodimas, Radwinski, and Pitanguy, 2011). The abstract outlines the following:

> Plastic surgeons should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. ... Plastic surgeons need to carefully evaluate the degree of deformity, physical and emotional maturity, and desired outcome of patients who request plastic surgery procedures. Science is a powerful force for change in modern society and plastic surgeons have a responsibility to shepherd that change with thoughtful advocacy and careful ethical scrutiny of their own behavior [p. 262].

Sterodimas and colleagues (2011) suggest a number of questions that can be used to assess these ethical issues that they divide into “purpose of surgery” and “degree of deformity,” such as “Is the proposed surgery realistic?” and “Is the deformity noticeable?” They end by calling for “a balanced relationship” between surgeon and patient, emphasizing that “shared decision-making requires participation of the patient in seeing the goals and methods of care, and therefore in formulating
the alternatives to be considered” (p. 266). Two of their assertions in particular piqued my interest in their relation to trans medical practices:

(1) “Ultimately, it is up to each plastic surgeon to call upon his or her experience, training, and judgment to make the decision of when to operate, when not to operate, and when to refer the patient to another medical professional such as a qualified psychiatrist” (p. 265); and

(2) “Surgeons must be cognizant of their actions when conducting a cosmetic surgery procedure that may enforce a cultural norm” (p. 266).

I wrote a letter to Aesthetic Plastic Surgery in response, which extended Sterodimas and colleagues’ analysis into the realm of trans procedures via the claim that “transsexual surgeries are almost always aesthetic surgeries, although they are rarely if ever interpreted this way” (Latham, 2013, p. 648). Although trans realities are discussed and analyzed in fields like feminist and gender studies, queer theory, sociology, anthropology, literary studies, and history, I could find little scholarly work on “trans criticism” in medicine. Could I do this work? Would I be published? What could I get across and to what effects? Seeking to draw attention to how Sterodimas and colleagues’ (2011) observations related to trans medicine, I suggested the following:

Many transsexual surgeries may be analogous to nontranssexual cosmetic surgeries. For example, breast reduction in the female patient is considered cosmetic unless the entire breast is removed. Requests for complete breast removal are pathologized as “radical,” and patients are routinely referred for psychiatric assessment solely on the basis that their aesthetic desires do not enforce a cultural norm (e.g., that females have breasts) [Latham, 2013, p. 648].

Following this analogy, I argued that “compulsory referral of all patients seeking transsexual surgeries may violate the patient’s ethical right to self-determination, to direct what happens to his or her body, and may therefore constitute a form of discrimination” (p. 648). Using the short sentences and simple language that form the journal’s general style, I kept my observations brief (the letter, including references, is two pages in length). I did not reference the work in feminist studies of these practices that highlights how reiterating cultural norms is the precise purpose of cosmetic surgeries (see Haiken, 2000; Blum, 2003; Heyes, 2007a; Jones, 2008). Instead I proposed, “Desiring a surgery considered to be gender inappropriate (e.g., breast removal in the female) is not sufficient grounds for requiring psychological evaluation” (p. 649). Yet it is precisely this combination—that cosmetic surgery (re)produces cultural norms (of gender) and that trans people require a diagnosis that we “really are” of “the wrong sex” to gain access to these interventions—that makes trans medicine what it is (practiced only subsequent to the psychiatric diagnosis). In the letter, I went on to reference research into the psychological problems of some (nontrans) cosmetic surgery patients, concluding the following:

Requiring the diagnosis of “gender identity disorder” [now “gender dysphoria”] for any and all transsexual aesthetic surgeries puts undo strain on the patient. Many transsexual surgeries differ from cosmetic surgeries only due to the sex [assigned at birth] of the patient making the request, such as breast removal. Psychiatric assessment can be intrusive and costly and should not be obligatory for transsexual patients merely because their surgical requests do not enforce a cultural norm. Aesthetic surgery clinics need to rethink their ethical treatment of transsexual patients. The ability for the transsexual patient to be deemed competent and to give informed consent without psychiatric assessment warrants consideration [Latham, 2013, p. 649].

The purpose of publishing the letter, specifically in a plastic surgery journal that in part is concerned with “discussions of ancillary problems in aesthetic plastic surgery, such as the role of psychosocial factors in the doctor-patient and the patient-public interrelationships” (Springer, 2014), was to prompt medical practitioners to discuss the possibility that it might be more appropriate to treat trans patients in the same ways as other (nontrans) patients. I was engaging in a form of ontological politics, trying to bridge the grand canyon of rifts that divides medical literature and transgender
studies; using a medical style and platform, I attempted to describe a way that trans people could be seen by (surgical) medicine as credible. To return to my letter, I argued,

Transsexual patients desire aesthetic surgeries to “look normal” and “enhance beauty” (Sterodimas, Radwinski & Pitanguy, 2011) just as other patients do, only their requests are “cross-gendered.” When considered in terms of “degree of deformity,” gynecomastia [breast development] for the male patient is treated routinely with breast removal (de Barros & Sampaio, 2012). This is analogous to the transsexual female-to-male patient’s request for breast removal (Colić & Colić, 2000) [Latham, 2013, p. 649; references in original].

A year later, Aesthetic Plastic Surgery published a response to my letter by plastic surgeon Gennaro Selvaggi and bioethicist Simona Giordano titled “The Role of Mental Health Professionals in Gender Reassignment Surgeries: Unjust Discrimination or Responsible Care?” (Selvaggi and Giordano, 2014). Their abstract describes the objective and results of their letter as follows:

Recent literature has raised an important ethical concern relating to the way in which surgeons approach people with gender dysphoria (GD): it has been suggested that referring transsexual patients to mental assessment can constitute a form of unjust discrimination. … Offering or requesting psychological assistance is in no way a form of negative discrimination or an attack to the patient’s autonomy. Contrarily, it might improve transsexual patients’ care, and thus at the most may represent a form of positive discrimination [Selvaggi and Giordano, 2014, p. 1177].

It is important to note that Selvaggi and Giordano (2014) frame their text as relating to the care of “people with GD,” a way of classifying patients I challenged in the letter. This slippage from people who make requests for transgender medical interventions (mine) to people with GD (theirs) demonstrates how “people with GD” and “requests for trans procedures” are made synonymous in medical literature. It also sidesteps the problem I was trying to draw out: that needing to acquire the psychiatric diagnosis differentiates trans from nontrans patients who request the same procedures. If trans men are men, and they are men who have breasts—how is it that we are (ethically) treated differently from other men who have breasts?

Selvaggi and Giordano (2014) dispute the validity of this analogy, citing “the complexities inherent to gender treatment” (p. 1178). They also contest my claim that psychiatric assessment is compulsory and argue that psychiatric referrals are instead “responsible care.” They conclude the following:

Whereas Latham’s aims are noble, it is the opinion of the authors that his arguments (i.e., leaving the choice for referral to psychiatric assessment completely to the patient) are potentially harmful toward that same category of people whose rights he proposes to defend. Referring transsexual patients for mental health counseling before surgery is not an absolute requirement, as Latham suggests. Even when the surgeon or other healthcare professional make it a requirement, this is not necessarily violating the person’s right to autonomy: on the contrary, it is improving the patient’s care [p. 1182].

I offer the history of these published articles in order to contextualize the analysis that follows. I did not reply via a rebuttal in Aesthetic Plastic Surgery because I did not think clarifying my original position—treating trans patients like all other patients is worth considering—would be of much value there. The fact that suggesting surgeons “reconsider referring transsexual patients for psychological evaluation as a matter of course” (Latham, 2013, p. 648) was met with such opposition had me asking some more questions. How is it that what I had said was interpreted as “leaving the choice for referral to psychiatric assessment completely to the patient”? At the outset of the letter I made clear this was not my intention: “Expert psychological assessment may be necessary, as with all patients requesting cosmetic surgeries. However, to respect patient autonomy, perhaps psychiatric referral should be made on an individual case-by-case basis, as it is with other aesthetic surgeries” (p. 648). This dichotomy of “chosen” or “compelled” psychiatric referral forecloses the very kind of engagement with the specificity of trans patients as individual cases I was attempting to encourage. What I was trying to ask (and, as I’ll argue, was impossible to get across) was this: What would treatment practices look like if we treated trans adults (and trans requests) on an individual basis via presuming them to be competent, like (nontrans) cosmetic surgery patients, instead of as a category of patients who have in common a psychiatric disorder? (A disorder whose validity is challenged with each revision to the Diagnostic and Statistical Manual of Mental Disorders [DSM]; see Winters, 2016; see also Heyes, 2009; Angelides, 2012).
My purpose in publishing this essay, here in *Studies in Gender and Sexuality*, is to explore how trans medicine and medical discourse is *practiced* in a way that *produced this interpretation* (a misreading that remained intact through the peer-review process in *Aesthetic Plastic Surgery*). Using Selvaggi and Giordano’s (2014) letter as a case study provides a means to interrogate a broader problem in medicine: commonsense realist understandings of what transexuality is, and what trans people want, prevail over the evidence that, as Sedgwick (1990) gently reminds us, “People are different from each other” (p. 22). Selvaggi and Giordano present an argument about how trans patients are and should be treated *without attention to how trans people experience these processes*. This way of doing trans medicine self-referentially excludes (and erases) trans knowledges and ontologies. In response, I present the testimonies of some trans people and trans research that describes trans people’s experiences of medical encounters—work publically available and yet persistently ignored by medical practitioners. I use this evidence to mount the argument that trans medicine is set up in ways that disallow the complexities of trans people’s individual experiences of gender. I do this via pursuing some bigger questions: How are trans patients treated different from other patients? How are these differential practices justified? Do these rationalizations do justice to trans patients (according to trans people)? If they do not, how is it that these unjust practices continue to dominate trans medicine?

**Doing trans medicine**

The protocol to psychologically evaluate trans patients dates back to the first medical guidebook, Benjamin’s *The Transsexual Phenomenon* (1966, p. 60; see also Latham, *in press-a*). Contemporary treatment guides and other texts continue to reinforce the need for psychiatric assessment without evidence that this protocol results in better outcomes and without consideration of the costs to trans people (see, e.g., Leli and Drescher, 2004; Lev, 2004; Bockting and Goldberg, 2006; Heath, 2006; Barrett, 2007; Coleman et al., 2012). On the contrary, trans medicine continues to be predicated on what Roth (2005) succinctly calls the “unreflexive pathologizing” of trans people (p. 282). What is useful about Selvaggi and Giordano’s (2014) argument is that their purpose is precisely to defend this axiomatic course of action. It is also *indicative* of clinical understandings and treatment practices in trans medicine more broadly. Analyzing Selvaggi and Giordano’s letter alongside work in the field of trans medicine and the related field of feminist cosmetic surgery studies provides a means to both examine and rethink clinical treatment practices for trans people.

In writing about his experience as a trans analyst with trans patients, Hansbury (2011) writes,

> As trans identifications continue to be pathologized by the mental health establishment, I prefer to float in negative capability and remain more curious about the “How.” How do trans children and adults navigate a world full of objects that are not just “not just right” but frequently hostile, indifferent, and exploitative toward the expression of trans subjectivity? [p. 213].

This essay explores how the very practices of clinical treatment form part of this hostility, indifference, and exploitation.

**Different motivations?**

One way trans patients are constructed as different from other (nontrans) patients is via their motivations. As Selvaggi and Giordano (2014) argue, “Not all the same surgery is the same” (p. 1178). They go on,

> It does not follow from the fact that technically the procedure is analogous, that also their purposes are the same, and that *the hopes and expectations of the patients are the same* [p. 1178; italics added].

Yet they do not offer any examples or evidence of any kind to back up this claim; rather, they *assume* the difference is *self-evident*. This demonstrates how commonsense realism acts in trans medicine.
As another example, in elaborating on what differentiates gender reassignment procedures, Castle argues, “What tends to drive people in terms of gender reassignment is very different from the purely aesthetic outcome. It’s more about a functional outcome in terms of their lifestyle in general and also potentially sexuality” (as cited in Salleh, 2013). Castle is also suggesting that it is the motivations for body modifications that differentiate trans people from nontrans people in their requests for aesthetic surgeries. Feminist scholars of cosmetic surgery argue that people who pursue, for example, breast surgeries tend to have psychological reasons for doing so as well as report psychological improvements post-surgery (see Haiken, 1997; Blum, 2003, especially, pp. 126–136; Jones, 2008, pp. 22–26; Davis, 2009; Heyes and Jones, 2009, pp. 5–6; Naugler, 2009; see also Gilman, 1999, pp. 258–268). 4 Castle, Selvaggi, and Giordano produce “patients with different motivations” without robustly investigating (or recognizing) the motivations of patients. This characterization simplifies and singularizes both trans and nontrans aesthetic surgeries (and ontologies) and produces them as different.

In his extensive research into female-to-male genital reconstructive surgeries, Cotten (2012) outlines some of the motivations for pursuing these kinds of surgeries, which includes to “align our genitals with our gender”; “feel fully integrated and whole”; “open doors of social bonding and intimacy”; access, more easily navigate, and avoid discomfort in public spaces such as locker rooms and swimming pools; “immerse and fully participate in the rituals and practices of these spaces”; open up “social and sexual connections”; to “function and be seen as one of the guys”; enhance “sexual and emotional intimacy with their partners”; “participate more fully” in relationships; “mitigate some of the stress [of interacting with airport security, law enforcement, public restrooms, and other agencies]”; increase “quality of life” and autonomy, including “changing the gender marker on one’s birth certificate and other identity documents”; and decrease the likelihood of being “ruthlessly victimized” by legal, social, and other entities that may exploit one’s ambiguous legal status if genital surgeries have not been obtained (pp. 1–2).

Nontrans patients’ motivations also vary widely, although they may be more similar than different to trans people. For example, in her study of women’s experiences of cosmetic surgeries, Davis (2009) describes,

To begin with, they told me that they had not had cosmetic surgery first and foremost because they wanted to become beautiful. Rather they explained that they were different or abnormal and wanted to become ordinary, normal, “just like everyone else” [p. 36; italics added].

Analyzing how the television show Extreme Makeover hinges on this very imperative of normalization, Heyes (2007a) recounts how nontrans people’s motivations are portrayed:

“My fantasy is to be able to walk down the street and I just blend in with everyone else … to be normal,” announces “before” Lori (on Extreme Makeover); and after her large hooked nose has been reduced and streamlined “I don’t have to do anything to hide any more. I’m normal.” The subsequent shot shows her arriving in a school classroom. “The next day, Lori picked up her children. … Like any normal mom,” runs the voiceover. We also want to become the distinctive people we are, on the inside, such that post-surgery our bodies will better represent our “hidden potential” [p. 62].

Considering the similarities between trans and nontrans patients might facilitate understanding trans people’s motivations to “look normal,” just like other patients (Latham, 2013). Indeed, it may be more useful to differentiate patients based on psychological competency, distress, or mental health rather than on their trans or nontrans status. The inability for clinicians to entertain this possibility reveals a suspicion of trans people for being trans. As Goldner (2011) cogently remarks,

While we approve, indeed applaud, any and all efforts at excellence in masculinity or femininity that “improve” upon the gender that is concordant with one’s sex assignment at birth, we fear and despise any gestures toward confounding that gender, or crossing over to the “other” one [p. 160; see also Salamon and Corbett, 2011, p. 224].

4It is important to note that, as Heyes (2007a) points out, reports on the positive psychological effects of cosmetic surgery are “mixed (and methodologically fraught)” (p. 56).
Different surgeries?

Castle’s choice of “sexuality” rather than “sexual functionality” also warrants examination. As I have argued elsewhere, trans people wishing to modify their bodies are routinely denied access to medical interventions if they fail to persuasively describe a set narrative, which generally includes a limited sexuality (Latham, 2016; see also Prosser, 1998, p. 107; Cromwell, 1999, p. 129; Freeheart as cited in Cromwell, 1999, p. 131; Laird, 2008, pp. 78–79; Davy and Steinbock, 2012). This is especially so for those who articulate explicit sexual desires or explanations for wishing to modify their bodies (see Whitehead and Thomas, 2013). To surgeons, sexual functionality seems rarely a priority in genital reconstructive surgeries and can be neglected completely (see Barrett, 2007, p. 218). For example, in his autobiography, Both Sides Now, Khosla (2006) describes his preoperative consultation with Laub, a renowned surgeon in the field of female-to-male surgeries (see Noe, Birdsell, and Laub, 1974; Noe, Sato, Coleman, and Laub, 1978; see also Levy, 2000; Bloom, 2003, pp. 21–32):

Before he got very far into his explanation, I interrupted, saying, “I’m most concerned about orgasm and sensation.”

“Well, the tip of the phallus is definitely sensitive because when I touch people after surgery, they say they can feel it.”

But when I asked, “Do you have full orgasm?” he admitted he didn’t know. … I found myself wondering why they did not follow up with their patients and keep better track of such important information [p. 177].

Similarly, Thompson (1995) describes his surgical experience in the United Kingdom in the 1990s in his book What Took You So Long?, where he is offered the choice between a penis that functions for sexual intercourse or urination (pp. 260–261). This same dichotomy is repeated by Selvaggi and Giordano (2014) as they write, “See for example, the female-to-male transsexual wish for urinating via the penis or the desire for penetrative sexual intercourse” (p. 1179; italics added). It is important to note that it is not accurate to characterize female-to-male genital reconstructive surgeries as making possible only one of these two functions (see Cotten, 2012). Laub’s conflation of erotic sensation with tactile sensation also highlights how such surgeons may understand transexual pleasure (as irrelevant or unimportant; see Latham, in press-a). Indeed, Laub’s rather shockingly dismissive attitude to Khosla’s erotic queries regarding genital surgery conveys a surgical priority for aesthetic rather than sexually functional outcomes. Speaking with one “tummy tuck” surgeon, Blum (2003) describes how he trivialized the extensive scarring indicative of such procedures by emphasizing that “this particular surgical body is made for clothing, [not for sexual encounters]” (p. 183).

Selvaggi and Giordano’s (2014) argument is premised on surgical procedures differing by purpose and context, yet it seems that aesthetic outcomes may take precedence regardless of the purpose or patient. Whitehead and Thomas (2013) argue that this figuration makes it difficult to examine “the double standard in sexed body modification that encourages cisgender [nontrans] people to make their bodies agents of sexual desire, but discourages the same motivation for those seeking transgender modifications” (p. 397). They go on:

Cisgender individuals seek breast implants, circumcision and laser hair removal in order to feel sexy and to appeal to potential romantic partners, but clients [with different stories of transexuality …] are prohibited from modifying their bodies in equally practical pursuits of love and sexual pleasure [p. 397].

In this way, the distinction between patients is made on the basis of being trans, or not. Selvaggi and Giordano (2014) define trans interventions as “gender-related surgeries” (p. 1179) and procedures (which may be exactly the same) performed on nontrans patients as “not gender-related” (p. 1179). This way of seeing skew practices of treating these patients. Even if we look beyond the genital procedures nontrans people undergo (e.g., penis lengthening, labiaplasty), aesthetic surgeries always work on the gender of the patient (see Fraser, 2003; Heyes and Jones, 2009). That is, following Barad (2007), these entities are better understood as “entangled agencies.” It does not make sense to consider nontrans people’s aesthetic surgery requests “not gender-related”; each of these procedures (and patients, and clinicians) are produced through these (gendered and gendering) practices.
Again, this way of thinking constitutes trans procedures and patients as a separate category that therefore must be treated differently. This becomes clear in Selvaggi and Giordano’s (2014) claim that

the surgical act is not merely reconstructing the look of a part of the body, or its function, but, far beyond that, the surgical act is aiming at reconstructing the person’s identity, or part of this identity. Healthcare professionals and patients are working on the person’s identity, and not simply on one part of the body [p. 1180].

Here, Selvaggi and Giordano (2014) take for granted that for trans people (and only trans people) surgery reconstructs identity. This reflects (and reproduces) a narrow understanding of sex-gender more generally, as well as transexuality in particular, and disallows the experiences of many trans people. Trans people tend to have a profoundly strong sense of their identity and often this may more logically be seen as what motivates them to pursue medical interventions rather than the interventions being the force behind “reconstructing the person’s identity.” As Cotten (2012) suggests in his introduction to Hung Jury, an edited collection of trans men’s stories of genital surgeries, “some trans men are unable to reconcile their sexual anatomy with the rest of their male body and identity [and thus pursue genital reconstructive surgeries]” (p. 1; italics added). Hence, it is not necessarily surgery that reconstructs one’s identity, and this representation seems to acutely misunderstand the motivations trans people have in pursuing surgical (and other) interventions. This tension in trans medicine is highlighted by Barrett (2007), a psychiatrist, who writes, “Some patients fiercely maintain that they do not care what others think of them, and that their own conviction of their gender is what matters. This position is at odds with the philosophy of a real life experience [a therapeutic hurdle to achieve the psychiatric diagnosis]” (p. 72). Selvaggi and Giordano (2014) reify trans patients as exceptional by emphasizing that this “identity work” is exclusive only to trans patients. However, as many feminist cosmetic surgery scholars show, nontrans patients also experience aesthetic surgeries as “reconstructive,” keenly impacting (or indeed, remaking) a range of feelings and experiences of themselves. For example, writing about the “before/after” narrative endemic to cosmetic surgery popular discourse, Blum (2003) suggests that “according to the makeover story of modern female culture, the after is always construed as the real you that was just itching to assert her identity, to reveal her real face” (p. 191; italics added; see also Heyes, 2007b, especially pp. 89–110; Jones, 2008, pp. 31–58). Similarly Jones (2008) describes how self-improvement via transformation is imperative for everyone. She writes, “Self-improvement is something that makeover culture insists everyone needs: it is a continuing enterprise that may be realised via home renovation, lifelong learning, career enhancement or body-work such as cosmetic surgery” (p. 57).

In sum, not all trans people experience aesthetic surgeries as “reconstructive,” and further, many nontrans people do. Thus, Selvaggi and Giordano’s (2014) justifications that motivations, purposes, and surgeries are necessarily different for trans and nontrans people produce this differentiation. What becomes clear is that this narrow understanding (and description of) transexuality cannot apprehend the realities of many trans people’s desires and situations. Medicine’s way of constituting transexuality in this particular way, as we shall see, is not necessarily how trans people understand themselves and these encounters.

Complexities

The ways transexuality is made clinically into something limiting and specific stifles the conditions of possibility for other ways of being trans. In addition to presenting trans surgeries as necessarily different, Selvaggi and Giordano (2014) emphasize that trans patients present “a specially complex case.” Similarly, Castle argues that “gender reassignment is a special case that absolutely requires psychological or psychiatric screening” (as cited in Salleh, 2013; italics added). This was exactly the kind of assumption I was trying to encourage debate and discussion about in my letter to the journal. But what makes trans patients “a special case”? Selvaggi and Giordano include a subheading in their letter titled “The complexities inherent to gender treatment” (p. 1178; italics added). In this section,
they assert, “The suffering associated with GD is all encompassing” (p. 1179). Assuming that any and all people requesting trans procedures are necessarily people suffering, and people suffering “extreme psychological discomfort” (p. 1179) is axiomatic in trans medical literature (see Latham, in press-a). Indeed, the very diagnostic category “gender dysphoria” demands “clinically significant distress or impairment” (American Psychiatric Association, 2013, p. 453; see also Meyer-Bahlburg, 2009). Undoubtedly, this is the case for some people. However, framing treatment practices in this way leaves no room for people for whom “gender dysphoria” (or other experiences of being trans) does not amount to suffering or discomfort of this kind.5 As Beatie (2008) recounts in his autobiography, Labor of Love,

Making these changes did not mean that I was miserable or confused before I made them. They were instead convenient ways to strengthen my image of myself, and to make it easier for me to adapt in a world that defines gender strictly [p. 7].

Assuming trans people suffer “gender dysphoria” limits the scope of clinical encounters. In so doing, we are precluded from asking such questions as, Who suffers from gender dysphoria? How do they suffer? (And, perhaps, how is it that others do not suffer, or suffer differently?)

In setting up a medical argument with these assumptions, Selvaggi and Giordano (2014) go on to suggest the following:

The constellation of difficulties associated with GD complicates enormously the clinical picture of a person who applies for medical intervention, as compared with the population of patients who request medical or surgical procedures for purposes that are not gender related [p. 1179].

In their collection Complexities Mol and Law (2002) emphasize how “On the one hand there is an order that simplifies, and on the other there is an elusive and chaotic complexity expelled, produced, or suppressed by it” (p. 5). Following poststructuralist thought (especially Kuhn, 1962; Foucault, 1967; Latour and Woolgar, 1979), Mol and Law argue that simplicity works by repressing complexities, and that is what is happening here. By suggesting that trans patients are “inherently complex” in this way, Selvaggi and Giordano (2014) are actually simplifying treatment practices by disallowing the complexities of individual cases. This performatively (re)produces transexuality as singular rather than (complex and) multiple. By assuming that trans people all necessarily suffer “extreme psychological discomfort” they compel those other people for whom that description does not fit to be subjected to the same psychological scrutiny. If, on the other hand, patients were treated on an individual case-by-case basis without the presumption of this “constellation of difficulties,” patients might then experience more appropriate care.

In a letter to the editor in the Journal of Plastic, Reconstructive & Aesthetic Surgery, plastic surgeons Salgado and Fein (2015) outline how they understand the different purposes of breast surgery for trans patients. They argue the following:

When a transgender woman presents for this same surgery, it is medically necessary. Though breast augmentation is technically the same procedure in natal [sic] and transgender women, the purposes are fundamentally different. The transgender patient usually has a long history of distress caused by gender dysphoria. When surgery is performed to alleviate such intense psychological suffering, mental health support is crucial (Selvaggi & Giordano, 2014) [p. 1471].

Here Salgado and Fein (2015), unlike Selvaggi and Giordano (2014), lean on the concept of medical necessity as differentiating trans patients. The claim of medical necessity, however, self-referentially relies on presuming trans people have “a long history of distress.” In setting up this dichotomy between trans and nontrans patients, Salgado, Fein, Selvaggi, and Giordano simplify nontrans cases by comparison, assuming complexities (and suffering) feature specifically in trans cases. As I outlined in the letter, some nontrans

5It is important to also note, as queer scholar J. Jack Halberstam (1998b) outlines, “The idea that only transsexuals experience the pain of a ‘wrong body’ shows an incredible myopia about the trials and tribulations of many forms of perverse embodiment” (p. 304; see also Heyes, 2007b, pp. 41–42; Wilson, 2013).
people who pursue (and receive) aesthetic surgeries experience psychological, psychosocial, or mental health difficulties (Latham, 2013; see also Sarwer, Wadden, Pertschuk, and Whitaker, 1998; Meningaud et al., 2001). Davis (2009) describes how women in her study “presented cosmetic surgery not as a perfect solution, but as the only way they saw to alleviate suffering” which had gone beyond the point of what they felt a woman should ‘normally’ have to endure” (p. 36; italics added).

In this way, how clinicians produce both trans and nontrans cases as definitive and divergent forecloses many of the realities (and similarities) for patients. Of course, all cases (patients, people) present complexities: clinicians can recognize, accept (and therefore investigate) them, or overlook them, making complexities invisible (although no less real). Surgeons take on hugely complex tasks routinely; surgeons cannot avoid complexity. Within medicine, trans people are assumed to be “inherently complex” in a way that denies the complexity of their individuality, and this happens in the very practices that purport to treat that “complexity.” This argument, based on a narrow and homogenous understanding of transexuality, then works to justify the seeming necessity of compulsory psychiatric referral, a separate path to surgery (or other medical interventions) than for nontrans people.

**Purposes of “mental health professionals”**

Treating trans patients as though they inherently and necessarily require their competency to be approved by “mental health professionals,”6 when this is not standard clinical practice for all other patients, constitutes trans patients as necessarily psychologically suspect because they are trans. Doing trans medicine in this way reinforces binary sex-gender normativity that disallows how people might experience their bodies and lives in more ways, such as trans or another ontology not normatively “male” or “female” or accept their own (bodily, financial, or other) limits. In so doing, this approach normalizes the pathologization of trans desires.7 It is also sets up a way of practicing trans medicine that makes it difficult to take seriously the lived realities of many different ways people are trans (or genderqueer, or other identities and ontologies; see Nestle, Howell, and Wilchins, 2002; Diamond, 2004; Hansbury, 2005; Sennett, 2006; Sycamore, 2006; Bornstein and Bergman, 2010). Relying on a narrow and homogenous definition of transexuality (as suffering a diagnosable disorder) with a specific trajectory of treatment will not care appropriately for those whose experience of being trans (or differently gendered) differs (see Latham, in press-a).

The role of psychiatric professionals in trans medicine is introduced “to assess competency” (following Coleman et al., 2012), yet the function of these encounters is more extensive than this. Selvaggi and Giordano (2014) suggest “mental assessment” is also intended to “have the diagnosis confirmed, and to explore what kind of further help they can be provided with, beside hormonal and surgical treatment” (p. 1181). Here the purpose of psychiatric referral is for diagnosis and psychotherapy. In a similar blurring of the purposes of psychiatric encounters, Salgado and Fein (2015) suggest the following:

The goal of mental health assessment is not to identify a pathology that needs a cure, but rather to enhance the relationship between patient and surgeon. The mental health professional should … ascertain that surgery will contribute to the alleviation of gender dysphoria, as well as that the patient is psychologically ready for surgery [p. 1].

Here, we might assume by “cure” Salgado and Fein (2015) mean “cure via psychotherapy,” as what follows clearly indicates that the goal of surgery is to “alleviate gender dysphoria.” What this

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6“Mental health professional” is the term preferred by Selvaggi and Giordano (2014, following Coleman et al., 2012). One can presume this is because there are a wide variety of qualifications people who perform in this area hold (e.g., medical doctors specializing in psychiatry; clinical psychologists; counselors). Yet this term does other work also: it dulls the seriousness of such clinical encounters for trans people who must navigate them (usually with one or more psychiatrists); it can also be read as a euphemism.

figuration then demonstrates is that surgical understandings of trans medicine conflate various purposes of psychiatric encounters, one of which is to diagnose “gender dysphoria” (see Latham, in press-b). Collapsing the various purposes of psychiatric encounters into “psychiatric assessment for competency” misunderstands the multiple experiences of clinical treatment for trans people.

Selvaggi and Giordano (2014) describe the purposes of involving mental health professionals as

- exploring gender identity;
- addressing the negative impact of GD on mental health;
- alleviating internalized transphobia;
- enhancing social and peer support;
- improving body image;
- promoting resilience;
- assisting the surgeons with the preparation prior the surgery and the patient’s follow up [p. 1177].

All but the final two points relate to the patient’s experience of themselves and, as I explore later, they assume a scenario of intrinsic psychological support that may not be possible. This description occludes the possibility of patients who do not require such “assistance.” Selvaggi and Giordano (2014) also emphasize this final point (“assisting the surgeon”) by returning to it repeatedly (pp. 1179, 1180, 1182).

**Assisting the surgeon**

Salgado and Fein (2015) argue similarly, “The mental health professional should assist the surgeon in evaluating the patient’s expectations and goals” (p. 1; italics added). Selvaggi and Giordano’s (2014) argument positions “acting as a mediator between patient and surgeon” as one of the most important roles of mental health professionals:

> The patient might strongly affirm that s/he knows what s/he wants; nevertheless, the surgeon might still require the help of a mental health professional to achieve a better understanding of the patient’s expectations and to explain better the limits of surgery [p. 1180; italics added].

If we consider the broad range of services offered and accessible to nontrans people, where surgeon and patient are understood to be able to discuss together the important facts, we see that this role of the mental health professional as mediator is specifically required only for trans patients. There is no need, according to clinicians, for a third party to translate aesthetic desires to a surgeon and to translate a surgeon’s description of surgery and its limits to a patient in any other circumstances. What is making trans patients different here?

Surgeons are routinely expected to be able to ascertain the mental competency of patients. Indeed, much work in the journal *Aesthetic Plastic Surgery* and elsewhere is committed to educating clinicians about various psychological issues that patients may present with. A particular area of concern is “Body Dysmorphic Disorder” (BDD; see especially Castle, Honigman, and Phillips, 2002; Hodgkinson, 2005; Heyes, 2009; Metcalfe et al., 2014; Sullivan, 2014). BDD is considered a delusional psychiatric disorder of “perceived ugliness” (Hodgkinson, 2005, p. 503), likely to lead to dissatisfaction with cosmetic surgery results. As another example, a recent paper in *Aesthetic Plastic Surgery* aims to educate surgeons about the nuances of “Borderline Personality Disorder” (BPD; Morioka, Ohkubo, and Amikura, 2014). In so doing, the authors (and the journal) imply that being able to discern certain psychological cues is a necessary part of patient intake for aesthetic plastic surgeons. This shows that surgeons are expected to have a critical eye for psychological competency (and incompetency) as a part of standard practice.

**Patient expectations**

Another way trans and nontrans patients are differentiated according to Selvaggi and Giordano (2014) is what they describe as the problem of “patient expectations” (pp. 1178, 1179, 1180, 1182).

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8On an episode of the Australian talk show *Insight* about cosmetic surgery, cosmetic surgeons agree that to request a (nontrans) patient to be psychiatrically assessed would be “offensive” to the patient (Filali, 2011).
Similar to Salgado and Fein (2015) quoted earlier, Selvaggi and Giordano suggest different patient expectations drive the need for the oversight of a mental health professional:

The surgeon, in fact, is (or should be) referring the patient to mental assessment in order to improve the professional relationship between surgeon and patient; particularly, the mental health professional should assist the surgeon in evaluating the patient's expectations [p. 1180; italics added].

Selvaggi and Giordano (2014) mention “patient expectations” 11 times, yet they provide no evidence that trans patients’ expectations are somehow “less realistic” than other patients. This characterization patronizes trans patients by representing them as unable to rationally comprehend surgical possibilities and limits, somehow different from all other (nontrans) patients, who are assumed to be able to understand this information. Yet Blum (2003) outlines that “unrealistic expectations” is a problem for surgeons with nontrans aesthetic surgery patients. She describes, “A surgical nurse told me that often patients absolutely cannot grasp the limitations of their individual bodies or surgical technique” (p. 182). Selvaggi and Giordano’s (2014) focus on patient expectations as cause for concern takes as axiomatic that people requesting trans interventions cannot be managed in the same way as other patients. Yet, the problem of unrealistic expectations is not restricted only to trans patients. As they reveal in this passage, the requirement for oversight seems to stem from surgeons’ needs rather than to assist or support patients. As Heath (2006) highlights in The Praeger Handbook of Transsexuality,

More often than not, the diagnosis is imposed … to protect surgeons and other medical specialists from being sued if treatments such as GRS [genital reconstructive surgeries], for example, lead subsequently to regret. Surely the surgeon only needs reassurance that the person is a suitable candidate for surgery. In cosmetic procedures such as breast augmentation, which can be at least as risky as GRS, the surgeon only requires consent from the client in order to avoid postoperative litigation [p. 190].

Furthermore, the ability to interpret what trans people’s expectations are is complicated by their need to articulate an imagined future of “physically embodying the other sex” in as many ways as possible in order to achieve the diagnosis in the first place and therefore access surgeries and/or other interventions (see Prosser, 1998; Latham, in press-b). That is, this diagnostic process obscures what trans people might actually expect (or, more accurately, might have expected if they were not subject to these practices).

**Gatekeeping**

The requirement to “achieve the diagnosis” as a prerequisite to medically supervised trans interventions has been a critical point for trans and feminist scholars for some time (see especially Stone, 1991; Prosser, 1998; Cromwell, 1999; Spade 2006). Clinicians continue to doubt trans people’s claims and indeed the very need to “achieve the diagnosis” requires this doubt (otherwise there would be no need for the diagnosis). As Prosser (1998) notes, placing the clinician in the position of “detective” is “a shocking equation when we remember this is supposed to be a healthcare/patient relation” (p. 111). In an Ontario-based qualitative study of physicians’ experiences of treatment barriers for trans people, Snelgrove, Jasudavisius, Rowe, Head, and Bauer (2012) note the following:

Dominant narratives of transgender experience are reinforced by the DSM criteria for GID [Gender Identity Disorder], but these exclude other gender variant individuals for whom transitioning treatment may be of benefit. An ethical implication extending from this is the possibility that patients feel compelled to provide disingenuous histories of their transgender identity in order to ensure treatment, should their actual experiences not align with GID criteria [p. 2; italics added].

There are important clinical implications for this unaccountability of other ways people experience being trans (or differently gendered).

Selvaggi and Giordano (2014) argue the following:
Mental assessment is not *compulsory*: the law in England and in many other countries does not require it. Mental assessment is typically recommended as a part of good comprehensive care, as suggested by the SOC [Standards of Care] from the WPATH [World Professional Association for Transgender Health]. Yet clinical guidelines are not the law and indeed the WPATH SOC are meant to provide flexible recommendations [p. 1180].

But psychiatric assessment *is experienced as compulsory*. This is due to the entanglement of the diagnosis and mental assessment: because the diagnosis is a prerequisite to medical interventions, clinicians in various fields *expect* and *require* it. In so doing, psychiatric encounters become compulsory through clinical practices. Regardless of whether the law demands it, trans interventions become available *subsequent* to the diagnosis. In this way, trans medicine is *practiced* via compulsory referral and thus trans patients experience psychiatric assessment as compulsory. As Selvaggi and Giordano (2014) explain, all Selvaggi’s patients undergo this treatment path without exception (p. 1181). Writing about her own experience in Ontario, McKinnon (2013) explains,

> For trans people, this [access to medical treatment] typically involves a psychologist or psychiatrist, as trans people still often require an official diagnosis of Gender Dysphoria (what used to be called Gender Identity Disorder). And this often requires convincing a psychologist that you “really are” trans, and deserve medical treatment such as hormone therapy.

Research by the Scottish Transgender Alliance involving 889 trans people ages 18 to 78 from across the United Kingdom confirms this is how trans people experience clinical pathways, as they report, “[trans people] felt that they are forced to access mental health services as part of the current requirements for obtaining gender reassignment treatment” (McNeil, Bailey, Ellis, Morton, and Regan, 2012, p. 49; italics added).

Understanding and describing psychiatric assessment as optional or voluntary misplaces the problems of guidelines, laws, and treatment. It also fundamentally misunderstands how trans people experience clinical pathways. Writing in 1997, Stryker elaborates on this tension:

> Until transsexuals believe they are being treated as equal partners in the process of transitioning from one gender to another, the trust and faith in the service provider which are so necessary for quality health care will simply not be possible. What is at stake here is who has the power to determine how one’s body is treated. … As transgender medical services are currently delivered in the United States [and elsewhere], it is the psychotherapist, not the transsexual, who ultimately determines what will happen to the transsexual’s body. This is an unacceptable situation [p. 244].

Here Stryker (1997) alludes to another pivotal point: there is a profound difference between psychotherapy, psychological support, psychiatric assessment, and diagnosis. These shifting roles of psychiatric encounters blur the purpose of such encounters as well as their justification (see Anderson, 1997; Pollack, 1997; Lev, 2005). Writing about her own doctor, McKinnon (2013) adds, “Often, I felt she wanted to place her comfort level above my health needs.”

In a similar defense of the need for mental health professionals as gatekeepers in cases of trans requests, Richards, Barker, Lenihan, and Iantaffi (2014) set up a dichotomy between accepting the benefits of psychiatric oversight and ignoring those benefits. They argue, “[Clinicians] do acknowledge the responsibility of ensuring that people recognize the decisions they are making and so are truly able to give informed consent. Professional judgement and experience cannot be ignored in endorsing medical interventions when it is sought” (p. 255). This figuration, however, disregards the possibility that informed consent may be attainable from a patient without the mediation of a mental health professional. It also denies the evidence that psychiatric encounters may be more detrimental than beneficial to trans people themselves.
Psychological support

When the involvement of mental health professionals is framed as “psychological support” and inherently of benefit to the patient, this makes many trans people’s experiences of clinical treatment practices invisible. There is a significant and fundamental difference between being offered psychological support as an option and requiring the diagnosis and approval of a psychiatrist in order to proceed with surgical (or other) interventions. Yet this difference disappears in Selvaggi and Giordano’s (2014) description:

WPATH recommends that both prior to the initiation, and after treatment has commenced, the patient is constantly offered psychological support. Mental assessment or support is not compulsory, differently from what Latham suggests; nevertheless, mental assessment and support are, in our opinion appropriately, offered to patients through their journey [p. 1181; italics added].

Conflating these conflicting roles (as in the phrase “mental assessment and support”) is typically how medical writing understands (and reproduces) this relationship, different from how trans people experience (and report) these processes, as I explore further later.

It is compelling that the precondition of psychiatric approval precludes the very possibility of psychological support from being provided in this way. This is because the requirement for approval (diagnosis and competency assessment) sets up a particular relationship whereby patients must prove themselves worthy of treatment (and this shapes their clinical narratives, as Snelgrove and colleagues, 2012, describe; see also Prosser, 1998). Lev (2005) makes this point: “The development of an authentic therapeutic relationship is severely impaired when the diagnostic evaluation casts the clinician in the role of gatekeeper who controls access to medical treatments” (p. 54). Bockting, Robinson, Benner, and Scheltema (2004) also emphasize this feature of clinical encounters:

The therapist’s role in guarding access to hormone therapy and sex reassignment surgery, as defined in the Benjamin Association’s [now WPATH] Standards of Care, presents a challenge to both patients and providers in establishing and maintaining a trusting and productive therapeutic relationship [p. 291; italics added].

In recounting his experience attempting to acquire chest surgery, Spade (2006) points to a larger problem:

After attending only three discussion group meetings with other trans people, I am struck by the naiveté with which I approached the search for counseling to get my surgery-authorizing letters. No one at these groups seems to see therapy as the place where they voice their doubts about their transitions, where they wrestle with the political implications of their changes, where they speak about fears of losing membership in various communities or families. No one trusts the doctors as the place to work things out [p. 326; italics added].

Spade (2006) paints an alarming picture of the sheer scope of this issue for trans people. As he conveys, trans people looking for psychological support struggle to find it from a mental health professional from whom they require an approval letter for medical interventions. Butler (2004), too, comments on this predicament:

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 transautonomy. It subscribes to forms of psychological assessment which assume that the diagnosed person is affected by forces he or she does not understand. It assumes there is delusion or dysphoria in such people [pp. 76–77].

Following Butler, Spade, Bockting and colleagues, and Lev, as long as the diagnosis and psychiatric assessment remain mandatory in practice, the person acting in this professional capacity is institutionally prevented from acting in this supportive capacity. It might be more appropriate to consider this tension as a conflict of interest for trans patients wishing to receive both psychological support and approval for medical interventions to do so from the same professional. Rather if a patient requests, requires, or is offered psychological support, this would be more suitably considered separately (by another professional) from an assessment of the appropriateness of pursuing surgery.
or other interventions. Although some trans people may have an ongoing relationship with a therapist who may act in both capacities, as Spade (2006) implies, many people seek counseling services only to receive authorizing letters.

**Patient experiences of psychiatric encounters**

Experiences of patients are central to treatment and care and thus should be taken into account in clinical practices as well as revisions of treatment guidelines (Bockting et al., 2004). In trans medicine, however, this is rarely practiced, as Selvaggi and Giordano (2014) demonstrate when they make the rather remarkable claim (regarding psychiatric assessment) that “there is no evidence to suggest that patients or a patients’ group have ever complained about such an approach” (p. 1181). Elsewhere in their letter they cite Cummings’ (1993) autobiography, *Katherine’s Diary: The Story of a Transsexual*, indicating that trans people’s memoirs are relevant to their field of inquiry. Yet the breadth of trans texts, as well as transgender studies itself, escapes their critical attention. How? In Cummings’ own account she describes the following:

> I had, in effect, passed the more exhaustive test of two psychiatrists over a period of two years. I resented the need to take the test and I resented the need to hide my resentment or run the risk of being rejected as an uncooperative patient. I smiled politely and took the test [p. 353].

Selvaggi and Giordano (2014) imply that even in their own experience they have encountered patients who are reluctant to undergo “psychiatric assessment”: “It is one of the authors’ experience (GS) that some of the patients might feel they do not need psychotherapy or mental counseling, but still they accept it as a part of their journey …” (p. 1181). If and when psychiatric assessment is set up as a barrier that must be overcome to achieve trans medical interventions, it becomes difficult to discern in clinical encounters whether trans patients do indeed accept (or resent, or feel otherwise about) such a treatment path. How is it that medicine is set up and practiced in ways that produce this inability to recognize that trans people have “complained about such an approach,” including, in my reading, Selvaggi’s own patients?

One of the difficult and most troubling aspects of trans medicine is how it is practiced with little and sometimes no evidence (see Heath, 2006, p. 89; Barrett, 2007, p. 72; Maycock and Kennedy, 2014; Plemons, 2015). Selvaggi and Giordano (2014) acknowledge that “in the scientific literature, there is a lack of randomized clinical trials or high-quality follow-up studies on high numbers of operated transsexuals: there is no evidence-based research above evidence level B or C” (p. 1181). There is also a lack of education on trans health care in medical curricula (see Safer and Pearce, 2013; Wilczynski and Emanuele, 2014). Yet trans people themselves have been writing about these issues for some time. In his autobiography, *The Testosterone Files*, Valerio (2006) describes some of his difficulties with this process in the United States:

> From the beginning, I had strategized to accomplish my transition as expediently and as cheaply as possible. Initially, I had gone to a therapist at a gender center who had peered at me skeptically and asked why I couldn’t just remain a lesbian. The prospect of having to explain this tired fact to him for six months to a year was simply too expensive and time-consuming [p. 15].

Here, Valerio (2006) points out some of the burdens of these encounters, including the amount of time and money required. He also implies that the purpose of these encounters is something more than a test for competency. In a comparable experience in the United Kingdom, Thompson (1995) details in his autobiography,

> When I tried to explain that it was entirely my need and my choice, she repeated the same question. It was irritating and insulting, and I had no patience for it. After each of my answers she would ask, “What do you mean?” I knew I was a reasonably articulate person and generally people understand exactly what I mean. This “third degree” and being treated like a moron thoroughly pissed me off [p. 256].
Thompson’s (1995) characterization of “being treated like a moron” conveys a powerful message about what it is to like to explain to a doubting professional something very intimate about yourself. Thompson himself highlights this point: “Revealing to a stranger something that causes you extreme humiliation makes you very vulnerable” (p. 82). Khosla (2006), who holds a degree in psychology, mirrors Thompson’s account:

It made my blood boil. I wanted to yell, “How dare you sit there and analyse me. This is my goddamned life. You know nothing about me and I have to pay you a hundred fucking dollars an hour so you can sit there and decide what I should do with my body? Of course I’m fucking agitated” [p. 35].

These brief excerpts of just a few men’s experiences of compulsory psychiatric referral convey the strain this rigorous regime puts on trans people.

As well as the accounts of individuals, a number of surveys and other research have been undertaken to examine the experiences of trans people in clinical treatment practices. Drawing on published research from Australia, the United Kingdom, and across North America that reports trans people’s experiences in psychiatric encounters gives us some insight into how trans people describe these processes.

In Australia, a survey of 189 trans, genderqueer, and gender-questioning people ages 14 to 25 found 77% of respondents nominated at least one reason for not seeing a mental health professional due to “negative past experience” (30%), “financial reasons” (32%), and “there isn’t anything they could do for me anyway” (35%; Smith and Ward, 2014). Those who described negative experiences of mental health professionals gave the following reasons: “Feeling interrogated; Not being believed or taken seriously; Misgendering and deliberate use of wrong pronouns or name; Privacy abused and lack of confidentiality; General feelings of discomfort.”

In the United Kingdom, a study found that “62% of people that had used Gender Identity Clinic [GIC] services experienced one or more negative interactions”; appallingly, “20% of respondents had wanted to harm themselves in relation to, or because of involvement with, a Gender Identity Clinic or health service” (McNeil et al., 2012, p. 88).

In the United States, interviews with 55 trans people and 12 health professionals about their experiences of stigma and discrimination characterizes trans people’s experiences in health care encounters as “Blaming; Shaming; Othering; and Discriminating” (Poteat, German, and Kerrigan, 2013, p. 27). In a Canadian survey of 54 trans people from British Columbia, respondents identified the following negative behaviors from health care professionals:

Refusal to provide care; ending care; using hurtful or insulting language; refusing to address trans-related issues; stating that one is not really trans; discouraging gender exploration; refusal to examine body parts; belittling or ridiculing; or stating that lack of knowledge meant they could not provide care [Heinz and MacFarlane, 2013, p. 6].

They also report, “Most respondents (59%) said they would feel uncomfortable or very uncomfortable discussing trans issues with a doctor they did not know” (p. 6), which is reminiscent of Thompson’s (1995) point earlier.

A report on Ontario’s TransPULSE surveys describes the processes and effects of trans erasure in health care; in particular key health concerns include the following:

Barriers to accessing trans-inclusive health care services, the lack of relevant and accessible information, systemic social service barriers, self-esteem and mental health issues, challenges to finding help, and relationship and sexual health concerns. These concerns were characterized by pervasive and diverse experiences of transphobia [Bauer et al., 2009, p. 351].

As is illustrated in this range of compiled experiences, some trans people may not benefit from seeing a mental health professional (and especially being compelled to do so). Trans people continue to have negative experiences and fears with regard to navigating cumbersome health systems including passing psychiatric tests (see, for contemporary examples, FTM Surgery Network, 2016; Zoe Belle Gender Centre, 2016). This shows that psychiatric encounters very often do not provide psychological support but instead make up an intrusive, expensive, and possibly harmful barrier to services.
and preclude support. Given the adverse effects of psychiatric assessment described by trans people in their own biographies, to researchers, and elsewhere, clinicians would do well to take the potential detrimental impact of psychiatric referral into account when prescribing such a course of action. If patients received treatment based on their individual needs and circumstances rather than according to a limiting definition of transexuality (that implies suffering and psychosocial difficulties), we might see a transformation of clinical encounters and the relationships between clinicians and patients.

**Conclusions**

If realities are being made in practices, then “this means they can, at least in principle, be remade in other ways” (Law, 2004, p. 143). Are there really options? Psychiatric encounters are not mere formalities for trans people. Indeed, conflating the various purposes of such encounters into “psychiatric assessment” hides many of the complexities (and difficulties) experienced by trans people trying to navigate these systems. Psychiatric assessment can be intrusive, costly, and is not necessarily beneficial to patients. Indeed, as the aforementioned examples depict, it can be harmful. Rather than automatically referring all trans people for psychiatric assessment as a matter of course, how can clinicians take into account the negative impacts of forced psychiatric assessment? It is standard for surgeons to cast a critical eye on all their patients for potential psychiatric issues. In order to satisfy the standard of equal treatment medicine demands, clinicians ought not to automatically synonymize “gender nonconformity” with psychiatric problems. Trans desires are not an indication of mental incapacity, yet they are treated this way in current clinical practices of trans medicine.

Understanding and describing psychiatric encounters only and inherently as beneficial severely limits clinicians’ abilities to appropriately care for their patients. Rather than adding to the stress and pressure of obtaining medical interventions (in addition to the range of other difficulties trans people are likely to be experiencing), clinicians have an opportunity to relieve trans people of some of the burden of this process by taking them seriously on their own terms and assessing patients on an individual, case-by-case basis. By Selvaggi and Giordano’s (2014) own suggestion, it is not appropriate to treat all patients the same:

> People need to be treated differently, so that they can all equally be helped to achieve their own goals. Medicine ought to, at the very least, minimize people’s suffering; but in order to do that, the specific predicaments unique to each individual must be understood. In other words, to equally alleviate people’s suffering, people ought to be treated with equal concern and respect, and to be given an equal opportunity to attain a healthy life: in order to do this, they need to be treated differently [p. 1178].

However, trans people are routinely treated without this respect. Overwhelmingly, trans people’s requests for medical interventions catapult them into a paradigmatic trajectory that treats us all the same and systematically differently from other patients for the sole reason that we are trans. It is recognized as inappropriate in so many fields and contexts to treat trans people according to their birth-assigned sex. Medicine needs to rethink the treatment practices of managing trans people and take trans people seriously on their own terms. This does not mean precluding psychiatric assessment when necessary. It does mean a shift in how trans people are considered by clinicians. Selvaggi and Giordano (2014) contend that patients requesting trans surgeries inherently present more complex cases. However, they omit how these cases are too complex for surgeons to handle without the involvement of mental health professionals. This lack of evidence, coupled with their insight that surgeons in many instances do not have the proper training to treat trans patients with appropriate care and respect, emphasizes the urgency of changing clinical treatment practices. Indeed, if knowledges (and ontologies) are produced through practices, as I have argued, then our knowledge of trans lives is limited by the inadequacies of clinical practice. What we do already know, however, is
that the current systems of medical management are often detrimental to trans people. This reality needs to be addressed by clinicians.

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References


