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Developing gender: The medical treatment of transgender young people

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ABSTRACT

Situating the contemporary medical treatment of transgender young people – children and adolescents – in the longer history of engagement between transgender activists and the medical community, this article analyzes the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC) concerning the medical treatment of transgender young people. It traces how the SOC both achieves medical treatment for children and adolescents and reinforces a normative gender system by cleaving to a developmental approach. Without rejecting the value of developmentally-based medical treatment for now, it offers some preliminary thoughts on queer theory's valuation of developmental failure as a potential future alternative to an emergent medico-technological transgender normativity.

The medical treatment of transgender children is among the newest additions to a history of medical engagements with transgender phenomena that include diagnoses of "transsexualism," "gender identity disorder (GID)," and most recently "gender dysphoria". As historians of transgender demonstrate, transgender medical treatment emerged in the United States from a nexus of medicine, technological change, and political activism in the face of the harsh and often violent oppression of transgender persons (Hausman, 1995; Meyerowitz, 2009). Given these historical conditions, the establishment of medical treatment was an achievement, but the costs of inclusion in a medical order of things – most obviously pathologization – also plays a part in this history. Together with the already existing history of adult transgender treatment, the long-established distinction between child and adult in Euro-US cultures – including medical culture – points to a linked yet particular story concerning the medical treatment of transgender young people. How does the child enter into this complex history? How has Euro-U.S. transgender medicine incorporated the child, and what are the potential effects of this achievement on transgender young people and on broader understandings of trans/gender?

1. Concerning gender

The field of medical provision for transgender young people is fairly well established today, with dedicated clinical teams in the United States (Boston, San Francisco, Washington DC), Canada (Toronto), the Netherlands (Amsterdam), the UK (London) and beyond. Each of these centers follows its own treatment protocol, but medicine is a collaborative practice, in which knowledge is shared through publications, meetings, and organizations. The World Professional Association for Transgender Health (WPATH, formerly the Harry Benjamin International Gender Dysphoria Association, or HBIGDA) is an international multidisciplinary professional association whose stated mission is "to promote evidence based care, education, research, advocacy, public policy and respect in transgender health" (World Professional Association for Transgender Health (WPATH), n.d.-a). It envisions the organization's work as "bring[ing] together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings" (WPATH, n.d.-a) This organization played a role, alongside other actors, in pushing for depathologizing diagnoses in the DSM-5. WPATH stipulates that its Standards of Care (SOC) are intended to "provide clinical guidance for health professionals" who wish to "assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves" and so to "maximize their overall health, psychological well-being, and self-

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fulfillment" (WPATH, n.d.-b). This approach, based on "the best available science and expert professional consensus," clearly works to support treatment that affirms "gendered selves" (rather than refusing or pathologizing them). As such, it does not articulate debates about treatment, but rather it provides a rationale for it, as well as a comprehensive statement of currently available medical protocols. I use these protocols as the basis for my analysis of the *achievement* of treatment for young people in this field.

The fact that standard terminology surrounding transgender phenomena continues to require explanation indexes the degree to which they are less than fully integrated in dominant Euro-U.S. socio-cultural orders despite a recent marked increase in their mainstream media representation. Furthermore, popular, medical and psychiatric languages undergo continual changes, often in relation to one another. In the SOC statements quoted above, the term "transgender" functions as a kind of shorthand ("transgender health") for a population that the guidelines otherwise identify more diversely as "transsexual, transgender and gender-variant people." This naming instantiates the current flexible usage of the term "transgender" as both a particular category, which signifies cross-gender identification, and an umbrella category for many different forms of nonconforming gender. I adopt this flexible use of the term in my analysis of the SOC guidelines for the purposes of brevity, but also to emphasize how "transgender" continues to morph both materially and semiotically, in this case particularly with regard to the medical treatment of young people. In addition, I use the term in support of transgender politics' refusal of the pathologization attached to the medical diagnostic term "transsexual," which refers to those whose gender identification conflicts with neonatally assigned gender, and often also to those who seek or have received medical treatment (Meyerowitz, 2009, p. 103). As suggested in the SOC guidelines cited above, the term "transgender" does not assume either a need or desire for medical diagnosis or treatment of any kind. However, in medical discourse the term "transgender" is consistently associated with medical treatment (Ehrensaft, 2012; Sadjadi, 2013), which includes hormone treatment and relevant surgical procedures (primarily chest or breast construction, and vaginal or penile construction, but also facial and other kinds of plastic surgery) to feminize or masculinize appearance. My analysis traces how transgender becomes a medically treatable category in the case of young people.

This analysis is complicated by the fact that the diagnostic language associated with transgender phenomena has changed fairly rapidly over time, even in the relatively short time since treatment for young people began in the 1970s. In its fifth and latest version, The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association adopted the language of "gender dysphoria" as compared to "gender identity disorder (GID)" found in the prior DSM-IV Tr edition, which, as the APA puts it, shifted the understanding of transgender phenomena from a notion of "cross-sex identification" to "gender incongruence" (American Psychiatric Association, n.d.); and, as the terms themselves suggest, a shift from pathology to a problem of dysphoria, or unhappiness, that is not necessarily pathological. Medical literature concerning transgender young people published before the DSM-5 (2013) often refers directly or indirectly to GID, but the SOC guidelines conform to the newer diagnostic language. My analysis considers how the SOC guidelines establish treatment for young persons *through* the concept of "gender dysphoria" as a condition that affects a subset of this group.

Finally, the SOC guidelines also employ a distinction between the (younger) child and the similarly historical-cultural category of the adolescent (Kett, 1993). I use the term "young people" to include both of these categories, and to signal a distinction between the conceptualizations of young people employed in the medical discourse and alternative possibilities that parallels my use of the term "transgender."

2. Developing gender

Some kind of gender trouble, some kind of "incongruence" between the sex assigned at birth according to a normative binary gender system and the person's self-identified or self-expressed gender lies at the heart of the medical treatment of transgender persons. Although the expression of this incongruence in adults has been and continues to be the object of some medical scrutiny, in young people it is an even more complex matter. Questions of medical diagnosis and treatment in this case follow from the dual problem of incongruence (shared by adults) and immaturity (unique to young people): what is the nature of the child's gendering, *who* knows (the child, parents or caretakers, professional diagnosticians?) and *when* can this be known for sure in the immature-but-maturing child? Like much of the medical literature concerning this issue (see (Fausto-Sterling, 2012), the SOC answers these questions through its account of medical treatment options for young people that are set aside from those of adults, rather than through an etiological account of (trans)gender itself. And yet accounts of gender necessarily permeate any discussion of transgender concerns.

While such concerns might appear to arise in relation to a previously established account of "normal" gender, historians of transgender phenomena in the United States and Europe have shown that the very concepts of "gender" and "gender identity" arose in relation to the mid-twentieth-century medical encounter with persons who did not identify with the sex assigned to them at birth. The medico-scientific discourse contrasted transgender phenomena with intersex and other conditions of "sex", which it could and did account for in fully biological terms. In this sense, the concept of gender originated from the need to account for people who claimed a felt sense of their "sex" that was not clearly written on their bodies in the medically legible form of genitals, hormones, and (later) chromosomes (Meyerowitz, 2009).

If we consider medicine in a Foucauldian sense, as a productive form of power (Foucault, 1978), then the task for the medical profession was to subject gender to the medical gaze, making it intelligible and, in the end, treatable. But what form that accounting took, and what treatment it entailed was in no way directly answered by the concept of gender alone (Meyerowitz, 2009, p. 103). In fact, accounts of gender have shifted over time as health professionals (primarily physicians, psychiatrists and psychologists) debated the genesis of transgender self-identifications. An early "bisexual" model held that all humans were born with male and female biological aspects that expressed themselves to different degrees in individual bodies (Meyerowitz, 2009, 103). This model accounted for cross-gender identification as one permutation within an innate range of potential variation that should be given full expression through medical intervention. The U.S. endocrinologist Harry Benjamin, along with Danish physicians, argued from this model that transsexualism was a physical condition, not a strictly psychological one, and so treatment in the form of hormones and sex reassignment surgery (SRS) was medically appropriate (103). In contrast, psychologists and psychoanalysts employed a model of gender as a strictly psychic phenomenon. This became the basis for a view of transsexualism as a pathological version of gender that required psychoanalytic or psychotherapeutic intervention aimed at transformation into a normal state (112).

The contemporary treatment of transgender adults – and young people, as we will see – relies on a third model of gender that superseded the second one. By the late 1960s, medico-scientific

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