Child and Adolescent Mental Health

Child and Adolescent Mental Health Volume **, No. *, 2018, pp. **–** doi:10.1111/camh.12272

Narrative Matters: A confusion of tongues – trans/historical voices

Zoë Playdon

University of London, London, UK. E-mail: zoe.playdon@london.ac.uk

Historically, perhaps the most famous trans child was David Reimer. Born in 1965, at 7 months old, David's penis was oblated in a surgical accident and his parents were referred to Johns Hopkins University Hospital in Baltimore, where John Money, professor of paediatrics and medical psychology, claimed he could successfully 'reassign' the child to be raised as female. Money and his colleagues believed that what they called 'gender identity' was malleable until the age of 3, after which a so-called 'gender identity gate' closed. Their work with intersex neonates subscribed to the idea that 'the intersex individual has always been a problem to himself and to his social group' (Finkler, 1948, p. 88) and they held that it should be the aim of the obstetrician and paediatrician to settle the sex of an hermaphroditic baby, once and for all, within the first few weeks of life, before the establishment of a gender role was too far advanced. To do this, 'social gender could be created to match genital shape' (Reis, 2009, 135), so that 'a great deal of emphasis should be placed on the morphology of the external genitals and the ease with which these organs can be surgically reconstructed to be consistent with the assigned sex' (Money, Hampson, & Hampson, 1957, p. 334). So-called 'gender-appropriate rearing', including keeping secret their surgery from the children, meant the child would experience no problems. Furthermore, just as gender could be moulded and shaped under proper parental guidance, Money and the Hampsons also believed that sexual orientation could be similarly guided. Their view was that sexual behaviour and orientation as male or female does not have an innate instinctive basis, so that most people, including intersex people, could be conditioned to be either women or men with suitable, and psychologically healthy, heterosexual desire. Their conflation of sex, gender and sexuality into 'gender identity' was to be as influential on medicine as it was disastrous for trans people.

David's twin brother, Brian, was supposedly a 'control' against which David's 'gender' could be judged, allowing Money to show how 'gender identity' could be created. His reports described his view of a successful gender role (Money & Tucker, 1976, p. 75):

> Although the girl had been the dominant twin in infancy, by the time the children were 4-year old there was no mistaking which twin was the girl and which the boy. At 5, the little girl already preferred dresses to pants, enjoyed wearing her hair ribbons, bracelets and frilly blouses, and loved being her daddy's little sweetheart... dolls and a doll carriage headed her Christmas list when she was five... quite unlike her brother, the girl was neat and dainty, experimented happily with styles for long hair, and often tried to help in the kitchen.

Thirty 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 (Diamond & Sigmundson, 1997). David had been deeply unhappy and distressed and had been forced by his parents to feign 'female' behaviour when Money visited (Colapinto, 2000). When he finally learnt his medical history from his parents, he immediately reiterated his male sex, changing his name and social identity to correspond with his biology. The stresses of the medical abuse to which he had been subject were so great that in 2004 David Reimer committed suicide. The world's most famous trans child had not been trans at all. The category error that collapsed sex, gender and sexuality together was not new medical science but the fantasy science that Foucault calls 'scientia sexualis' in his '*The History of Sexuality*'.

By contrast, the most historically famous trans adolescent is the person known only by her medical case-study name of Agnes. Studied extensively by clinician Robert Stoller and ethnographer Harold Garfinkel, Agnes attended UCLA's Department of Psychiatry in 1958, when she was 19. Although her internal and external genitalia followed a usual male formation, she had well-developed breasts, and a conventionally female appearance. They concluded that she was a remarkable example of spontaneous pubertal feminisation and as an intersex person, they were happy to provide her with the reconstructive surgery she required (Schwabe, Solomon, Stoller, & Burnham, 1962). However, in 1966, just as Money was starting his experiment on David Reimer, Agnes rocked the sexological world by revealing that she had commenced self-medication at 12-years old with oestrogen, avoiding male puberty. She was trans, not intersex, but she had posed as intersex in order to get the surgery that was then routinely denied to trans people. Embarrassed, Stoller and Garfinkel had to retract their lengthy, published analyses and conclusions, exposing and destabilising medical and sociological certainty.

How do we make sense of these histories, and what do they speak to in today's treatment of trans children and adolescents? To dismiss them as unfortunate mistakes, irrelevant to today's UK medical practice, is to descend into an a-historical politics of amnesia, a location as unreasonable as it is unethical. Rather, it is important to set them in context, which, for children and adolescents, who have relatively little autonomy, means the adult world of being trans, and particularly, trans healthcare.

In this context, Krafft-Ebing's publication of *Psychopathia Sexualis* in 1886 is a key moment: he identified trans people as experiencing 'metamorphosis

Published by John Wiley & Sons Ltd, 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main St, Malden, MA 02148, USA

sexualis' but without the paranoia of descending into homosexuality. For the next 60 years, being trans was treated as a congenital, asymptomatic intersex condition, and as medical science advanced, from the 1930s onwards, by invoking the typical patient narrative established by Krafft-Ebing, trans people had direct access to hormone therapy and surgery. In the United Kingdom, until the early 1960s, this was usual treatment for trans people, who had their Birth Certificates corrected, and merged back into society unnoticed, unless discovered by the tabloid Press. Endocrinologist Joseph Adler and surgeon Lennox Broster at Charing Cross Hospital, for example, treated countless trans people in this way for 35 years.

But in 1960s in the United States, a 'turf war' broke out between endocrinology and psychiatry as to whether being trans was a form of asymptomatic intersex or a mental illness created by poor parenting (Meyerowitz, 2002). From 1962, UCLA's Gender Identity Clinic [GIC] began to 'cure' gay men, lesbians, cross-dressers and trans people, using aversion therapy, ECT and leucotomy. In 1967, the First International Symposium on Gender Identity, hosted in London, extended psychopathologisation to UK trans people, creating the London GIC, whose head, John Randell, explained its purpose as 'to breed out of our genetic inheritance' people with 'adverse genetic propensities', through 'some form of eugenics, in fact' (Randell, 1973, p. 146). Through processes that have still not been fully explained, trans people were subjected to enforced, compulsory sterilisation as a part of their care pathway, while records of their treatment were not collected in the public record, and their basic human rights were removed. Trans people could no longer have their birth certificates corrected, could not marry or adopt, had no employment rights whatsoever, and if they were unable to pay their parking fines, could be sent to the wrong sex prison where they would be raped by inmates and warders alike. Epistemological hostages to diagnosis as an independent entity, trans people became 'Other', morally degenerate, sexually perverted and socially deviant. What amounts to a eugenic project – biological genocide, cultural genocide and social disenfranchisement – took place without parliamentary debate, without new legislation and without protest or support from other minority groups. When the Tavistock Clinic for trans children opened in 1989, its clinicians faced not just medicine's confusion of tongues, but the knowledge that young trans people would be confronted by an adulthood of social exclusion.

Change did not arrive until 1996, when a trans woman successfully prosecuted the UK government in the European Court of Justice for discrimination in employment. It was the first piece of case law to come into existence, anywhere in the world, that prevented discrimination against trans people. By 2004 the *Gender Recognition Act* had provided a kind of second-class citizenship to trans people, and in the United Kingdom, being trans was no longer a mental illness or a personality disorder. But medicine is still finding it hard to accommodate to these changes. Parents are critical of the Tavistock service for its perceived reluctance to prescribe 'hormone blockers', so trans children can avoid the wrong puberty, and of the NHS for setting 16 as the minimum age for prescribing cross-sex hormones. They see both practices as not keeping pace with social change or scientific advance, and as refusing children the 'Gillick competence' to informed consent they are guaranteed by UK law. Meanwhile, the point at which children and adolescents transfer to adult services is increasingly problematic, as they continue to be housed in Mental Health Services, where trans people are conscripted into lengthy psychiatric encounters, without consent and irrespective of the usual legalities, while some General Practitioners refuse to prescribe hormones for trans people. To add to the confusion, in an ironic reversal of the Agnes case, intersex people who have been wrongly 'assigned' at birth are increasingly presenting as trans, as the only means to gain access to the measure of citizenship provided by the *Gender Recognition Act*. Trans people of all ages seem to be caught by a nightmare from which medicine is unable to awake: an anachronistic body-politics, a cultural antipathy turned into a medical diagnosis, a mistaken duty to cure society of diversity. Perhaps this brief account may support one purpose of medical humanities: to awaken medicine from antihuman discourses, policies and practices, and to restore its ethical self.

Acknowledgements

The author has declared that she has no competing or potential conflicts of interest.

References

Colapinto, J. (2000). *As nature made him: The boy who was raised as a girl*. New York: Harper Collins.

Diamond, M., & Sigmundson, H.K. (1997). Sex reassignment at birth. Long term review and clinical implications. *Archives of Pediatrics and Adolescent Medicine*, *151*, 298–304.

Finkler, R.S. (1948). Social and psychological readjustment of a pseudohermaphrodite under endocrine therapy. *Journal of Clinical Endocrinology*, *8*, 88–96.

Meyerowitz, J. (2002). *How sex changed: A history of transsexuality in the United States*. London: Harvard University Press.

Money, J., Hampson, J.G., & Hampson, J.L. (1957). Imprinting and the establishment of gender role. *AMA Archives of Neurology and Psychiatry*, *77*, 333–336.

Money, J., & Tucker, P. (1976). *Sexual signatures: One being a man or a woman*. London: George G. Harrap.

Randell, J. (1973). *Sexual variations*. London: Priory Press.

Reis, E. (2009). *Bodies in doubt: An American history of intersex*. Baltimore: Johns Hopkins University Press.

Schwabe, A.D., Solomon, D.H., Stoller, R.J., & Burnham, J.P. (1962). Pubertal feminization in a genetic male with testicular atrophy and normal urinary gonadotrophin. *Journal of Clinical Endocrinology and Metabolism*, *22*, 839–845.

Accepted for publication: 21 February 2018