

From official transexuality to transexualities

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Sexuality, culture and politics A South American reader

Although mature and vibrant, Latin American scholarship on sexuality still remains largely invisible to a global readership. In this collection of articles translated from Portuguese and Spanish, South American scholars explore the values, practices, knowledge, moralities and politics of sexuality in a variety of local contexts. While conventionally read as an intellectual legacy of Modernity, Latin American social thinking and research has in fact brought singular forms of engagement with, and new ways of looking at, political processes. Contributors to this reader have produced fresh and situated understandings of the relations between gender, sexuality, culture and society across the region. Topics in this volume include sexual politics and rights, sexual identities and communities, eroticism, pornography and sexual consumerism, sexual health and well-being, intersectional approaches to sexual cultures and behavior, sexual knowledge, and sexuality research methodologies in Latin America.



From official transexuality to transexualities*

Berenice Alves de Melo Bento**

First of all, I would like to point out that this is one of the first meetings in Brazil to debate the issue of transsexuals and the intersexed outside the framework of the “psi” sciences¹. This indicates the birth of a new way of interpreting these experiences that moves beyond the notion of pathology and the normalizing framework of medicine.

Over the past few years, a new understanding of these experiences questions the explanations of the psi sciences and its monopolized understanding. I believe *queer studies* has radicalized the Foucaultian proposal of analyzing the medicalization of behavior.

During this period, I have been researching transsexual experiences,² first at a Brazilian public hospital that performs genital reassignment surgery, and later in a transgender association in Valencia, Spain.

When I first started studying the transsexual experience, an unusual “object of study” for sociology, I was frequently asked such questions as: “What are they like? How do they live?” At the beginning of the study, I answered with an air of satisfaction for such interest in “transexuality”. However, my immersion in fieldwork and my exposure to other transgender experiences outside the hospital walls and to *queer studies* itself produced a certain discomfort with the use of the pronoun “they.”

This “they” imposes and establishes an unbridgeable distance, where “we” are the insiders, and “they” are outsiders. No one knows how *they* live or anything about *their* sexualities, dreams and desires. It is easy to exoticize a new field of study, a process that is often disguised as “de-familiarizing”.

When I talked of “their” lives, I contributed to this exoticization, which is a sure path to pathologization. Every account of how “they” lived resulted in a widening of the

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¹ The author refers to the seminar “Sexuality and knowledge: conventions and frontiers,” where her paper was delivered at State University of Campinas, June 2003.

² Research conducted for my doctoral thesis. See Bento (2003b).

margins and the construction of an absolute otherness between “us” and “them”. I was constituted in those narratives as the one who is inside “their” world, empowered by the authority of fieldwork and science. But then the question “How do they live?” began to elicit a different response. Instead of a dissertation about “them”, my answer became an affirmation of a different sort: “They? There is no ‘they’”.

There is no specific process for the constitution of transsexual gender identities. Gender only exists in practice and in experience. It is produced by reiterations whose contents are interpretations of what is male and what is female in an often contradictory and slippery interplay of established gender norms.³ The act of wearing an outfit, choosing a color, one’s accessories, hairstyle, the way one walks...In short, all bodily aesthetics and style are acts that make gender, enabling and stabilizing bodies in a dichotomized order. Biological men and women are constituted in the repetition of acts that are supposed to be natural. Through the reference to a supposed origin, transsexuals and non-transsexuals are made equal in this scheme.⁴

Based on this theoretical assumption, I would like to make a preliminary statement: I do not share the hegemonic pathological view of the medical centers that perform genital reassignment surgery. Their operations are organized around a universalized concept of transexuality.

The general objective of this article is to problematize the medical approach. I will introduce my theoretical grounds, showing that there is no transsexual that is universalized by official documents⁵ and embodied in the protocols of the medical centers that perform genital reassignment surgeries.⁶ In these documents, we find descriptions of transsexual people that are defined as “true”. However, the criteria for classifying a subject as transsexual run into a series of responses to conflicts between body, sexuality and gender identity which are inherent to the transsexual experience.

1 - The stollerian transsexual and the benjaminian transsexual.

Several authors propose theories to explain the origin of transexuality and, at the same time, point out adequate “treatments”. I organize these theories into two main groups: the first operationalizes its interpretations from a psychoanalytic perspective while the second supports its arguments using a biological structure. These two positions

³ According to Butler (1999) “gender norms” are based on dimorphism, heterosexuality and idealizations. “Gender norms” aim to establish what is intelligibly human and what is not; what is considered “real” and what is not; delimiting the ontological field in which bodies are given legitimate expression.

⁴ See Butler (1998a, 1998b, 1999).

⁵ I refer to the “official documents” produced by the Harry Benjamin International Association for Gender Dysphoria and the American Psychiatric Association.

⁶ The medical centers which perform genital reassignment surgeries establish a set of rules that patients must obey. One of the obligations established by these medical protocols is the completion of a minimum of two years of psychotherapy.

conceived two types of transsexuals. The first type I name the stollerian transsexual and the second the benjaminian transsexual, referring respectively to the works of psychoanalyst Robert Stoller and endocrinologist Harry Benjamin. These proposals will be discussed below as structuring parts of what I understand to be “the transsexuality device”.⁷

Rare are the moments when you can see psychoanalysts and endocrinologists entering into openly declared disputes. Generally, they work together in teams which are responsible for producing the medical reports about transsexuals' demands. There is an apparently invisible link between these two understandings. The endocrinologist waits for the day when science will finally discover the biological origins of transsexuality, which would lead to a repositioning of the role and power of psychotherapists who currently have the final say on sex reassignment surgery. Psychotherapists, in turn, expect that psychotherapy and the waiting time will change the “applicant's” disposition to undergo reassignment surgery.⁸

During the *International Seminar on Gender Identity and Transsexuality*⁹, these two positions clearly clashed. French psychoanalyst Chiland Collete (2001) highlighted in her lecture the successful treatment carried out with “effeminate” kids and revealed data showing a high level of regret among people who had performed surgery without undergoing a rigorous psychological treatment. The subtext of her presentation was the reaffirmation of the authority of the psi professionals competency to make a transsexuality diagnosis. By contrast, Dutch scientist Jos Megens (1996), member of the principal association responsible for conducting applied research into transsexuality, the *Harry Benjamin International Gender Dysphoria Association (HBIADG)*, showed data revealing a high level of satisfaction among post-op persons, which contradicted Chiland's presentation. According to Megens, people coming to him already know what they want, and diagnosis criteria are based primarily in self-diagnosis. Chiland disagreed with Megens, stating that: “It is unacceptable, nonsense, for you to agree with self-diagnosis. These people are not able to accomplish it.”¹⁰

⁷ According to Foucault, devices “are formed by a heterogeneous set of discursive and non-discursive practices that have the strategic function of domination. Disciplinary power obtains its efficacy from its combination of theoretical discourses and regulatory practices” (1993: 244).

⁸ “Applicant” is the name assigned in the official documents to those who demand surgery. I use quotation marks to distance myself from the official field which establishes protocols for the operation of teams.

⁹ This seminar took place between the 24th and the 28th of September 2001, in València, Spain.

¹⁰ Self-diagnosis clashes directly with the power of psi professionals to define the fate of persons asking for surgical intervention. Self-diagnosis is indeed what happens, however. While attending reassignment programs, transsexuals establish a strategy of convincing team members in order to obtain a diagnosis that will authorize their surgery. All transsexuals I interviewed reported that they identified their own conflicts by themselves, either by listening to a TV show, speaking with a friend or through other sources. Their visits to clinics only served to deepen their beliefs. An interviewee remembers his psychologist suggesting that he should go to church because his feelings of having a body at odds with his mind didn't exist. When transsexuals seek a hospital with a transgenitalization program, they have already self-defined themselves as transsexuals and, during the time they are required to undergo therapy, they elaborate a biographical narrative and develop strategies to convince team members that they are a man or a woman trapped in the wrong body.

Given the differences between the data on “satisfaction versus regret” presented by Chilland and Megens, one must question the theoretical foundations that underlie these two positions and which generate apparently different diagnoses and procedures. These differences do not prevent us from considering such understandings as structuring components of the device of transexuality. This device is not homogeneous and its internal understandings create a heterogeneous group that seeks effectiveness via multiple paths.

Jos Megens (1996) interprets the transsexual experience from the same theoretical perspective as Harry Benjamin. Chilland (1999, 2001), in turn, was influenced by the theories of Robert Stoller. I will discuss both of these concepts using as an argumentative resource the narratives of individuals who experience a transsexual experience.¹¹ At the same time, I will suggest that the central point of unity between these understandings is the assumption that bodies are naturally heterosexual. Sexuality and gender, according to the device of transexuality, can only be understood when they reference sexual difference.

2 - The Stollerian transsexual

Stoller's book¹², *A transsexual experience*, is an essential reference for professionals who work with transexuality. Written in 1975, it claims that a main indicator of “abnormal”¹³ sexuality (homosexual, bisexual, transvestite and transsexual) in children is the desire to play while wearing clothes of the opposite gender.

For Stoller, the explanation for the genesis of transexuality can be found in the child's relationship with their mother. According to this author, the mother of a transsexual is a woman who, because of her envy of men and her unconscious desire to be a man, is so happy with the birth of her child that she transfers her desire to him.¹⁴ This implies an extreme connection between son and mother, which in turn does not allow the Oedipus complex to arise due to a lack of an effective rival father figure. According to Stoller, entering the Oedipus conflict and solving it are decisive moments for the constitution of a child's gender and sexual identities.

¹¹ I will call biological men who feel as if they are women “female transsexuals” or “transsexual women” and biological women who feel like they are men “male transsexuals” or “transsexual men”. For a discussion of the differences that this naming establishes through the device of transexuality, see Bento (2003b).

¹² Stoller was a pioneer in the systematization and publication of discussions regarding transexuality in the United States. His ideas were initially considered advanced because they sought in social relationships the basis for the formation of gender identities. However, the “social” in Stoller is fundamentally the relationship between mother and child. For Stoller's contribution to gender studies, see Izquierdo (1994).

¹³ For the historical process of the construction of the “abnormal” subject by medical science that has come to occupy the position previously attributed to the “monster”, see “The monster as the ancestor of the ‘abnormal’ of the nineteenth century”, in Foucault (2004). For the construction of the concept of “aberration” as linked to sexual behavior and the role played by hermaphrodites, see also Foucault (2004).

¹⁴ Before starting to “treat” the child who shows signs of transexuality, Stoller examines the mother because it is the relationship that she has with her son and how she plays her gender role that explains the origin of transexuality. According to the author, the further away the mother is from the standards of femininity, the greater is her likelihood of having a transsexual child.

For Stoller, then, the truth about a transsexual can be traced to his childhood and, more specifically, to his relationship with his mother. The essence of a transsexual is his mother. Stoller believes that a diagnosis of transexuality is problematic if the patient has a different mother from the one characterized as the typical mother of a transsexual.¹⁵

Contact with boys who liked to wear women's clothing, play feminine games and with feminine toys led Stoller to develop his hypothesis that, if not "treated" by a psychoanalyst since childhood, these children would develop into transsexuals in their adulthood. Stoller therefore believed that only those boys who could not be subjected to early treatment could truly become transsexual adults. These boys would be a minority among the men applying for gender reassignment and are, possibly, the only ones for whom surgery should be recommended.

Stoller's work is not limited to addressing the causes of transexuality. He also presents cases of children who visited his office and who, through intense therapy, became masculine.¹⁶ According to the author:

There are two counter forces acting on him [the child], currently fighting on both sides of his bisexuality, trying to win over one another, and, at this stage of his life, repeating the forces that previously created his bisexuality. One is his therapist, who (as the representative of society, health, and compliance with external reality) is on the side of [the child's] his masculinity; the other one is his [the child's] family (his mother, in particular), that despite their conscious desire to cooperate with treatment, acts in a way that maintains [the child's] femininity (Stoller, 1975:80).

Stoller's interpretation develops of the transsexual experience is supported by Freudian-oriented psychoanalysis, especially the castration complex. Stoller, in fact, is not far from Freud (1933a) who, in discussing the riddle of femininity, says:

I believe we have found this specific factor [the end of mother-daughter bond], and indeed where we expected to find it, even though in a surprising form. I say where we expected to find it, for it lies in the castration complex. After all, the anatomical distinction [between the sexes] must express itself in psychic consequences. It was, however, a surprise to learn from analysis that girls consider their mother to be accountable for their lack of a penis and do not forgive her for their being, in this way, put at a disadvantage (Freud, 1933a:153).

¹⁵ If we think of femininity as a masquerade (Rivière, 1979), the stollerian mother does not wear a mask, as she does not disguise her anger and penis envy with femininity. She does not admire her husband: instead she competes with him, nullifying him and her son. She likes to wear men's clothes, is authoritarian and does not express "feminine delicacy." According to Rivière, all women wear masks. Stoller would disagree. For him, the mothers of female transsexuals are unmasked women. One may suggest another interpretation, however. Stoller actually agrees with the theory proposed by Rivière insofar as he suggests "treating" the mother initially; in other words, leading her to incorporate the femininity mask. For a discussion of Rivière's thesis, see "Prohibition, psychoanalysis, and the production of the heterosexual matrix" in Butler (1999).

¹⁶ If the patient is an adult, the goal would be to make him abandon his or her repulsion for their genitals, which is understood as something which would allow him or her to become a homosexual, a transvestite or bisexual. In these cases, treatment is considered successful if the patient moves from "sexual aberration" to "perversion".

Sexual difference in this line of thought will also definitely impact upon a boy who, observing a girl's body and her lack of a penis, awakens in his memories

(...) the threats he brought on himself by playing with that organ. He begins to give credence to such threats, and falls under the influence of the castration fear, which will be the most powerful moving force in his subsequent development. The castration complex of girls is also starts with the sight of the genitals of the other sex. They at once notice the difference and, it must be admitted, its significance, too. They feel seriously wronged, often declare that they want to "have something like it, too," and become victims of the "penis envy", which will leave permanent traces on their development and on the formation of their character and which will not be surmounted in even the most favorable cases without a severe expenditure of psychic energy (Freud, 1933a: 154).

The explanation for a girl's connection with her father lies in her original desire to possess a penis, which is denied by the mother. However, the feminine situation, or femininity, only imposes itself if the wish for a penis is replaced by the desire for a baby. Through strong psychic energy expenditure, "the baby takes the place of the penis in accordance with an ancient symbolic equivalence" (Freud, 1933rd: 158). That is to say, motherhood and heterosexuality are fated in the constitution of what Freud calls "*normal femininity*" (1933a: 163).¹⁷

(..) A mother can transfer to her son the ambition she has been obliged to suppress in herself. She can expect from him the satisfaction of all that has been left over from her masculinity complex. Even a marriage is not safe until a wife succeeds in making a child out of her husband and acts as a mother to him (Freud, 1933a:164).

Here, then, we find the "stollerian mother". She is a woman who cannot resolve her castration complex. Her penis envy has no limit. The care and pampering she gives to her child are characterized by excess. Her son is her phallus, which creates an extreme symbiotic relationship between him and her, excluding the father figure. With this exclusion, the Oedipus complex cannot be established.

The transsexual experience reverses this logic. Penis envy becomes, metaphorically, "vagina envy". The penis (the universal signifier) loses its power and is transformed into "something that will not let me live", "a piece of meat between my legs", according to testimonials of transsexual women when justifying their desire for reassignment surgery. The same logic holds true for male transsexuals when they refuse to "fit" the definition of "normal femininity" and deny the destiny of motherhood, usually requesting breast

¹⁷ Regarding the castration complex and its resolution, Freud also affirms that: "(...) Not until the emergence of a wish for a penis does the doll-baby become a baby conceived by the girl's father and, thereafter, the aim of the most powerful feminine wish. Her happiness is great if, later on, this wish for a baby finds fulfillment in reality and quite particularly so if the baby is a little boy who has the longed-for penis." (1976: 158).

removal as their first surgery—precisely the body part which visibly marks them out as women. Both transsexual women and transsexual men develop techniques to hide their penis and breasts, respectively, even before performing surgeries.

Stoller's theories, based on his psychoanalytic perspective, have been weakened by the theories which eliminate the penis as a symbol of *status* and/or as the original referent. This has resulted in a challenge to the direct link between gender, sexuality and subjectivity. From the stollerian viewpoint, the gender performances of transsexuals must be interpreted and normalized as disorders, aberrations and disease. Pathologization individualizes the conflicts, since the expert will focus upon the mother-child dyad or the mother-son-father triad. By discussing conflicts as "personal problems" or linking them exclusively to family history, stollerians are able to save castration theory and the canons that underlie the binary reading of bodies—the foundation of the heterosexual matrix.

The therapist's task, according to Stoller, is to induce the Oedipus conflict so that a "normal" femininity or masculinity may arise. The author reports cases of mothers who took their children to his office, desperate because their sons liked to play with dolls, wore "improper clothes" and indulged in other "abnormal" behavior. According to the author, the sooner the mother became aware of these "deviations", the easier the "treatment" and "cure" was.¹⁸

We feel that it does not matter how much these children may experience the feminine part of their bisexuality: femininity is not yet fixed as it is in adults. We begun to have some success in the treatment of children and we thus believe that femininity can be changed when we show them a new "country." We are optimistic that, after lamenting their losses, these boys will realize that it is worth being a man. We hope that, since it is easier for children to learn the language of a new country than it is for adults, even "displaced" children may learn the language of masculinity (Stoller, 1975: 93).

An indicator of the treatment's success (or that the Oedipus conflict was properly induced) is seen when "*a broad hostility towards the mother begins to appear.*" (Stoller, 1975: 33)

Stoller names this treatment "*therapeutically induced Oedipus complex*" (1975: 101). The success of this induction occurs when the structural elements of hegemonic male

¹⁸ Analyzing the case of a child who was brought to his office by his mother, Stoller says, "She waited until he was 5 years old to seek help (...). Without treatment, it may be too late for the child to develop as a male person" (1982: 42). According to Stoller, the therapist can only act on the gender identity of a child if the "problem" is detected early on, because after a certain age it becomes irreversible, fixing the subject definitively in a certain position within gender relations and sexuality. The period of flexibility would be around the first year of life, when the child develops the fundamental and unalterable roots of his masculinity or femininity.

identity become emphasized.¹⁹ From the moment the penis is recognized as something which differentiates between masculine and feminine, new meanings are attributed to the genitalia.

Stoller describes an example of an induction which he claims was successful:

The boy began to appreciate his penis (for example, he started to stand up when he urinated, as opposed to sitting down). He developed phobias; physically attacked women, dolls and girls with pleasure rather than anger, a dominant affection. His jokes seemed more intrusive, such as throwing and hitting balls at his mother and other women (Stoller, 1975: 29).

After the boy was encouraged to express hostile feelings, it was observed that he gradually became more aggressive and “began punching Barbie [a doll] violently in the face, shouting angrily, ‘shut up’, or ‘take that, Barbie’, or another girl’s name” (1975: 105). Some indicators of successful treatment, other than aggressiveness, were identification with the male therapist, sexual curiosity, aggression and increasing distance from the mother. According to Stoller, “these signs of the Oedipus complex seem to be the product of therapy” (1975: 105).

In order to prove that it is possible to “cure” those who display effeminate behavior, Stoller relates several stories of children who have managed to recover their masculinity, thus preventing them from becoming transsexual adults. One of these children made a list of rules that a real boy should follow. This is once again reproduced by Stoller as an example of a successful induction:

1 - Do not play with girls; 2 - Do not play with girls’ dolls 3 - Do not wear girls’ clothes; 4 - Do not even look in your sister’s closet; 5 - Do not sit like a girl; 6 - Do not talk like a girl; 7 - Do not stand like a girl; 8 - Do not comb your hair like a girl; 9 - Play like a boy; 10 - Do not wear make-up; 11 - Do not let your room look like a girl’s room; 12 - Do not pose; 13 - Be a boy (Stoller, 1975: 102).

This child was able to “recover” the masculinity which was being emasculated by his mother. The therapist thus successfully played the role of a “(...) representative of society, health and compliance with external reality” (Stoller, 1975: 80).

I agree with Billings & Urban (1982) when they suggest that in the case of transexuality, doctors cure neither the body nor the mind, but perform a moral function.²⁰ The device of transexuality puts into operation what is probably one of the most dramatic examples

¹⁹ Regarding “hegemonic masculinity” and “masculine identity”, see Bento (1998) and Cornell (1987 and 1995).

²⁰ The authors spent four years analyzing and interviewing dozens of physicians and patients in various clinical environments in the USA. Urban (1982) was a participant observer for three years (1978-1980) in a transgenitalization clinic.

of contemporary professional authority. This authority is obtained and based on an inversion: it is assumed that the source of conflict is the subject and not gender rules. Through the naturalization of conducts, the depoliticization of the conflict eliminates engendered power relations that naturalize the truths that underpin the operation of the device.

2.1 – Where is the overprotective mother?

The relationships between the transsexual people who were interviewed and their mothers and families, in general, are far from Stoller's model. These transsexuals' stories show different degrees of closeness with their mothers, ranging from a certain proximity to total absence. For Sara, Carla and Mary, their mothers were absent during large periods of their lives.²¹

Sara defines her mother as “very methodical and prejudiced.” At age 16, Sara decided to leave home because she couldn't stand to be under her mother's control anymore. At this point in her life, Sara could not define her conflicts, which were experienced in secret. She was moving away from her mother, from one place to another, from one relative's house to another's. Currently, Sara defines her mother as a stranger. At the age of 22, now in college, Sara began to wear women's clothing. When she noticed the visual changes her “son” had produced, Sara's mother commented: “You can undergo a thousand plastic surgeries, but you'll never become a woman.”

Sara: Do you know what my mother told me? That if I want to become a real woman, I'll have to perform many surgeries on my face, on my whole body (...). Now what can you expect from a mother who says things like that? How can she talk to me like that? She's the one who always abandoned me, always left me alone... She abandoned me! Abandoned me! My father? He does not even count. But she abandoned me, not because I'm like what I am: I only came out recently. It was always like that. It never changed.

Carla went to live with a maternal uncle when she was still a child. Those times were “hell” for her because her relatives treated her like a “slave”. Like Sara, Carla also had to hide her interest in “girls' stuff.” She began to develop a closer relationship with her mother at age 16, when she went to live with her.

Maria's mother was the mistress of a farmer who had three children from her first husband. When Maria was born, her father demanded that his legitimate wife take over her education. Maria used to meet her biological mother during holidays. Her father died when she was five. At the age of 12, Maria ran away from home and started to

²¹ For a better understanding of the interviewees' stories, see Bento (2003b).

work because she could not stand her father's wife's mistreatment and her biological mother's consent to this. At the age of 16, Maria became a sex worker.

Maria: I was twelve when I ran away. I went to my mother's. I stayed with her for a while, during nine months, and my mother tried to convince me to return to my father's house, to the people who raised me, who looked after me, right? I said: "I am not going." I was afraid of my stepmother, who used to beat me because of who my mother was. She mistreated me so much! She twisted my ears and even wounded me sometimes. When I ran away to find my mother, my head would hurt like hell and it was covered in wounds because [my stepmother] used to beat me with a stick.

These narratives lack the presence of an overprotective strollerian mother, jealous and envious of the penis, emasculating her son through exaggerated care and affection. Instead, abandonment, prejudice and lack of maternal references are the main features of these transwomen's stories.

The same motif is repeated in Katia's story. Her relationship with her mother is strongly marked by feelings of rejection. When interviewed after surgery, Katia said she wanted so much to return to her hometown, where her mother lived, in order to show her mother that she had finally got what she wanted.

Katia: As soon as I finish my surgeries, I want to return and meet my brothers and my mother. I will arrive looking very pretty, and preferably with a boyfriend. I want to prove to them I was right all along.

Katia's mother always rejected her, although Katia was responsible for the household while her brothers worked in the fields. She remembers her father as a very caring and protective person. Katia recalls that when a visitor came to the farm where they lived, her mother would ask her not to appear in the living room. Her uncles would not let their children touch Katia's hand, because they were afraid of the children would "catch this disease".

Katia: Oh, I was beaten so much! So much and so many times and I did not understand why my mother would do it. I think she saw me being born as a man and saw that man suddenly turning into a woman, although I never felt anything in my penis. I never got an erection.

My mother tried to force me, beat me, to change the things I liked, the way I played... But it is interesting, as I told you: she beat me, but forced me to take care of the house, do the washing-up and cooking, take care of the plants. When my father was there, he would even help me, defend me. And I had my little toy house. It was made of wattle-and-daub. There was even a little stove like that one [she points to her home's wood stove]. But nothing is worse than rejection! I wanted to have her

around to tell her when I was in love, when I saw a cute guy... Recently, she's begun to call me "daughter", but before that she didn't call me anything, she did not know what to call me.

Andreia, Helena and Peter maintain relationships with their families. Their mothers are not defined as "loving women", however. Andreia, who lives with her parents, acknowledges their difficulties in accepting her situation, especially in the face of pressures from their neighbors.

Helena lost her father when she was 10. When she started to behave like a woman, enjoy women's clothing and hang out with gay friends, she was already a teenager. Her mother worked hard to raise her three children, not having time to "dedicate to pampering" any of them.

Peter's story is similar to Helena's. He lost his father when he was a child. His mother had to raise the children on her own, spending a lot of time away from home. Peter's relationship with his mother was tense, because she used to condemn him for "behaving like a man." In order to put an end to these quarrels, Peter even tried dating a boy and wearing women's clothing, but had no success in these efforts, which only increased his conflicts.

Marcela and Barbara claimed to have unconditional love for their mothers. According to Marcela, "my mother is everything". Barbara lost her mother when she was 25, and although her mother did not support her "different" behavior in relation to other boys, she was the only family tie Barbara had.

Barbara: I think my mission on earth was to take care of my mother. My father never called me. He only brought me into this world and then abandoned us. My mother did not have much time. [She was] always working in other people's houses. I even had to live with my aunt until I was 10, when I was raped. My three cousins raped me. It was only then that I went to live with my mother. She never really accepted the way I was, but I understand her.

These family histories are marked to a greater or lesser degree by poverty, by women who were abandoned by their husbands, by fragmented families. The stollerian view would seek out in the relationship between the children and their mothers the explanation for the child's transsexualism and probably come to the conclusion that none of the above cases represent "real transsexuals". Because of this, the transsexuals would be barred from performing reassignment surgery and would possibly be assigned therapy in order to accept their homosexuality. Although transexuality is an experience that relates to gender issues and therefore says nothing about an applicant's sexuality, therapists interpret gender identity by linking it directly to sexuality.

According to Stoller's point of view, surgery would be recommended only as a last resort and the "real transsexual" would be very rare. In order to prevent gender identity from becoming "a freak show", parents—and especially mothers—are required to be very alert to their children's behavior. Therapeutical intervention would be successful if it were performed early on in life, when it is still possible for social factors to intervene in the trajectories that gender identity follow. After this brief period, any "treatment" would be jeopardized. Thus the importance Stoller places on childhood behavior (games, colors, clothing, relationship with parents and relationships with friends) and play during therapy in producing a diagnosis of transexuality.

3 - The Benjaminian transsexual

The construction of definitions for determining "true transexuality" has not been limited to Stoller's work. Harry Benjamin has devoted part of his intellectual life to this task and to developing another explanation for the genesis and the "treatment" of transexuality. There is thus a dispute, sometimes implicit other times explicit, among psi professionals regarding the criteria which should be used to establish the ultimate truth when determining transexuality.

From Benjamin's point of view, "sex" is comprised of various kinds of sex: the chromosomal (or genetic), the gonadal, the phenotypic, the psychological and the legal. Chromosomal sex is responsible for determining sex and gender (XX for women and XY for men).

When an applicant begins a gender identity program, one of the first required tests is the karyotype. The detection of a chromosomal malformation changes the diagnosis from transexuality to hermaphroditism. In this case, reassignment surgery is automatically recommended. For many, this exam represented a moment of hope:

Marta: I thought, "I hope I have a problem." I really wanted this to happen. But unfortunately, I am now convinced that the origin of transexuality is social.

Benjamin considers that chromosomal sex plays a key role in determining gender identity. According to this author:

Barring accidents during gestation, which could bring about hermaphroditic deformities, the newborn boy or girl will reveal their sex through the presence or absence of primary and secondary genital organs. The testes (and the ovaries) are "primary" because they are directly concerned with reproduction. The secondary organs of the male are the penis, scrotum, prostate, masculine hair distribution, a deeper voice, and so on, and a masculine psychology (such as aggressiveness, self assurance and related traits). All these are further developed and maintained by the

testicular hormone called androgen. The secondary female characteristics are the clitoris, vulva, uterus (with its menstrual function), vagina, breasts, a wide pelvis, female voice, female hair distribution, and the usual feminine mental traits (shyness, compliance, emotionalism, and others) (2001: 16).

“Tell me which hormones you have and I will tell you who you are!” is perhaps the best way to summarize Benjamin’s ideas. The riddle of gender identity is thus located in hormones for this author, and all discussions regarding this topic are doomed to failure if they do not take this inexorable truth into account.

Returning to the definition of the sexes, gonadal sex is divided into two: germinal sex (used for procreation) and endocrinal sex. For Benjamin,

Germinal sex serves for procreation only. **The normal testes produce sperm and where there is sperm, there is maleness. The normal ovary produces eggs (ova) and where they are found, there is femaleness.** (...) The masculine man and the feminine woman are primarily inherited qualities, but to a large extent they are also the products of endocrinal sex (2001:10) [our emphasis].

Determination of gender and sexuality is thus directly linked to the body’s hormonal composition. Finally, Benjamin presents psychological sex as the most flexible of all the sexes, sometimes even occurring in opposition to the others: “Great problems arise for those unfortunate persons in whom this occurs. Their lives are often tragic and the bulk of all the following pages will be filled with their misfortunes, their symptoms, their fates and possible salvation” (Benjamin, 2001: 16). For Benjamin, then, it’s this sort of opposition between the biological and the psychological that characterizes the “transsexual phenomenon”.

Normality occurs when the various constituent levels of sex are not in disagreement. A behavior that shows any sign of shifting between these levels is a symptom of some disease. Besides hormonally determining femininity and masculinity, the natural heterosexuality of bodies incorporates the different kinds of sexes into “sex.”

It may seem contradictory that Harry Benjamin, who believed in the biological determination of gender identity and sexuality, has faithfully defended reassignment surgery, given that transsexuals can be seen as proof that his theories are wrong. In Benjamin’s opinion, however, there is no contradiction. He claims that with the development of the biomedical sciences, an answer to this “phenomenon” can be found. For this reason, Benjamin constantly criticizes psychoanalysts and psychologists who advocate listening therapy as the most appropriate treatment for transexuality.²²

²² There is currently a group of scientists conducting research on the Netherlands with the brains of deceased transgender women and men. They are mainly researching the hypothalamus, which is supposed to be responsible for behavior, including sexual behavior. This team is led by endocrinologist Gooren (papers s/r), an advocate for and researcher of the neurobiological causes of transexuality.

Self-diagnosis is defended as legitimate by Benjaminians. For Benjamin, surgery is the only possible therapy for “real transsexuals”. By locating the origin of gender identities in chromosomal sex, Benjamin indicates that the subject’s ultimate truth should be sought not in their behavior, but in the biology of bodies, especially in hormones. The immediate consequence of Benjamin’s assertions is the definition of transexuality as a disease.

According to Ramsey (1998), an author who partly agrees with Benjamin,

(...) As much as this sounds harsh, transsexuals are not normal. To say that a transsexual—or someone who has a cleft palate or congenital heart defect—does not have an anomaly is only an illusion. But to say that all of these patients may be approximated to normality with the help of medicine and psychology is correct... As much as they feel “normal” inside about their gender identity, transsexual people are not really complete or whole if the inside is not consistent with the outside. Once again, to say that the transsexual does not deviate from biological and psychological norms is misleading. In my opinion, it is preferable to consider the real problems inherent in this disorder and to solve them rather than to deny them (Ramsey, 1998: 80).

Benjamin has selected certain indicators which he considers constants in the stories of transsexuals and which establish the parameters for defining the “true transsexual”. It did not take long for these criteria to be considered references in evaluating applicants for reassignment surgery. These indicators have been established in terms of features that establish transsexual identity from a limited number of attributes. I am referring here to the process of the constructing of a universal transsexual person.

This universalization has established only one possibility for the resolution of conflicts between body, subjectivity and sexuality and at the same time has differentiated transexuality from other “disorders” (in Benjamin’s conception) such as homosexuality and transvestism. Transexuality has thus gained its own statute and a different diagnosis in this scheme of things. According to Benjamin:

Some investigators believe that these two conditions, transvestism and transexuality, should be sharply separated, especially on the basis of their “sex feelings” and their chosen sex partners (object choices). The transvestite—they say—is a man who feels himself to be a man, who is heterosexual and merely wants to dress as a woman. The transsexual feels himself to be a woman (“trapped in a man’s body”) and is attracted to men. This makes him a homosexual, provided his sex is diagnosed from the state of his body. But in diagnosing himself in accordance with his female psychological sex, he considers his sexual desire for a man to be heterosexual, that is, normal (2001: 30).

The “true transsexual”, for Benjamin, is fundamentally asexual and dreams of having the body of a man / woman, obtained through surgical intervention. Surgery allows them to enjoy the social status of the gender with which they identify, at the same time allowing the exercise of a proper sexuality with the appropriate body. In this sense, then, heterosexuality is defined as the standard from which one judges what is “a real man and a real woman”.

During my fieldwork, I had contact with many transsexual persons who have an active sex life, who lived with their partners before surgery, who undergo surgery not to maintain heterosexual relationships and consider themselves to be gay and lesbian. I approached others who do not believe that surgery will enable them to achieve masculinity or femininity, because they claim their gender identities are not determined by the existence of a penis or a vagina. These transsexuals do not claim rights to reassignment surgery, but instead the legal right to use the identity of the gender they identify with, through changes in the name and sex specified on their official documents.²³

3.1-From the Benjaminian transsexual to other transexualities

The definitions proposed by Harry Benjamin in his book “The transsexual phenomenon”, published in 1966, still exert great influence upon the construction and determination of what is considered to be the “true transsexual”. This is characterized by:

- 1 – A total psychosexual inversion; 2 – Living and working as a woman, but wearing clothes is seen as being not enough; 3 – Strong gender discomfort; 4 – A longing for relationships with normal men and women; 4 – Urgent requests for surgery; 5 – Hating one’s male organs (Benjamin, 2001: 45).

If all transsexuals hate their bodies, one can assume they have no sex life. Therapeutic listening is carried out in order to observe if these people feel they can obtain some pleasure with their genital organs. If they can, they will be probably be diagnosed as non-transsexuals. The “official transsexual” is almost asexual, since he or she cannot bear to touch their own organs.

The stories of games and sexual negotiations that some of my interviewees perform with their partners allow us to challenge the conception of the “true transsexual”. Katia maintained relations with a man for almost three years. They lived together and had a sex life that was “satisfactory”, according to her. Pedro defines his sex life as “good” and considers himself to be a good sex partner. He has had many “affairs”. He lived

²³ This is one of the main debates within the Spanish transsexual movement, given that there is a proposal pending in the Spanish Senate to make document changes conditional upon completion of reassignment surgery. For the Collective of Transsexual Women of Catalonia, legal changes of name and sex should not be conditioned by surgery.

three years with a partner and, similar to Katia, his partners (short or long term) did not know he was a transsexual.

Pedro: “I told them I did not like them touching my chest and we only had sexual intercourse in the dark. I even had a prosthesis that I hid very well. Now I’m living with another girl.”

For many years, Maria was a sex worker. She had several stable affective relationships. “I love sex”, she says.

These stories erode the image of the transsexual subject as asexual. All the interviewees except for Sara were sexually active. The present article is not the place to discuss the complexities and negotiations that take place with regard to sexuality in these contexts. I would like to emphasize, however, that the construction of the asexual transsexual, so dear to Benjaminians, finds no support in many of the life stories of the people who define themselves as transsexuals.

If people hate their genitals it is basically because the organs do not allow them to have sex. Surgeries would thus supposedly enable them to resolve this issue, according to advocates of the Benjaminian transsexual model. The main motivation behind gender reassignment surgery, then, becomes the desire to exercise normal sexuality as a normal person, with an appropriate body. The supposed natural heterosexuality of the body thus functions like a matrix that gives meaning to the differences between sexes.²⁴ It is from this matrix that the transsexual experience is interpreted.

Many transsexuals think it is not the desire to maintain heterosexual relationships that leads them to undergo surgery, however. Many transsexual women define themselves as lesbian and male transsexuals often define themselves as gay.

Annabel was married for 20 years. She had a daughter and adopted a boy. In her relationship with her ex-wife, she performed tasks that are socially linked to feminine gender. She was never able to convincingly play the sexual role of the virile man. Her conflicts were maintained in silence for many years. There came a time, however, when Annabel could no longer live with her doubts and anxieties. When she finally sought the help of experts, she was still with her ex-wife. Her marriage became “unsustainable” when she started wearing women’s clothes and joined a transsexual group. The love Annabel felt for her ex-wife did not diminish, however. All her fantasies and erotic desires were related to the female world and involved her wife. In Annabel’s case, discussion of surgery and hormone therapy is not attached to the desire to maintain heterosexual relationships. After her divorce, in fact, Annabel’s first stable relationship was with a woman.

²⁴ For a discussion of the construction of dimorphism, see Laqueur (1992). For a discussion of the “heterosexual matrix”, see Butler (1993, 1999).

Juana Ramos²⁵ discusses the construction of her gender identity, the representation of the body and the intersection of these levels in the construction of her sexuality. Her discussion provides a multiplicity of possible connections with discussions regarding the construction of identities:

In my case, being sexually attracted to women (whether they are transsexuals or not: I do not make distinctions) was a personal conflict that required a true effort in terms of accepting myself as lesbian, in a way which is completely different from accepting myself as woman. This dissociation is not easy, although it may seem to be.... Over the years, lesbianism among transsexual women has gained increased visibility. This has resulted in more groups taking positions both for and against it. Back in the day, these situations constituted one or two isolated cases. But now a new category has been created: “lesbian transsexual women”. [This involves] lesbian meetings which bar access to transsexual women, lesbian groups offering special invitations to transsexual lesbians, non-transsexual lesbians who have begun to wonder about the possibilities of having or not having sex with transsexual lesbians, etc... (Ramos, 2002: 20).

A new category has thus arisen which is internal to the transsexual experience under discussion: lesbian transsexual women. The visibility of this new identity configuration has caused a radicalization of the displacements initiated by this experience. It is no longer just the body that presents itself as being at odds with gender identity: sexuality has also moved away from biological norms.

The life stories of Annabel and Juana are placed in a complex web of meanings that open up space for new interpretations of sexuality and its relationship with gender, bodies and subjectivities. Undergoing surgery and coming out as a lesbian are experiences that shuffle the binary categories which produce bodily appearances, raising questions regarding the causal relationship between surgery, sexuality and the “true transsexual.”

Moisés describes himself as a gay transsexual man. His story also points to the scrambling of boundaries and the displacement of sexual and gender identities:

In many cases, having a loving or sexual relationship with men may cause doubts and contradictions concerning their sexual identity, perhaps making them question their homosexuality or heterosexuality (the same thing happens in relationships with women). Is there competitiveness with that other man in the relationship? What about the threat of the other person's heterosexuality? And what happens in a homosexual relationship between two male transsexuals?

²⁵ Juana Ramos is the president of *Transexualis* in Madrid. She is also the coordinator of the Lesbians and Gays State Federation /Spain.

Ah! And the phallocracy. The cult of cock [penis]! How do you move in a circle where everyone assumes that all men have a cock, except for you? What happens when you do not know what you have? (Moisés, 2002: 30) ²⁶

The existence of lesbian and gay transsexuals contradicts any possibility of comprehension for those who believe in the device of transsexuality: “So I do not understand the reason for undergoing surgery. If he was a man and he liked a woman, or she liked men, then why do surgery? What’s the point of having a vagina if what you want is to have intercourse with other woman?” These were the questions a psychologist asked when she encountered these sexual configurations among transsexuals.

Many psi professionals cannot understand homosexuality among transsexuals. But when a person says “I have the wrong body. I am a man / woman trapped in the body of a woman / man”, it does not mean that being a woman is the same thing as being heterosexual.

Those who operate the transsexual device in the psi fields claim that sexuality plays a role in determining gender identity and that it can only be understood when referenced to bodies’ dimorphic structures. When society defines that the true man / woman is actually heterosexual, we can immediately assume that a transsexual man / woman also should be heterosexual and devices are built around this fact.

The definitions of what is a “real man/woman” influence the definitions of what is a “true transsexual” based on the values that structure genders in society. These are concepts that guide doctors and health professionals when dealing with transsexuals. If society says that heterosexuality is normal, then when someone affirms that “I’m a woman / man”, it is like they are assuming heterosexuality as a natural fact which determines the coherence and existence of sexual bodies. Gender reassignment surgery would thus allow them to “naturally” exercise their heterosexuality.

The reasons why someone decides to undergo surgery are not always the same and are often not immediately related to sexuality. They vary according to the moments and conditions of each biographical trajectory. Andreia, for example, only felt the need to undergo surgery because she realized that a vagina was important in order for her to be considered a woman, not because she immediately wanted one upon understanding herself to be a transsexual. According to Andreia:

I believed I could live normally like a lady without any problems, that this thing between my legs would not matter. I did not think anatomical sex would cause any inconvenience to me. But I thought one thing and life showed me another. When I

²⁶ Moisés is the director of the Male Transsexuals Collective from Catalunya. (Text read at the State Meeting of Transsexuals. Valencia, Spain, 02 to 04 November 2002).

went to school at age ten, I began to realize the difference and, even though it didn't make any difference to me, it started to make a difference. That's when the problems began.

I do not want a vagina just because of sex. I want to prove to people that I can take a shower in the bathroom with other women and be happy about it. They will not doubt if I am woman or a man.

To Andréia, the vagina is not fundamentally related to her sexuality. It represents, however, a currency she must trade in support of her gender identity in social relations.

So far, definitions of the “true transsexual” have been contrasted with the diverse experiences of conflict between body, subjectivity and sexuality found among those people who are living the transsexual experience. Now, however, we shall turn to discussing the possible disruptions and displacements that the transsexual experience causes in gender norms.

Transsexual experience is characterized by detachments and shifts. When someone says: “I am a man/woman in the wrong body”, they are stating that their gender is at odds with their sexed body. There is no such correspondence between anatomical and cultural levels, however. Instead, we face a diverse and plastic set of bodies: a clitoris that, through the use of hormones, has developed into external sex organs; wombs that do not procreate; prostates that do not produce semen; voices that change tone; beards, mustaches and hair that covers “feminine” faces; unexpected breasts.

Recognizing the existence of these shifts does not mean, however, that all transsexuals require the same surgeries. Many do not want surgery at all, limiting their demands to changes in documents. In such cases, the appearance of the desired gender is obtained through the use of hormones, silicone and makeup.

The changes claimed by transsexuals are located in body regions which have been the object of constant discursive shifts, mainly involving religious and scientific understandings. Whether interpreted as sin or pathology, this experience casts doubt upon some of the categories that underlie our thoughts and structure our perspectives regarding the engendered world. In this sense, we can see the subversive potential of such experiences, since they shift and displace notions of “real” (true) and “fiction” (lie). The body is no longer a safe means of positioning the subject in the polarized world of genders and “gender reality” becomes as fragile a concept as anything else. The transsexual body puts this “truth” in a maze: it is no longer possible to have a judgment about supposedly stable anatomies based simply upon the clothing that covers a person's body.

Therefore, it seems to me that the transsexual experience allows us to challenge the foundations that underlie gender norms and questions about “what is a man, and a woman?”.

When these categories are put to the test, they become confusing and undermine the idea of a gender identity rooted in the body. The real and the unreal become confused. The “real”, something we assume to be the naturalized knowledge of the self, turns out to be a reality that can be changed and reconsidered.

4 - Final considerations

The purpose of this article has been to introduce and discuss the theoretical frameworks employed in the device of transsexuality. I emphasized that the two main constituent perspectives employed in this device are based on the presumption that bodies are naturally dimorphic and heterosexual. In other words, that gender norms provide the central arguments that organize these theories.

From the accounts of people whose lives engage in different levels of conflicts and differences with gender norms and who often diverge from what has been officially established as “true transsexualism”, one can conclude that there is no such thing as the “true transsexual”. Instead, different transexualities exist and experiences must be understood as interpretations regarding male and female which are negotiated in acts.

The “official transsexual”:

- a) Hates his/her body;
- b) Is asexual; and ...
- c) Wants to perform surgery so he/she can exercise the normal sexuality, namely heterosexuality, with the appropriate organ.

I have suggested instead that requests for gender reassignment surgeries are not motivated by sexuality and are not asexual: they claim changes in bodies so that those bodies’ inhabitants can achieve social intelligibility. If society is divided into male bodies and female bodies, those who have no such foundational correspondence tend to be left out of the category of “human”. I also noticed in the narratives I collected that sexuality does not have a direct relationship with gender identity. When someone says “I am a man/woman in the wrong body”, this should not be interpreted as if they were affirming that being a woman/man is equal to being heterosexual. The stories of lesbian transsexual women and gay transsexual men indicate the need to interpret gender identity, sexuality, subjectivity and the body as relatively independent modalities.

The transsexual experience highlights elements that reveal the functioning of gender

norms, creating a contradictory field of movement and fixation of those norms. The moment we let go of the body as the demiurge of wishes and identity positions, it leads us to question what underlies the experiences of transition between genders and also what ultimately sustains the bipolar sexualities of today's pathologizing norms.

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