Gone, Missing

Queering and Racializing Absence in Trans & Intersex Archives

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WHO APPEARS IN THE MEDICAL ARCHIVES THAT DOCUMENT THE treatment of intersex and trans subjects? Who is missing? What can we learn from these absences?

This chapter takes on these questions, examining the phenomena of patient disappearance and the broader archival absence of queer folks and folks of color in the archives of US-based sexologist John Money, who served as one of the primary architects of trans and intersex medical pathologization (see Rubin, "'An Unnamed Blank that Craved a Name,'" this volume). I read these absences and disappearances as a method of resistance to the imposition of what María Lugones has termed the modern/colonial gender system (2007), and explore the implications of the fact that folks whose desires for transformation run counter to hegemonic, white, bourgeois understandings of masculinity and femininity were systematically prevented from accessing technologies of transition, deemed unacceptable candidates or noncompliant patients. By "technologies of transition," I mean the ensemble of medical practices utilized in the process of transition, both hormonal and surgical. This exclusionary, highly regulated system of medical gatekeeping has prompted two linked phenomena: a legacy of trans folks tailoring experiential narratives—lying—to fit the heterosexist, highly binarized logic utilized by classic models of transsexuality, as well as a history of intersex folks critiquing the pathologization of intersex traits and refusing to be interpellated by the medical establishment as disordered, in need of surgical and hormonal gender normalization.

Racialized, classed, and queer absences are central to understanding how access to technologies of transition have become intensively compromised for poor folks, trans folks of color, and gender-nonconforming, nonheterosexual folks while they have, simultaneously, been coercively imposed on intersex folks in the interest of normalizing our divergent forms of sexed embodiment. This selective utilization of technologies of transition helps explain why it is we currently lack holistic approaches to trans and intersex health that move beyond surgical and hormonal techniques of gender normalization and focus more heavily on the structural violence that too often compromises the life chances of trans and intersex subjects.

Repairing Gender: Tactics of Medical Normalization

John Money opened the first clinic in the United States that specialized in intersex and trans conditions—the Johns Hopkins Gender Identity Clinic. This clinic began performing gender reassignment surgery on trans and intersex folk in 1966, and enabled Money to become one of the first sexologists to engage in the substantive study of trans and intersex conditions, treatments, and long-term outcomes. In 1968, he published *Sex Errors of the Body and Related Syndromes*; in 1969, he coauthored *Transsexualism and Sex Reassignment*. These books laid the theoretical and practical groundwork for contemporary forms of intersex and trans diagnosis. They were rapidly translated; Money quickly became an international authority on intersex and trans counseling, surgery, and continued care. He also coined the term "gender role"; our contemporary conceptual habit of separating sex from gender is rooted, in part, in his work.

I approached his archives skeptically. As an intersex person, I am deeply critical of his treatment protocol, which advocates binary gender assignment and genital reconstructive surgery. These surgeries were (and are) performed on infants and toddlers nonconsensually, because Money believed gender identity was solidified before the age of three and that, after that, it would be too psychologically destabilizing for intersex folk to grow up with atypical genitalia. He argued that "gender role is so well established in most children by the age of two and one-half years that it is then too late to make a change of sex with impunity" (Money, Hampson, and Hampson 1955b, 290).

For Money, a "normal" vagina was one capable of intromitting an average-sized penis. This was his gold standard for a well-realized genital reconstruction, and it always, in the case of intersex patients, came coupled with the surgical removal of the clitoris (considered "abnormally large," too phallic for someone being reared as female). He argued that this was an A-OK practice that didn't compromise sexual sensitivity in the least:

> There has been no evidence of a deleterious effect of clitoridectomy. None of the women experienced in genital practices reported a loss of orgasm after clitoridectomy. All of the patients were unanimous in expressing intense satisfaction at having a feminine genital morphology after the operation. . . . There is considerable evidence that an amputated clitoris is erotically sensitive. (295)

It is apparent that, for Money, gender-typical aesthetics trumps erotic functionality. His musings, here, also raise an important question: How can something missing—the amputated clitoris—be "erotically sensitive"? While I certainly don't buy Money's assertion that a missing clit is erotically sensitive, I do want to think about the effects of other forms of absence in relation to coercive forms of medicalized transition: patients who go missing, who refuse to show up for medical appointments, as well as those beings who can't get their foot in the door of the clinic because they're too poor, too queer, too gender-nonnormative.

Money argued the importance of referring to vaginas, reductively, as "baby tunnels" (Money, Hampson, and Hampson 1955b, 295) when discussing anatomy with intersex children. His logic was, if you avoid mentioning the clitoris, intersex children won't realize it exists, and thus won't be upset that they had theirs removed! He also advocated years of invasive continued care, including regular manual dilation of the reconstructed vagina by the child's caretakers (until they were old enough to do so themselves) and a lifelong hormonal regimen meant to "normalize" secondary sex characteristics. He encouraged doctors and family members to lie to the child about their intersex condition. Parents were encouraged to go to great lengths to obscure the realities of invasive forms of gendered normalization, and to do so in the name of protecting intersex folks from the supposedly devastating truth of their own nonconventionally sexed embodiment. As if we wouldn't figure it out!

The literature within the growing field of intersex studies, not surprisingly, has unequivocally critiqued the medical protocol developed by John Money. Anne Fausto-Sterling, in her landmark volume *Sexing the Body,* reviews the modern medical management of intersexuality and concludes, with no uncertainty, "stop infant genital surgery" (2000, 79). Suzanne Kessler, in *Lessons from the Intersexed,* asserts that his method of treatment implements a medical fix—surgical and hormonal gender normalization—for what is actually a social dilemma: a body that doesn't fit neatly within the parameters of sexual dimorphism, our prevailing narrative of biological sex differentiation (1998). Alice Dreger, in her history of the medicalization of intersex conditions, examines the contemporary autobiographical writing of adult intersexuals and concludes that, "despite the effort to make intersexed children look and feel 'normal,' the way intersexuality is treated by doctors in the United States today inadvertently contributes to many intersexuals' feeling of difference and defectiveness" (2000, 190). More recently, Elizabeth Reis has written that "ever since the early nineteenth century, when doctors began to professionalize and publish their cases in medical journals, we can trace not only their cruelly judgmental descriptors of these conditions and people but also the damaging therapeutic treatment they have dispensed" (2009, 157). Rounding out this chorus of academics against the medical pathologization of intersex conditions is Georgiann Davis, a sociologist as well as someone with an intersex trait, who asserts that gendered expectations are what "force intersex people, who do not fit neatly into the gender structure, to undergo medically unnecessary and irreversible surgeries that . . . may be intended to help but are often quite harmful" (2015, 157).

Relatedly, within trans studies, there is a growing number of scholars insisting on grappling with the harm caused by forms of medical gatekeeping that green-light transition only for folks who provide straightforward life narratives that rely heavily on gender stereotypes to claim they are trapped in the wrong body, have a high likelihood of effectively passing as cisgender post-transition, and can attest to their lack of queerness—that is, promise exclusive heterosexual behavior post-transition and demonstrate both chastity and sexual disgust with their bodies pretransition. Historian Joanne Meyerowitz summarizes, in brief, the foundational premises of a more recent generation of trans scholars:

> As a group they tended to start with [the premise] that sex, gender, and sexuality represent analytically distinct categories, that the sex of the body does not determine either gender or sexual identity, that doctors can alter characteristics of bodily sex. Some disputed binary definitions of biological sex . . . many combined the feminists' critique of the constraints of rigid gender dichotomies and the gay liberationists' goal of freedom of expression, and rendered healthy the variations that doctors had routinely cast as illness and disorder. (2004, 284)

Meyerowitz's intellectual touchstones, here, are scholars, activists, and performers like Susan Stryker, Sandy Stone, Kate Bornstein, Henry Rubin, Jason Cromwell, and Riki Anne Wilchins—names now associated with the emergence of both trans studies and contemporary transgender activism. Critiques of binary gender, rejection of the pathologization of trans embodiment as a form of deviance or disorder, and deconstructions of the disciplinary regulation of access to technologies of transition are integral to the field, taken up across the landscape of contemporary trans scholarship.

Legal theorist Dean Spade, for instance, offers an intimate account of his failure to provide the correct gender narrative to psychiatric professionals as he was seeking access to technologies of transition:

> From what I've gathered in my various counseling sessions, in order to be deemed real I need to want to pass as male all the time, and not feel ambivalent about this. I need to be willing to make the commitment to "full-time" maleness, or they can't be sure that I won't regret my surgery. The fact that I don't want to change my first name, that I haven't sought out the use of the pronoun "he," that I don't think that "lesbian" is the wrong word for me, or, worse yet, that I recognize that the use of any word for myself—lesbian, transperson, transgender butch, boy, mister, FTM fag, butch—has always been/will always be strategic, is my undoing in their eyes. They are waiting for a better justification of my desire for surgery, something less intellectual, more real. (2003, 21–22)

Spade highlights the difficulty medical professionals have in cognizing forms of gender variance that don't subscribe to classic narratives of transsexuality, and articulates the realization of his own naiveté in believing

that he could actually communicate the complexities of his desires to medical professionals invested in these narratives. He becomes involved with a trans support group, and realizes that this space—not the doctor's office—is open to honest, complex, and mutable truths about queer forms of trans embodiment: "I have these great, sad conversations with these people who know all about what it means to lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want" (2003, 23).

While Spade excoriates the medical establishment as a regulatory system deeply invested in stereotypical binary gender, he also complicates transnormative narratives of transition that are invested in the reification of hegemonic medical constructions of transition as a linear, teleological path (from male to female, or female to male). By *transnormative*, I mean subjects who, save for their status as trans, are otherwise highly assimilable—gender-normative, heterosexual, middle-class, well-educated, white. It is transnormative subjects who populate the medical archives of transsexuality most heavily, and it is transnormative subjects who have the least mitigated access to medical technologies of gender transition—hormones, surgery, and continued care. Conversely, it is non-transnormative subjects who are systematically exposed to institutional and interpersonal violence, up to and including death—by homicide and suicide, yes, but also by lack of access to quality, affordable, trans-competent health care.

I understand the utilization of technologies of transition by both intersex and trans folks as forms of gender transition. While the medical rhetoric surrounding the surgical and hormonal normalization of intersex folks frames these procedures as correcting or repairing an "unfinished" (that is, not unequivocally male- or female-typical) form of sexed embodiment, these experiences are lived as major reconfigurations of one's gendered reality. With this in mind, I apply the concept of transnormativity to both intersex and trans experiences, using it as a shorthand means of indexing narratives that embrace gender stereotypes, understand technologies of transition as a means of deliverance into the promised land of gender normativity, and utilize heterosexuality as a means of shoring up and verifying gender normativity. We find transnormative narratives of gendered becoming in both contemporary accounts of transition as well as in the archives of medical sexology, issued by intersex and trans subjects alike—although, as Spade points out so eloquently above, often under

conditions of coercion, as a means of playing into and verifying the medical establishment's investment in gender and sexual normativity.

Popular accounts of gendered becoming rely heavily on what I understand as *transnormative structures of feeling*. The most popular, palatable narratives of transition confirm gender-stereotypical truisms regarding the biology and psychology of sex difference. The narratives offered up most consistently within John Money's case studies do the same sort of confirmation work, shoring up his idea that gender is a matter of indelible psychological imprinting at a young age. His preferred examples are those that testify to indelibly male-typical or female-typical gender roles, and he relies on narrations of childhood memory that conform to transnormative structures of feeling. For instance, one of the few patients cited at length in his case studies—a male-identified intersex person with hypospadias who had been reared as male—recounts,

> "I remember myself squirting the hose. I think I squirted my father in the process. And it was lots of fun." This memory, dating from the age of two, had been reinforced from a photograph taken on the occasion; "and yet, when I look at it, it kind of brings me back, you know, that wonderful feeling of power you have when you're watering something! Well, it kind of brings back something of being a master in your own domain as you squirt this blasted hose around." (Money, Hampson, and Hampson 1955a, 313)

Not only does Money's paradigmatic patient enjoy the rush of power that comes with squirting the hose, he also explains that he is heavily preoccupied with sex, but only the strictly heterosexual variety, while also manifesting some concern about being too sex-obsessed: "I would think about all kinds of sex, what kinds there were, and then I would wonder if I was safe or not. Whether I would find myself liking it too much or something. Yet, if I ever started making any image of homosexuality, I could never get myself into it" (315).

This narrative shores up the dominant expectations regarding male sexuality of that era—a man was a person who had to, for the social good, rein in sexual drive and make sure his preferred objects were exclusively of the opposing gender. It is no surprise, then, that Money—in his assumed role as arbiter of the truth of gender identity—declares "all in all, beyond

every possible doubt, this person was psychologically a man. He was fortified with a diplomatic arrogance which adjusted to the human demands of the occasion, yet enabled him to choose and select his standards rather than run with the herd" (318). Diplomatic arrogance! Pronounced individualism! A natural-born leader, this patient, possessed of all the hallmarks of rugged American machismo. We need no further proof of the immutability of psychological gender, even in cases of ambiguously sexed individuals. In other words, all intersex people have an "indelibly imprinted" psychological gender; it is the job of the medical sexologist to discern what that is and green-light technologies of transition accordingly. His function is, then, only one of enhancing the potential of intersex and trans persons to live unremarkable, gender-typical, and sexually normative lives.

One of the great risks of late gender assignation, for Money, is the possibility of queer sexuality. In a 1965 article, he writes,

> after a child has entered school, a sex reassignment is extremely perilous psychosexually and is liable to produce a person who lives socially in the reassigned sex but falls in love as a member of the other originally assigned sex—and thus has all the outward appearances of being homosexual. These late sex reassignments also may issue in nonspecific, moderate to severe psychopathology of the personality. (187)

To put it bluntly: Not only does Money think late gender reassignment might make you queer, it may also produce mental disorders. This rigorous effort to guard against any association with queer sexuality is not only present in intersex cases, but—as mentioned above—in trans cases as well. The aim of intersex and trans medical treatment was—and in many cases, remains—the production of gender-normative heterosexuals.

Trans Necropolitics and Archival Absence

What if technologies of transition sometimes make us feel like shit, but we utilize them because of the more intense social cost of not being passable as cis? What if we reject hormonal therapy? What if we have reservations about submitting to technologies of gender normalization? What if we can't afford or can't geographically access technologies of transition?

What if transition, for intersex and trans folk alike, is not always a triumphal narrative, but instead a sort of necropolitical calculus wherein negative effects are weighed one against the other?

Trans necropolitics, as theorized by C. Riley Snorton and Jin Haritaworn (2013), refers to the exposure to violence, debility, and death that shapes nontransnormative lives. Trans necropolitics is a useful concept in thinking through how intensely stratified access to medical care is for trans and intersex subjects, how the rise in trans visibility comes coupled with an intensification of violence toward nontransnormative subjects, and how the livability of transnormative lives is interwoven with institutional mechanisms that expose less privileged trans and intersex subjects to systemic violence and disenfranchisement.

Can we understand decision-making that takes place within this milieu an instance not of willed, autonomous self-making, but instead as consent compromised by conditions of coercion? Why have we not paid more attention to the historical incidences of folks who experience trauma in their interface with medical professionals, rather than validation? Those who reject the notion that medical specialists are also, somehow, saviors? What about the experience of affect aliens who, as Sara Ahmed writes, "do not experience pleasure from proximity to objects that are attributed as being good" (2010, 41)?

I began thinking about this while working on a project documenting my own experience growing up intersex. I was diagnosed late—around the age of sixteen—and promptly put on Premarin, a conjugated estrogen that was, at the time, commonly used to treat intersex conditions, as well as for hormone therapy in both cis and trans women. This was meant to normalize my intersexed body along female-typical lines, resulting primarily in breast growth and fat redistribution. After months of severe depression, including suicidal ideation, I stopped taking it, and haven't been on hormones since. It's difficult, existentially speaking, to tease apart the side effects of that particular drug from the general trauma of grappling with an intersex diagnosis, but I do know that my decision to cease hormonal treatment was directly linked to a substantial decrease in the intensity of depressive symptoms I experienced. I also understood my refusal of hormone therapy as a refusal, more broadly, of medical tactics of gender normalization aimed at intersex youth and adults; a refusal of the notion that my corporeal queerness needed to be fixed or remediated.

When, some years later, I visited the archives of the medical sexologists who produced the treatment protocols I'd been subjected to—and run away from—I found my experience mirrored, although it was obfuscated by the curatorial impulses of these medical professionals, veiled by their desire to protect and render watertight their theories. I discovered anger on the part of intersex patients over the trauma they experienced within the medical establishment. Patients repeatedly refuse to return for further examination, finding their own gendered and sexual inclinations at odds with Money's recommendations for treatment. Several patients, when slated to have their genitalia photographed by Money's assistants for medical publications, simply don't show up. One patient—an androgen-insensitive person reared as male whom Money, in concert with this boy's parents, insisted on reassigning as female—went so far as to call Money on the coercion evident in his treatment methods:

> I think you're a rotten guy. I told my father that you were trying to make me do what he wants. And I think the same thing of you. . . . You're trying to make me say what you want me to say. And I don't want to say that. . . . I told you what I want. You said we won't mention nothing about the other sex that I don't want to be. . . . What you're saying is to imagine that I'm the other sex, that's what you're saying, and I don't like imagining that way. (Money 1991, 45)

What is shocking is that Money doesn't interpret this anger as directed at him, as stemming from the patient's profound disagreement with his dogged insistence on gender reassignment. Rather, he believes it is the product of a wrongly assigned gender, believes this child is upset because he was reared as male despite being intersex, and thus not possessing what, for Money, was the ultimate arbiter of manhood—a "normal-looking" penis. Money concludes the case history noting the patient's eventual suicide, which he argues would not have happened had this patient heeded his advice and accepted gender reassignment as female. This misreading of patient affect is consistent across Money's case studies, and prompts my concern that, in trans and intersex narratives alike, the elements of coercion involved in medical procedures of gender normalization have been significantly downplayed.

Historically speaking, folks whose desires for transformation run counter to hegemonic, white, bourgeois understandings of masculinity and femininity were systematically prevented from accessing technologies of transition. The forms of gender normativity utilized by the medical establishment were—and remain—undergirded by race, insofar as what was understood as a normative gender ideal was implicitly white, shaped by the typologies of masculinity and femininity that apply to what decolonial feminist philosopher María Lugones has called the "light" side of the colonial/modern gender system.

Lugones reasons that white bourgeois ideals of gender embodiment have been shaped by a deeply dimorphic understanding of gender complementarity that emphasizes white female sexual submissivity, domesticity, and minimized agency and access to the public sphere, and white male providence, epistemic and political authority, virility, and naturalized dominance. This "light side" of the colonial/modern gender system stands in contrast to a "dark side," constituted by the ways in which the sexualities, embodiments, and kinship forms of colonized peoples were constructed within the colonial imaginary. As Lugones writes in "Toward a Decolonial Feminism," "the hierarchical [gendered] dichotomy [that characterizes the 'light' side] also became a normative tool to damn the colonized. The behaviors of the colonized and their personalities/souls were judged as bestial and thus non-gendered, promiscuous, grotesquely sexual, and sinful" (2010, 745). In short, the gendered norms and mores that have determined the *telos* of biomedical logics of gender transition are also those that have been utilized to frame the kinship forms, sexualities, and embodied intimacies of peoples with legacies of colonization as aberrant and in need of rehabilitation and assimilation.

Emily Skidmore, in her media analysis of mid-twentieth-century representations of transwomen, argues that those women with the most "proximity to bourgeois white womanhood" were represented most frequently, and their stories "came to define the boundaries of transsexual identity" (2011, 271). Moreover, access to technologies of transition was, and remains, doubly compromised for trans folks of color; as Delisa Newton attests, in a 1966 issue of *Sepia* cited by Skidmore,

> Because I am a Negro it took me twice as long to get my sex change operation as it would have a white person. Because I am a Negro many

> doctors showed me little sympathy and understanding. "You people are too emotional for such an ordeal," one doctor told me. But finding medical attention wasn't the only problem complicated by the color of my skin. Even with my college and nursing education, I couldn't get a good, steady job to raise money for the operation. (292)

My own work in the Kinsey archives verifies this phenomenon of compromised access, which manifests most often as archival absence. Trans and intersex folks of color are conspicuously missing from the medical archives of sexology; moreover, many folks—white folks and folks of color—appear briefly in medical records, only to never return, in effect going AWOL from the medical protocols of transition and gender normalization. Despite this, never in the work or correspondence of either of these massively influential sexologists I've researched was there any reflection on the partiality of knowledge manifest in such a racially homogenous, Westocentric archive. In the rare moments that folks of color appear in these archives, they are framed, in accordance with the logic of the "dark side" of the colonial/modern gender system, as deviant, sexually perverse, and culturally both aberrant and anachronistic.

For example, take the image of an indigenous American—a member of the Diné people—that I found in a box of photographs marked "intersex" in the Kinsey archives. This person may or may not have had an intersex condition, but was more possibly *nadleeh*—a Diné conception of embodiment that is not accurately translatable into Western gendered logics, although it is often referred to as a type of third gender. This was the only photograph of a nonwhite subject in that box, as well as the only photograph that was not formally composed and set indoors, in a photo studio or medical clinic. The text beneath the photo reads:

> A Navajo Indian. Age 27. Height 5'7", weight 150, length 2.0", diameter 0.3". No hair on body and no sign of testes. Scrotum contained only a soft mass of indistinguishable tissue. Erection and orgasm possible but orgasm slight with emission of a few drops of what appeared to be semen. Intelligent and normal in other ways. He had attended Indian Boarding School. Was rejected by army draft board because of his sex organs. He tries coitus and enjoys it. Gets most satisfaction with little girls, but prefers adult women. They ridicule him because of the size

> of his organs. He feels his condition deeply, and begged to be told how he could "make it grow, so he could get married and have babies." His concern was over the size of his penis, not seeming to attach much importance to the lack of testes. He is probably one of those individuals who some tribes develop for pederasty through non-instrumental castration while small boys, although he denied it. If he is, he apparently has rebelled and desires to be normal. They are usually very effeminate in appearance and actions, but he was not. He is experienced in fellatio and pederast, the anal muscles being quite relaxed. Adult male organs attract him very much and he delights in handling and gazing at them. He is particularly fascinated by semen, which, however, is not unusual in Indians. He was reluctant to pose which, combined with lack of seclusion, prevented more and better pictures. (Kinsey Institute Archives, n.d.)

This man is framed as living proof of the sexual and gendered deviance of the Diné people; he is presented as both irrefutably perverse in relation to Western gendered and sexual norms, engaging in nonheterosexual, age-inappropriate sexual activities, but also as victimized by the ostensibly strange sexual customs of the Diné and desperate for the forms of gendered normalization Western medicine can provide. His desire for gendered and sexual "normalcy" is implicitly linked to his time spent in the viciously assimilatory Indian boarding school system. White, Westocentric gendered and sexual normalcy is aspirational for this person; the medical specialist is simultaneously the gatekeeper and the benevolent colonial patriarch, able to make these dreams come true.

Racialized, classed, and queer absences and misrepresentations of this sort are central to understanding how access to technologies of transition have become compromised for poor folks, folks of color, and gender-nonconforming and queer folks. Popular understandings of trans and intersex identity are linked indissolubly to medicalized transition. Access to medicalized technologies of transition is too often understood as the sine qua non of trans and intersex livability and health. We are in dire need of holistic approaches to health that move beyond surgical and hormonal techniques of gender normalization and focus, instead, on remediating the quotidian and structural violence that so often compromises the life chances of trans, intersex, and gender-nonconforming subjects. It is imperative to interrogate this exclusionary legacy of medical treatment

as the transnational market for medicalized transition grows while the communal, nonprofit networks of support, advocacy, and assistance that are able to address the exigent needs of trans and gender-nonconforming subjects remain relatively stagnant.

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