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The Anthropologist, Doctors and the Transgender Experience: Some Questions for Laurence Hérault

Laurence Hérault is an anthropologist and specialist on the transgender experience She is an Assistant Professor at Aix-Marseille University and a member of IDEMEC*, the research center of the Maison Méditerranéenne des Sciences de l'Homme. Her research has led her to carry out observations of transgendered persons and hospital doctors. *Clio* asked to interview her regarding the circulation of medical knowledge and the impact of theoretical debates within the triangle formed by the anthropologist, "patients" and medical personnel – surgeons, endocrinologists, psychiatrists and psychologists. Lawyers, associations and collectives also have a role in this context. The interview is the result of written exchanges and was carried out in winter 2012-2013 by Sylvie Steinberg.

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***Clio*: As an anthropologist, you work on the medical experiences of transsexual and/or transgendered individuals. Can you describe these experiences within the medical world as well as the various therapies that exist?**

First of all, I would like to say that my work on medical experiences is only one part of my research into contemporary transgender experiences; I also address other dimensions such as those of kinship/parenthood and family ties, for example. Regarding medical trajectories in France, trans-identified individuals can turn to the protocols offered by specialized hospital teams (there are 6 of these) or instead choose an "extra-protocol" path by consulting private practice doctors for part of the transition and having surgery (particularly genital operations) performed abroad – in, for example, Thailand, Belgium, the UK, Spain or Canada. Some individuals also combine the two, either beginning with the hospital path and at one stage or another abandoning it, due to waiting periods or the quality

of care that is offered, or by beginning with private practice consultations and entering the hospital path for operations, since in France, genital surgery can only be reimbursed by Social Security if it is carried out in this framework.

Regarding the actual content of the experience, several points touching upon the pathological definition of transidentity must first be specified in order to understand the particularities of these medical protocols. Transsexualism, or Benjamin's Syndrome, was developed in the mid-twentieth century and has since been given a fixed definition in international diagnostic manuals such as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases) under the heading Gender Identity Disorder (GID). It is defined by four main criteria: an intense and persistent identification with the other sex, a persistent feeling of discomfort relative to the assigned sex, the absence of physical intersexual affection and "clinically significant suffering". This disorder is therefore essentially conceived as a psychiatric disorder based on the idea of an inconsistency between sex and gender, that is, fundamentally on an essentialist and dualist conception of the sexual identity of individuals: the trans individual belongs to one sex but claims to be of the other gender. Logically enough, therapeutic offerings have been aimed at re-harmonizing these two dimensions and there was for a time controversy over the proper site of intervention: was it necessary to act on the mind or on the body? Since the psychotherapies that were attempted did not prove effective, in contrast to the endocrino-surgical treatments that were simultaneously developed, the latter gradually became widespread. GID nevertheless continues to be referenced as a psychiatric disorder.

The protocols available in France, generally adapted from international care standards (defined among others by the World Professional Association for Transgender Health), thus before all else provide for a psychiatric evaluation at the request of the patient. For hospital teams, this evaluation fairly often plays a sort of gatekeeping role, even though the evaluation is multidisciplinary and the final decision requires joint agreement of the psychiatrist, the psychologist, the endocrinologist and the surgeon. When a patient calls upon a

hospital team, he/she is thus received on several occasions by the psychiatrist and the psychologist (the latter submits him/her to various classic personality tests like the Rorschach and the MMPI, Minnesota Multiphasic Personality Inventory), who see to it that the criteria defined in the framework of GID are met and that associated psychopathologies are absent. He/she also meets the endocrinologist and the surgeon, who for their part ensure that there are no contra-indications for hormone treatment and surgery. This phase of evaluation can last from several months to two years, before the team reaches a decision on the case and offers or refuses to include it in the protocol. When the request is accepted, the "treatment" then begins with a hormone regimen that lasts around one year before surgery can be contemplated (the object of a second decision on the part of the medical team). The surgical operations that are generally suggested are mammoplasty and vaginaplasty for MtF (male to female), mastectomy, hysterectomy, ovariectomy, phalloplasty and, more recently, metoidioplasty[1] for FtM (female to male); other plastic surgery operations can also be suggested and/or performed at the same time (facial surgery, hair removal, etc.). It should be underscored that these operations are not all equally desired by trans individuals, with many FtM, for example, opting not to have a phalloplasty (because they do not think it is useful to have a neo-penis or because it involves extensive surgery of uncertain outcome, nor even a hysterectomy or ovariectomy (either because they want to limit the number of operations or because they want to retain their reproductive capacity). Yet performing these genital operations remains important if one is to subsequently change one's civil status. Doing so is only authorized [in France] on condition that one can demonstrate the irreversibility of the transformation, something that judges have become accustomed to associating with vaginaplasty for MtF and hysterectomy and ovariectomy for FtM (though a recent circular from the Ministry of Justice requests that judges above all take the effects of hormone treatment and the individual's social integration into account). In a way, this legal procedure, which is

[1] Or metaoidioplasty: an operation that consists in freeing the clitoris, which has grown under the influence of testosterone, making it appear as a micro-penis.

thought of as the end result of the medical experience, serves to authenticate the latter. But it also clearly imposes its vision of what a trans body must be, by implicitly requiring that a certain number of transformations be carried out beforehand, changes which result in the sterility of the individual. In both cases, one may wonder whether that should really be its role. In contrast to the choice recently taken by other countries such as Argentina, for example, the medical and the legal domains in France remain closely dependent on one another and one of the major issues in the years to come will no doubt concern the redefinition of their relationship.

***Clio*: What characteristics are specific to the medical "field" for an anthropologist of contemporary Western society?**

First, the term you suggest, "field", can be understood in two ways: in a broad sense (that of the medical approach to transidentity in general) and a narrower one referring to the site of study (i.e., my presence in a specialized hospital service). In both cases, the place of the anthropologist is not to be taken for granted, even if it takes different forms. First, to work on the medical approach to transidentity is to re-contextualize the classic Western approach to the trans-identity question, which has long been defined in pathological terms. It is thus to venture upon very well-charted territory, with many specialists and an extensive literature (the vast majority of which is psychiatric and psychological in nature). The anthropologist is considered to have some deficit of legitimacy, and is more or less obliged to make up for it: you are constantly asked to justify your interest in the question and above all to define your approach in terms of complementarity. Indeed, the idea – more or less explicitly stated by many of the doctors among my interlocutors – is that an anthropological approach is only legitimate and relevant if it takes an interest in the "narrowly" social aspects of the trans issue (an individual's social inscription, professional or family integration, etc.) and serves to in some way complement theirs. Few expect it to examine the very manner in which this issue has been understood in our societies, to specifically question the pathological definition it has been accorded, or actually to take an interest in the manner in which they themselves work.

Furthermore, if one understands "field" in the second, narrower sense, one comes up against the fact that a "concrete" medical system for admitting observers is generally not provided and it is difficult to occupy any of the normally available places (impossible to be a doctor, nurse or psychologist, difficult to be a "patient"). Unlike other sites where I have conducted research, one is as a result unable to melt into the woodwork and so is extremely visible. In fact, in this proximate field the anthropologist can be as obviously out of place as in more exotic fields and his/her incongruous position also makes it difficult for interlocutors to understand him/her. The perception people have of the anthropologist's objective and stance is often full of misunderstandings: they wonder what you are doing there and what possible use you can be. I therefore find myself up against one of the well-known difficulties of practicing classic anthropology: being at once welcome and unwelcome, familiar and foreign, useful and in the way.

Moreover, the ethical questions involved in the inquiry proper are more salient here than in other fields. It is important to consider these questions beforehand and that is what we did with the medical team with whom I worked, laying down rules as to data confidentiality and personal anonymity. But at the same time, things are never settled once and for all. And what I discovered in this field – something that had not presented itself to me in this way in my earlier fields – was that the ethical requirement my interlocutors and I shared was ever present and most often played out in context, which obviously is not easy. Given this complexity, it is not surprising that the anthropologists who have put forward well-developed thoughts on ethical questions in anthropology have generally long worked on health-related issues, and when I discovered this field for myself, their thoughts were of great value to me. In fact, this type of field forces you into reflexivity; more than others, it obliged me to wonder about my place: the place that I could / wanted to take, the place that one group or another gave or refused me. Asking these questions can be productive too: for example, doing so allowed me to see and understand essential aspects of the medical arrangements.

***Clio*: What are the specificities of the anthropologist's gaze vis-à-vis other approaches and, in particular, medical ones? Do you have the impression that these specificities are perceived by the various actors with whom you work?**

I believe that the specificity of the anthropological gaze stems from its associated capacities of translation and perspective. It is always a matter of showing a world and understanding it as it is, one way among others of seeing, doing, acting, etc. I try to hold on to these two things in my research on the Western trans experience by conducting, on the one hand, field work on the medical approach – that is, on one of the main sites of the production of "transsexuality" (understood as the medical version of this experience) – and, on the other, by offering comparisons between ways of understanding the trans experience in France and ways of understanding it elsewhere, particularly in historically and/or geographically remote societies. The effect of these two dimensions of my approach has obviously been to deconstruct the dominant conception of the trans question and in particular its medical conception, since that amounts to demonstrating certain of its characteristics, showing the manner in which it operates, both theoretically (by questioning well-developed pathological categories) and practically (what do these categories become in practice? What does GID become in an actual medical system? How is it used? etc.). This amounts to bringing to the surface questions that are not usually raised: for example, why is the transsexualism clinic so interested in trans individuals' sexuality, when this syndrome has precisely been defined as a gender identity disorder, not a sex disorder? Why are we ready to more or less explicitly require a hysterectomy of someone to whom this might not be either necessary or desirable, without even considering that we are depriving that person of the possibility of being a parent?

It is clear that, depending on their positions, interests and objectives, this deconstruction is capable of interesting and/or disconcerting my interlocutors. Moreover, they often misunderstand it somewhat, either because they think that demonstrating the manner in which their version of the trans experience has been constructed is enough to discredit it – whereas they are understandably attached to a version which took time to develop and is useful to them, since it

supports their action on a daily basis; or because they interpret the alternative conceptions found in other societies as simple models to imitate, something they are obviously not ready to do, and which fairly often leads to either defensive cultural relativism ("they're that way, we're this way, and their conception is of no use to us") or towards an ethnocentric re-interpretation which preserves the essence of the subject: ("trans experience is a pathology in all universes, but elsewhere this pathology is simply treated differently"). A way must thus be found to dispel these misunderstandings and it is here that the attention given to translation is important. One must try to capture the specificities of non-Western trans experiences, showing for example that they are based on a conception of gender that is different from ours but is not, for all that, foreign to us, in such a way as to communicate or at least try to communicate that other ways of understanding and living the trans experience are not "solutions" to our problems, nor even responses to our questions, but rather occasions to formulate those questions differently, which is also to say to transform them. Moreover, the anthropological translation of medical practices that I propose also tries to respect the positions and points of view of my various interlocutors: it is not enough to show what they do from a different perspective, they must also recognize themselves there, it must also do them justice. If my translation is successful, my interlocutors must at once recognize themselves in the descriptions that I offer of their practices and world – without which I have lost something of the experience I am seeking to convey – yet at the same time render them capable of seeing in another light unexamined certainties and expectations, as well as the constraints to which they are subject, and from which they might free themselves.

***Clio*: There is an accumulation of rapidly evolving knowledge regarding transsexuality. But this knowledge is also a matter of constant debate. How do you work with these parameters?**

Since the very birth of "transsexualism", controversies and debates have pitted against one another, among others, psychoanalysts, sexologists and psychiatrists. These debates have not completely died out but they are much less fierce than they once were, since the definition in terms of identity disorder has on the whole triumphed.

Roughly put, the sharpest debates today pit trans collectives against doctors and, in particular, psychiatrists, over precisely this definition of trans identity, as well as relating to the knowledge held by one group or the other, a sort of conflict of expertise: Who is an expert on this question? Health professionals or the individuals concerned? This new debate is part of a more general movement to take the patient's experience into consideration, and also reflects the growing influence that trans activist associations have enjoyed in France since the 1990s and particularly over the last decade, which has witnessed the birth of several dozen associations in the space of just a few years. This activist movement, like many others, is at once local and global: the associations are solidly anchored at the regional level (often in order to receive local funding) but also maintain national and international ties in order to support larger causes – for example, the "depsychiatrization" of the trans issue during the reform of the DSM. At the same time, what can be seen as a form of "professional activism" has very recently taken shape on the occasion of ministerial consultations and reports (HAS / Haute Autorité de Santé; IGAS / Inspection Générale des Affaires Sociales) concerning the trans question, with the creation of two associations of health care professionals and lawyers over the course of the past two years. Working in this context therefore requires constant adaptation, for everything is changing very rapidly – approaches, positions, conflicts, debates and so on – to such an extent that I can say that the field in which I got my start less than ten years ago has completely changed. The other difficulty is to avoid losing sight of the complexity of positions in the context of high stakes debates that are generally extremely intense. The very contentious character of these debates can lead the scholar down the dangerous slope of typification, especially as the opposing actors themselves tend to typify their "adversaries". Faced with blocs that can too easily appear monolithic, it requires considerable vigilance to keep in mind the full complexity of the positions, the full complexity of the debates and their ramifications. For example, there are many areas of disagreement within the trans activist movement as well as within the associations of professionals. Finally, the third point that seems important to me in such a framework is the place of my own productions. It is easy to

see how the remarks I may make here or there at colloquia and the papers I may write have no chance of remaining confined to the academic universe but will on the contrary be read, commented upon, criticized and generally get "mixed up" in ongoing debates and controversies. It is obviously not a problem in itself, and in a general way, moreover, I help to make my texts publicly available by putting them on open access archival sites. But this also means that I need to reflect on their content in ways that go beyond the usual academic requirements.

***Clio*: In various types of knowledge that have accumulated regarding transsexuality, what place did medical expertise occupy in the past? What place does it occupy today? How might you describe the state of the various types of knowledge and their circulation?**

In general, medical expertise has occupied a significant place and still does, due both to the pathological definition of transidentity and the corporeal nature of the transformations that are offered and desired. But you are right to speak of 'types of knowledge' in the plural and, to answer your question, one must distinguish between the various types along disciplinary lines, because the psychiatrist, the endocrinologist and the surgeon, for example, occupy different positions in terms of legitimacy, evolution and use. Since it contributed to conceptualizing GID, psychiatry has played a central role and is still important since its expertise is always required in contemporary protocols. Yet at the same time its legitimacy has been called into question, particularly by activist demands for depsychiatrization. Psychiatric knowledge on the trans question is therefore at once strong and weak, and its future is uncertain; moreover, attempts to modify GID in the framework of the present reform of the DSM, with new proposals followed by changes of mind and a retreat to the old version, are entirely symptomatic of its paradoxical and uncomfortable position. The other forms of knowledge that are involved, endocrinological and surgical, pose less of a problem because they are more immediately perceived as "technical": they offer molecules and operations, and their representatives, like those who call upon them, see them in terms of

competence, often even in terms of individual competence. Their legitimacy is therefore never called into question but their manifestations can be, as we see when someone criticizes a colleague or when individuals or trans collectives cast doubt upon or, on the contrary, praise the competence of a given surgeon. The future of these forms of knowledge/expertise is not in doubt and their essential task consists in improving and becoming more refined (better mastering hormonal treatments and their effects, improving operating techniques, offering operations that render neo-organs more sensitive and aesthetic, etc.). Due to this situation, the question of their coordination, which had been consolidated in the framework of the protocols, implicitly becomes an open question once again. At present, psychiatric evaluation still makes it permissible to guarantee the legitimacy and well-foundedness of a surgical intervention that might in certain conditions be understood as mutilation, but does this evaluation allow for a reliable diagnosis when its foundations are themselves a matter of controversy? Could it be dispensed with, and, if so, how and on what conditions? Should we continue to refuse requests for partial transformation because psychiatrists do not approve of them?

The question of the legitimacy of forms of knowledge also arises in another way with regard to their internal and external appropriation. There are thus conflicts of legitimacy regarding the diagnosis and the recommendations made within or outside of the hospital protocol: for some people, for example, GID cannot properly be treated outside of specialized teams, and private practice doctors, even if well-informed, are not seen as legitimate independent consultants. Moreover, these types of medical knowledge are not solely the preserve of professionals and, as in other places, they are the object of "profane"/"lay" – but nevertheless expert or knowledgeable – appropriation. A number of trans individuals have become very competent in the area, and they are sometimes in a position to make proposals permitting their transformation. There are, for example, lively and knowledgeable discussions of hormonal treatments on forums and at associative meetings, where experiences are shared, and discussions take place with consulting doctors. Elsewhere, the appropriation of these forms of knowledge is more

strategic and takes the form of exploiting knowledge that is a priori seen as illegitimate and without foundation: there are thus many exchanges concerning the criteria of GID and what one should tell a psychiatrist in order to receive authorization for the operations one wishes to have performed. In these cases, the individual is not seeking to discuss with a professional the well-foundedness of his or her diagnosis, but rather to meet expectations in order to get what he or she wants.

***Clio*: The place occupied by transsexuality in the theoretical elaboration of the concept of gender is well-known. Has your anthropological work led you to reconsider this concept?**

As you underscore, the notion of gender was born in the clinic of transsexualism and intersexuality before being adopted by the social sciences and feminist scholarship. That obviously had an impact on my own work, since gender is not simply an available tool of analysis but also a notion that my interlocutors and I have in common. The fact that we share this notion is not evidence of agreement because, while everyone or nearly everyone uses it, it must be noted that it is not necessarily to refer to the same thing, nor even to do the same thing. Crudely put, two major references to gender are to be found in the framework of transidentity: the transsexualist version of gender, and the queer version of gender, both of which are at the origin of, and fundamental to, grasping the possible versions of the contemporary trans experience.

In the transsexualist version, gender fundamentally remains a characteristic and property of individuals. It denaturalizes less than it complicates the possible description of individuals. In this version, transsexual individuals are conceivable because sex and gender are different things, and it is possible to describe their situation in terms of incoherence: their sex and gender are in contradiction but one can / must re-harmonize them. In the historically later, queer version, there is on the contrary a clearer desire to denaturalize and de-essentialize the question, going beyond the sex / gender distinction (understood as a distinction between nature and culture). When what we might call first-wave queer thought seized hold of sex/gender, it was not to say, as psychology and sexology had done before, that

gender identity is as important – if not more important – than sexual identity (which historically allowed transsexuations to develop). Queer thought seized hold of sex/gender to say that sex-gender *identity* does not exist, that there are only sex-gender *performances*. But this first queer performativity was doubtless very / too discursive and many criticized it, particularly trans scholars and activists, who emphasized that the body had been left out of this account. Judith Butler, for example, tried to respond to this with *Bodies That Matter* (without always convincing her critics, it must be said) and in her most recent work the body is also present via the question of vulnerability. Whatever the case, later queer perspectives made an effort to move beyond this sex/gender distinction in non-discursive ways, particularly by attending to the multiple "technologies of gender" that go beyond drag, by showing how, via hormones, Viagra and the knife, we all fabricate our sex-gender. At the same time, this new approach remains based on the notion of performativity and is actually still a matter of making something *oneself* in order to produce one's sexual identity. The subversive use of these technologies moreover allows one to constitute multiple alternative identities, presented as so many ways of escaping the man/woman binary pair. In order to do this, it seems to me that, in a number of cases, one has simply reproduced that which one seeks to overcome – that is, an identity-based version of gender – by way of multiplication. It is true that one escapes from the binary pair, but less than anticipated from the notion of sexual identity. Moreover, I also see a difficulty in conceiving what is unperceived by the subject (what lies beyond the performance) otherwise than via a paradoxical recourse to biology ("the power of hormones" is sometimes praised, for example) or an often arbitrary reference to norms.

It seems to me that the relational approach that developed in anthropology on the basis of Marilyn Strathern's work[2] is less of a dead end from this point of view. It was developed on the basis of a comparison of genuinely alternative conceptions of individuals,

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2 *The Gender of the Gift*, Berkeley & Los Angeles, University of California Press, 1990. See also Irène Théry, who developed this relational approach, particularly in her book *La distinction de sexe*, Paris, Odile Jacob, 2007.

conceptions developed in other societies in which, as the volume edited by Catherine Alès and Cécile Barraud shows,[3] one is less attached to categories (man/woman) than to status (brother, spouse, mother, etc.). In these societies, individuals are conceived neither as simple products of other bodies nor for that matter as the products of ego-centered performances. Rather, they are the products of relations. Relations are not secondary here in the sense of being activities in which individuals already provided with an identity engage (whether it be by exo- or auto-identification); on the contrary, relations are at the basis of the individual, including their very materiality (the body). Organs and substances jointly supply the basis of these relations, for the body is not only what individuates us, it is also what ties us to others. This is how Marilyn Strathern can say in *Gender of the Gift* that "Western women make children, Melanesian women do not". By preferring the status to the category, moreover, the relational approach seems to me better capable of grasping the instability of individual engagements. Queer thought presents itself or is sometimes presented as the last manifestation of modern individualist ideology, to the degree that it is said to be a refusal of assignment ("I am not what you say I am"), a demand for mobility ("I am this but I can/want to/will change") and an assertion of plurality ("I am this but I am also that"). This sometimes provokes angry protest from many opponents who say that identities are much more solid than that, and/or that this disruption of identity is undesirable. Yet the demands attributed to queer thought are finally no more or less than the everyday stuff of any social life. To recognize this, however, one must abandon the identity-based version, discard the performance / norms opposition, and enter into the established game of expectations and possibilities. In all societies, status does indeed make us mobile, plural beings and also offers us diverse possibilities of involvement: acceptance, refusal, negotiation. In other words, our theory does not describe our practices, and gender is for us also a form of action and relation: it is a "factish" in Bruno Latour's sense of the term, that is, something that makes us do

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3 *Sexe relatif ou sexe absolu?*, Paris, Éditions de la Maison des Sciences de l'Homme, 2001.

and act in a certain manner, at once "like" and "as". I have found this way of understanding things to be very useful, for example, in grasping the particular – and on the face of it disconcerting – experience of T. Beatie and other pregnant men who have given birth "as men in the manner of women."

Translated by Ethan Rundell