


A history of scientific, medical and psychological approaches to transsexualities and their critical approach¹

História das abordagens científicas, médicas e psicológicas sobre as transexualidades e suas aproximações críticas

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Abstract

This study provides a brief historical background of scientific, medical and psychological approaches to transsexualities. It also makes considerations on how such approaches based the concept of pathology that is associated with trans people and how it has been responsible for maintaining the pathologization in the collective imaginary. More specifically, we will establish a chronology of events that, throughout history, have affected the study on and the intervention with trans people, based on the biomedical model. We will also refer to some Western figures responsible for creating this biomedical vision of trans people. Finally, the discussion about the (de)pathologization of transsexualities is presented, based on the emergence of the paradigm centered on the human rights of trans people and proposals for self-determination of their bodies and identities.

Keywords: Transsexualities; Biomedical Model; Critical Psychology; (De)Pathologization of Trans Identities.

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Resumo

Neste artigo, apresenta-se um breve enquadramento histórico das abordagens científicas, médicas e psicológicas sobre as transexualidades, tecendo um conjunto de considerações sobre a forma como tal enquadramento foi fundacional da noção de patologia associada às pessoas trans e como tem sido responsável pela manutenção da patologização destes indivíduos no imaginário coletivo. Para atingir tal objetivo, é desenhado um mapa cronológico dos acontecimentos que têm vindo a marcar, ao longo da história, o estudo e a intervenção com as pessoas trans a partir do modelo biomédico, referenciando algumas das personalidades que, no contexto ocidental, tiveram responsabilidade nesta visão biomédica das pessoas trans. No final deste trabalho, apresenta-se a discussão em torno da (des)patologização das transexualidades a partir do surgimento do paradigma centrado nos direitos humanos das pessoas trans e em propostas de autodeterminação dos seus corpos e identidades.

Palavras-chave: Transexualidades; Modelo Biomédico; Psicologia Crítica; (Des)Patologização das Identidades Trans.

Introduction: scientific, medical and psychological approaches to transsexualities

The history of scientific, medical and psychological approaches to transsexualities is² old. In the early twentieth century, Magnus Hirschfeld (1868-1935), a Jewish German physician, sexologist and homosexual, distinguished sexual orientation (at that time called “desire orientation”) from gender identity.³ Hirschfeld was one of the pioneers in using the term “transsexual”. He was also a researcher in the field of homosexuality and the sexual behavior variant (Mancini, 2010; Missé, 2014).

Besides Magnus Hirschfeld, there are other names in the history of transsexualities, namely in the history of Endocrinology, such as Eugen Steinach and Harry Benjamin. In 1910, Eugen Steinach discovers the morphological effects of sex hormones and devotes himself to investigating transplants of male gonads into females and vice versa in animals.

After the studies carried out by Steinach, Hirschfeld used the results of those studies to perform sex change in humans. In 1919, Magnus Hirschfeld created the Institute for Sexual Science in Berlin, where he performed the first sex change surgeries throughout the 1920s. In this institute, Felix Abraham was the first surgeon, in 1921, to operate on the first transsexual, Dorchen Richter⁴ (Castel, 2001; Mancini, 2010). In 1930, in the same place, sex reassignment surgery (although it did not encompass the same procedures as the one performed nowadays) was performed on Lili Elbe⁵ (Hoyer, 1933/2004; Meyerowitz, 2002). In 1933,

2 In this part, we will predominantly use the terms “transsexual” and “transsexuals” to refer to people who are sex/gender non-conforming, as these designations have been adopted by the medical model over time. When reference is made to other designations, such as “transvestism” or “transsexualism”, these aim to explain their contexts of emergence. It should be noted, however, that some of these designations may not correspond to what they currently mean. The designations “sex change” and/or “sex reassignment surgery” have also been used internationally in the biomedical context, although the importance of adopting terminology changes that give greater plurality and diversity to these procedures is recognized, for example, transgenitalization surgery in the Brazilian medical context.

3 The term “gender identity” was not yet used in the early twentieth century.

4 The Dorchen Richter surgery is known for the Rudolf case; however, we will use the name Dorchen because we refer to a person who identified himself in the female gender, having chosen the name Dorchen to designate himself (Mancini, 2010).

5 According to Niels Hoyer, editor of the book *Man Into woman: the first sex change: a portrait of Lili Elbe*, published in 1933, Lili Elbe was an intersex person (intersex means a person who has fully or partially developed characteristics of both sexes, Lili Elbe had internal organs not corresponding to the male sex), although she only had the confirmation of ambiguous genitality when she assumed herself as Lili Elbe. This is mentioned here on account of the fact that Lili was considered one of the first people to undergo a sex reassignment surgery. Lili was designated as male in her birth certificate and subsequently identified herself as female. In this sense, it is essential

the Institute suffers, by deliberation of Adolf Hitler, the destruction of the archive it housed.

As mentioned earlier, the first known surgeries were those of Dorchen Richter, in 1921, and Lili Elbe, in 1930. However, the event that marks the birth of transsexuality as a nosological category is the surgical intervention⁶ performed in Denmark, in 1952, on Christine Jorgensen, a former soldier of the US Army.

According to Dave King (1998), Dorchen Richter was the first person to change sex in the Western hemisphere, but this case was not widely publicized. Prior to Christine Jorgensen undergoing sex reassignment surgery in 1952, there had already been several surgeries in Germany, Switzerland, Austria, Sweden, the Netherlands, Denmark and Morocco. However, only when Christine Jorgensen's surgery was publicized in several American newspapers (e.g. the *New York Daily News*, with the headline, "Former GI becomes blonde beauty: operations transform Bronx youth," and *The Daily Mirror*, under the headline "Dear Mum and Dad, son, wrote, I've now become your daughter"), did this practice gain wide visibility and began to be adopted exponentially worldwide by the medical model of intervention on persons who did not conform with gender norms (Docter, 2008).

Although sex reassignment surgeries had been performed before 1960, it was only in that decade that issues related to transsexuality achieved greater prominence in medicine, with Harry Benjamin (1954/2006). In 1954, Benjamin popularized the term "transsexual" and used it to distinguish people who wanted surgery from those who did not (the latter were considered transvestite people⁷). Besides introducing the topic, he defines the first diagnostic criteria of transsexuality in his book *The Transsexual Phenomenon* (Benjamin, 1966), which allowed thinking about this category and working it in a medical context (Ortega,

Romero-Bachiller; Ibáñez, 2014; Platero, 2014). Benjamin's clinical practice, as well as his publications, were adopted by the medical approach with transsexual people (Benjamin, 1954/2006).

While Benjamin (1954/2006) advocated surgical intervention as the most appropriate response to situations of transsexuality, David Cauldwell did not support it (Soley-Beltran, 2009). Cauldwell (2006) termed "transsexual psychopathy" a psychological state in which an individual feels and lives as a member of the sex to which he does not belong, which means, according to such a contention, that this person is not mentally healthy.⁸ Cauldwell's work (2006) had several contradictions on account of labeling transsexuality as a psychopathy while simultaneously admitting that there are perfectly adapted transsexual people.

Between the 1950s and 1970s, the first medical units began to emerge in North American universities aimed at people with gender non-conformity. Later, university programs were converted into medical programs, and hormonal and surgical treatments began to be carried out. The first programs were created at the University of California, Los Angeles in 1962 and at John Hopkins University, Baltimore in 1966. By then, sex reassignment surgery began to spread across different locations in the U.S.

In 1963, Reed Erickson began a process of masculinization administered by Harry Benjamin. After his connection with Harry Benjamin, Erickson contributed to the creation of the Erickson Educational Foundation and to his links with the World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association (HBIIGDA) established in 1979 (Devor, 2013).

HBIIGDA published the first official sex reassignment treatment protocol, called Standards of Care Gender Identity Disorders (SOC), seeking to provide health professionals with guidelines for

to talk about Lili Elbe, even though she is considered an intersex person, because she experienced non-conformity between the sex she was assigned in her birth certificate and the gender to which she felt she belonged.

6 The practice of sex reassignment surgeries at the time is not the same as today, and even this medical practice varies according to the professional who performs it. In the case of Christine Jorgensen, performing a vaginal reconstruction (currently called neovagina using the vaginoplasty technique) was not considered.

7 A term that designated people who wore clothes that did not conform with the gender norms of the time.

8 This concept had already been referred to by Kraft-Ebbing in his book *Psychopathia Sexualis*.

making decisions regarding referral of transsexuals to the process of physical sex change. At first, the decision went through an attempt to distinguish the different types of transsexuals. Individuals who were assessed as “true” transsexuals were prescribed hormonal and surgical treatment, while to all the others who were not considered “true” transsexuals, psychotherapy was recommended in order to reduce gender dysphoria (APA, 2002; Nieder; Richter-Appelt, 2011). It is worth saying that Benjamin (1954/2006) had previously stated that psychotherapy would not be an adequate type of intervention.⁹

In the 1960s and 1970s, medicine grows increasingly interested in explaining homosexuality, transsexuality and intersexuality. Robert Stoller, Richard Green and John Money played a pioneering role here in the debate on the criteria that individuals had to meet in order to be diagnosed as transsexual and, therefore, fit for bodily modifications (Coll-Planas, 2010; Missé, 2014). Robert Stoller developed a theory about the origin of transsexuality and created, in the 1960s, the Identity Center at the University of California, Los Angeles (Stoller, 1960/2006). Subsequently, the same professor developed work at the HBIGDA (Platero, 2014). In 1973, Norman Fisk instituted a psychiatric nosography for transsexuality (Castel, 2001; Fisk, 1973).

In 1980, the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) included, for the first time, transsexuality as a category of “gender dysphoria” (APA, 1986). In 1990, transsexuality enters the World Health Organization ICD-2 for the first time as a “sexual identity disorder”, more specifically as “transsexualism” (Missé, 2014). In 1994, the DSM-IV replaced the category “gender dysphoria” with “gender identity disorder” (APA, 1994). In 2000, the fourth revised edition of the DSM keeps transsexuality as a “gender identity disorder” (APA, 2002). Currently, the fifth edition of the Diagnostic and Statistical Manual

of Mental Disorders (DSM-5) replaces the category “gender identity disorder” with the category “gender dysphoria” (APA, 2013).

Transsexuality remains in ICD-11 designated as “gender incongruence” (WHO, 2019). The WHO removed “sexual identity disorder” (more specifically termed “transsexualism”) from the disease-related chapter of the ICD and relocated it as “gender incongruence” into another chapter associated with “other conditions related to sexual health” (WHO, 2019).

These classification models have placed transsexualities as a problem of the individual and have not discussed transphobia in society. In other words, the individual is responsible for sex-gender non-conformity, and not society for transphobia (Arán; Zaidhaft; Murta, 2008). Harry Benjamin’s reading of transsexuality continues, therefore, to be the reading adopted by the medical model, which, instead of recognizing trans people as people of rights, regards them as pathological.

The recommended procedures, recognized and adopted in the Western context, are currently established through the previously mentioned SOC of WPATH. They provide guidelines for decisions regarding the (non-)referral of subjects to surgery. These protocols were created with the aim of ensuring the mental and physical health of people with sex-gender non-conformity (Coleman et al., 2011; WPATH, 2012). However, countless problems associated with, and arising from, SOC have emerged, showing that these have not corresponded to all trans realities (Fernández-Fígares, 2010; Nieder; Richter-Appelt, 2011). There are trans life paths which are not included in SOC or are opposed to these procedures, after all there are people who wish to undergo hormonal treatment, but do not intend to undergo surgery. If the situations described by trans people who use health services are not included in the SOC, or are opposed to them, psychologists and doctors may not authorize the process of sex change. If these people wish to change

⁹ Precisely because his successive attempts to modify the identity with which the person identified themselves were not successful, Benjamin understood that since psychotherapy was unable to make a person identify with an identity corresponding to their sex, the only possibility was to “repair” the body so that conformity between sex and the intended gender could be given legitimacy at that time (Rodrigues, 2016).

their gender, non-authorization may endanger their physical and psychological health, going against the objectives of SOC procedures and jeopardizing the guarantee of mental and physical health of trans people (Carvalho, 2010).

In 1998, in the fifth version of the WPATH SOC, five phases for intervention with transsexuals were listed,¹⁰ one of them being the “real life test”.¹¹ The “real life test” was regarded as a necessary test preceding hormonal and surgical treatments. It was designated as a “non-compromising medical” phase¹² since it does not endanger the person’s life. This is the most socially compromising/harmful phase of the whole process because it exposes the trans person to possible loss of their family and work, among other situations, which may be irreversible (Fernández-Fígares, 2010).

In 2008, WPATH published a document agreeing with the American Psychiatric Association’s definition of transsexuality as a mental disorder. This document states that physical sex change is effective for the treatment of transsexuals and included “real life experience”¹³ as one of the sex change procedures (Fernández-Fígares, 2010). This publication kept the pathological character of transsexual experiences and the prescription of medical criteria for the “integration” of transsexualities.

The pathologization of trans identities has resulted in continuous insistence on understanding transsexual people as subjects who understand intervention on the body to be the only solution to their identity construction (Nieder; Richter-Appelt, 2011). For trans people who do not want medical interventions, the possibility and feasibility offered by the medical treatment model make their life path more complicated (Nieder; Richter-Appelt, 2011) since diagnostic criteria are based on a single transsexual trajectory, departing

from the idea that all transsexual people wish to change their sex (Suess, 2010). This situation reveals the lack of assistance to cases that do not wish to progress to surgery or hormone therapy and cases that do not fit the description of what a “true” transsexual is (Carvalho, 2010).

The sixth version of SOC refers to the existence of a variety of therapeutic pathways. Professionals are increasingly aware that not all transsexual people need and / or want all the elements of tripartite therapy¹⁴ (Suess, 2010). This is no longer the only way, and the need for individualized attention with multiple options is gradually emerging (Lev, 2009).

The medical practices of specific care for trans people have adopted the SOC, but they are interpreted very differently, not only by each country, with its own specific application contexts, but also by the different teams of health professionals. Besides the differences in application models, SOC tend to maintain a pathologizing character of trans experiences, although there is an attempt in its seventh version (WPATH, 2012)¹⁵ to emphasize the variety of trans experiences by distinguishing “gender dysphoria” from “gender variability”, thereby moving from a paradigm of identity evaluation to a paradigm of evaluation/measurement of suffering (Platero, 2014; STP 2012, 2012).

According to Miquel Missé (2014), in the clinical context, when many trans people hear the criteria that they are supposed to meet to be considered “true transsexuals”, they incorporate these medical discourses to define and explain themselves. More than a conscious act, it is often an act of survival. It illustrates the case of a 7-year old who answered the following question: “Why were you once a boy and now you are a girl?”. The answer was this: “Because I had a girl’s brain in a boy’s

¹⁰ Diagnosis, psychotherapy, the “real life test”, hormone therapy and sex reassignment surgery.

¹¹At this stage, according to these criteria, the individual must learn, for two years of follow-up, to live according to the culturally determined norms for the gender in which he feels he belongs. Real life experience means that professionals observe whether people live according to the gender in which they feel they belong in their real lives (Missé, 2014).

¹²Which does not call into question, which does not pose a threat to the person.

¹³Previously, this procedure was called “real-life test”.

¹⁴ Tripartite therapy or triadic treatment integrates psychological evaluation, endocrinological treatment and surgical intervention (Fernández-Fígares, 2010).

¹⁵Previous revisions were carried out in 1980, 1981, 1990, 1998 and 2011.

body.” As Miquel Missé (2014) points out, we do not understand what came first: the transsexual experience or the diagnostic criteria (medical discourse). Whether or not this is known, the most important thing is that discourse exists and has concrete impacts on people’s lives. The medical model creates in the imaginary the idea that all people with sex-gender non-conformity want surgery; it pathologizes gender non-conformity and reinforces the idea that it can only be “cured” in the operating room; it reiterates that the only “cure” treatment is body change, especially through sex reassignment surgery (Missé, 2014).

In spite of countless people reporting “feelings” of rejection on account of their bodies due to sex-gender non-conformity and wanting bodily modifications, others do not report such feelings; even if they wish to modify their bodies, they do not wish to undergo sex reassignment surgery. The way people live and build their bodies is, therefore, plural (Missé, 2014).

According to Carneiro (2006), it is important to recognize that “femininity” and “masculinity” are flexible, subjective and socially constructed categories. To this extent, gender identity refers to how people identify themselves and build a sense of themselves as men or women, as well as how they refuse these identifications.

It is difficult for a therapeutic process to succeed if a person feels compelled to reproduce a specific narrative, the medical model narrative, in order to have a diagnosis that grants them access to medical treatments and to the change of legal identity (a requirement in some countries). These therapeutic processes, which ought to be follow-up processes, become evaluation and, consequently, judgment processes of the people who request support (Missé, 2014).

Besides the impacts resulting from the attempt to reproduce the medical model with a view to legitimizing identity, many trans people do not keep relationships with other trans people after undergoing sex reassignment surgery or body modifications in general. They “erase” their trans experiences and begin to live as men or women as if there had never experienced sex-gender non-conformity. Moreover, this erasure leads to a non-existence of trans models and to even disengagement from the trans movement.¹⁶

With the recognition that all identity is subjective, plural and heterogeneous, it is important to admit that its limits are not clear. Although there is a wide variety of ways of experiencing masculinities and femininities today, social boundaries are deeply rooted (Viñuales; Guasch, 2000) and greatly hinder the lives of people who cross or transcend the gender binary (Bockting et al., 2005). Social boundaries influence surgical practices and body modifications of those who do not reproduce the social norm. Adopting these surgical practices on non-conforming bodies emerges as the only possibility for these people to be desirable, accepted and legitimate. According to Miquel Missé (2014, p. 60, our translation) “the desirable body will never be fat, ugly, deformed or transsexual”.

(Des)pathologization of transsexualities and the premise of self-determination: final considerations

I believe that to accept being pathologized is to tear up your civil rights, to infantilize yourself in exchange for social acceptance (which never

16 It should be noted that it is not our intention to hold trans people responsible for binding relationships with other trans people and with the trans movement, nor to compulsorily defend the need for belonging, binding or building these relationships and these communities. We only intend to show that when a trans person legitimately avoids narratives and experiences that she went through, that makes other trans people lack known models and appreciation of their life experiences. Nuno Santos Carneiro (2006) states that engaged people, when compared to people who are not engaged in LGBTQ NGOs, have higher levels of pride and integration and evaluate their sexual orientation and/or gender identity as a “fundamental and very positive” part of what defines them as people. However, and according to McCann and Fassinger (1996), “imposing participation” is not legitimate; moreover, the relevance of social discrimination is such that “imposing” participation is to forget that often one does not participate because one cannot, not because one does not want to; and finally, there are people who achieve integration without ever having any form of political/associative participation.

happens), to describe yourself as a being without a choice, to resign yourself to an infallible destiny, to leave your future and your present in somebody else's hands, to deny that we only have the present and we look forward to a future where we are the result of a past that we also built [...] it is to authorize somebody else to control your life and your body, to hand the whip to the inquisitor and torturer to thrash you with their definitions, reports, tests, proofs and all the tricks that these owners of minds and souls use to tame all the life instinct that exists: the instinct to exist as you want. (Oliveira, 2014, p. 102)

This excerpt by social scientist and trans man André Lucas Oliveira (2014) brings to discussion the implications of the process of pathologization of trans experiences and the right to self-determination of their bodies and identities. The meaning that each trans person assigns to their life experience is one that must prevail, to the detriment of a medical model that, as we saw previously, pathologizes and regards them as homogeneous and with no autonomy to decide their lives (Freire, 2020; Sennott, 2010).

In 2009, the recognition that pathologization causes negative consequences in the experiences of trans people (Missé, 2014) was the starting point for the launch of the international campaign *Stop Trans Pathologization 2012*¹⁷ (STP 2012, 2012). Organized by the International Trans Depathologization Network, the initiative aims to remove gender identity disorder from the DSM¹⁸ and the IDC, to abolish the mandatory status of psychiatric diagnosis for hormonal and surgical treatments and for changing name and sex in the civil registry. This campaign became one of the

largest international mobilizations of the trans¹⁹ movement (Missé, 2014; Platero, 2014; Suess, 2010).

Since 2009, the STP 2012 campaign has called, always in October, for an International Day of Action for Trans Depathologization, with simultaneous demonstrations and other actions in several cities around the world (STP 2012, 2015). In October 2015, due to the stipulated date, more than 100 actions had already taken place in 45 cities of several around the world. The campaign is currently supported by 397 groups and activist networks, public institutions and political organizations from Africa, Latin America, North America, Asia, Europe and Oceania. In addition to the annual mobilizations in October, this international network promotes activities to spread information about the campaign (STP 2012, 2015).

The perspective of depathologization focuses on questioning the processes of trans pathologization, stating that it is not the trans person who is sick, but a society unable to conceive realities outside the hegemonic social model (Missé, 2014; STP 2012, 2011). Raquel (Lucas) Platero (Nabal, 2015) says in an interview that trans people do not have a pathology; instead, they just need support to be able to live according to what they feel.

In response to the concern of some trans people that the depathologization of transsexualities might result in the loss of their medical rights, some texts of the STP 2012 campaign include, in addition to the main need to remove the gender identity disorder from the DSM and the ICD, the proposal for a non-pathologizing mention of the process of physical sex change in the ICD²⁰, with the aim of ensuring public coverage of hormonal and surgical treatments for those who want it (STP 2012, 2011; Suess, 2010).

17200 groups from four continents supported the STP 2012 International Campaign (STP 2012, 2012). The revised version of the DSM was announced for 2012, but it came out only in 2013.

18 After the publication of the fifth version of the DSM, replacing gender identity disorder with gender dysphoria, the STP 2012 campaign proposes the removal of gender dysphoria from the DSM-5. This new edition of the manual (DSM-5) thus continues to regard transsexuality as a mental disorder (Platero, 2014; STP 2012, 2013).

19 Trans people were the drivers of the STP 2012 campaign, but plural voices and places were quickly raised to support this campaign, namely health workers and social researchers (Garaizabal, 2010; Missé, 2014; Platero, 2014).

20 The difference between the DSM and the IDC is that the DSM refers exclusively to mental diseases, while the IDC includes, in addition to the criteria for diagnosing diseases, medical care processes not based on diseases.

Although the diagnosis “enables” public treatment through financial support for sex reassignment surgeries, the effects of this diagnosis are questionable (Arán; Zaidhaft; Murta, 2008; Missé, 2014).

Faced with the position of non-acceptability of the (bio)psychomedical diagnosis as an official way of legitimizing an identity, which tutors people’s lives because it is deterministic (Almeida, 2010; Oliveira, 2014; Rodrigues, 2016), Susan Stryker (2008) advocates depathologization by proposing a liberating and plural action of conceiving trans (de)constructions in opposition to medical models of homogenization of bodies, self-meanings, desires and behaviors of trans people. These people, according to the medical model, have been considered as “appropriate” subjects of rights only when they go through “normalization devices”.

Belissa Andía (2009), one of the representatives of the STP 2012 campaign, says that it is essential to avoid a false dilemma between depathologization and health rights. For the author, depathologization is not opposed to the recognition of the right to health, nor does it mean a universal and/or unwanted demedicalization by subjects who find meanings in it and who need it as a vehicle for determining their bodies and their identities. The positions of depathologization do not defend medical and psychological monitoring only in situations of clinical illness - even for those who are integrated from an organic and psychosocial point of view, the right to health services is defended, since they may continue to be necessary (and the tendency is that they will), as they continue to be for all people throughout their lives. The psychological/medical service needs only to know that these circumstances are possible; to trust the person who asks for help, because there are no means of objectifying this need and monitoring and informing trans people about the implications of their decisions (Fernández-Fígares, 2010; Hammarberg, 2010).

Although trans identities are not, as we have advocated, a pathology, some trans people need medical support and understandably demand a quality public service to access hormonal treatments and / or surgeries. The desire for body modification of trans people is legitimate, therefore this modification must be self-determined.

According to André Lucas Oliveira (2014), it is not easy to live in spheres that are socially viewed as being outside the “norm” and to live in a body that, in some situations, is considered an abject body. In this sense, access to quality health should be ensured, but the contexts that lead trans people to the need to change their bodies need to be discussed (Missé, 2014).²¹

Not all countries (e.g. Portugal, France, Sweden and Spain) are in favor of pathologization, even if the DSM-5 describes this situation as being pathological (Oliveira, 2014; Platero, 2014; Sanmartín, 2010), since they recognize that trans people have the right to autonomy and management over their bodies and identities founded on the recognition of the human rights of these people.

In fact, some societies are organized in such a way that conceiving this idea of a non-conforming body is not acceptable. They delegate to the average power the action of pathologizing and “disciplining” human experiences, in this case of non-conforming bodies and genders. Doctors thus become “guardians of the binary sex / gender system (Missé, 2014). This power is also supported by the idea that the regulation of bodies has to be in accordance with the regulation of (social) identities and, therefore, the processes of body modification become a single way of maintaining gender conformity (Oliveira, 2014). In other words, processes must follow gender norms (male sex - male gender and female sex - female Gender) and heterosexual sexual orientation as the only possible and acceptable ones (Butler, 2009; Oliveira, 2014).

²¹Amets Suess, a sociologist, trans activist and one of the coordinators of the STP 2012 campaign, claims that depathologization proposals do not presuppose demedicalization, in other words, the right to access health for bodily interventions if trans people so wish. She also stresses that participation through the public health system must be guaranteed, since depathologization and medicalization are not two opposing objectives, but effectively allow the fulfillment of Basic Human Rights (STP 2012, 2011).

Also according to sociologist and trans activist Miquel Missé (2014), the trans body has been exposed in an “error” paradigm as if a problem had happened at some point in a person’s life. This paradigm emphasizes that trans people were born in a wrong body, but fortunately they will be able to correct it and recover it. The “error” paradigm has done trans people much more harm than it has brought them benefits because it embodies the idea that, because people “feel” that a body is not theirs, they tend to mistreat it, maim it and destroy it. Having said that, keeping the error paradigm and the need to correct and recover it carries its own risks (Garaizabal, 2010; Missé, 2014; Platero, 2014).

Besides all the issues involved in the process of pathologizing trans identities, symbolically these bodies have also been defined as abject and “monstrous” bodies (Oliveira, 2014; Platero; Rosón, 2012; Stryker, 2013). In order to be accepted, these bodies have undergone heteronormative “normalization devices” (and, on account of that, possibly resulting in transnormative experiences). Keeping the pathology in these bodies is to keep the idea that these bodies will only be desirable and able to desire if they undergo process of heteronormative²² and cisnormative²³ “disciplinarization”, which creates a process of hierarchization and legitimization of bodies and people’s lives according to these determined systems (Butler, 2009; Louro, 2009; Oliveira, 2014, Teixeira, 2013).

A trans person has accessed health with the label “trans”, but this label/diagnosis only occurs when people become absolutely “obedient” to a system that has the power to try to normalize their bodies and identities. When people become disobedient, access to health is blocked, creating paths of increased oppression for these people.

According to some authors, when we talk about disobedient people, we talk about people

who are faced with a situation of not following the medical model that says how men and women should be and behave. Not reproducing the medical model may condition the legitimacy of their identity (Braz, 2018; Missé, 2014; Oliveira, 2014). For example, if a person adopts a behavior that deconstructs some gender stereotypes, they may be delegitimized by the health professional (Oliveira, 2014).

Having said that, the (pathologizing) medical model has an impact on the very construction of the identity of subjects. People who go through medical processes often print / reproduce constructions of stereotyped masculinities and feminilities. These stereotypical reproductions of some trans people can also be explained by the fact that there is a socially reinforced idea that trans people are “a bad copy of the gender in which they live”, which devalues their identity constructions and deconstructions.²⁴ Some trans people reproduce gender stereotypes precisely as a way to reaffirm themselves and, consequently, legitimize themselves. Also, in order to access health care, some trans people create the legitimate narratives of the medical model, expressing the desire to live in the other gender since childhood, the feeling of rejection of their genitalia and of being heterosexual (Missé, 2014).

The perspective of depathologization focuses on the premise of trans people’s right to self-determination. Thus, assuming this premise entails a critical stance of the models, but also the lives themselves (Missé, 2014). As an example, Miquel Missé (2014, p. 71, our translation) states: “our bodies have no problem. The problem lies in the system that does not know in which drawer to place them, sort them, read them. But of course, the operating room is much more economical and less questioning than social change”.

Not all people see themselves in the paradigm of pathologization of transsexualities and,

22 This process of heteronormative “disciplinarization” is based on readings of Judith Butler (2009), but the emphasis is also placed on cisnormativity. That is, cis (non-trans) bodies are more valued, legitimate, accepted, recognizable and recognized as human than trans bodies.

23 Considering that only men with penises and women with vaginas are accepted and desirable.

24 This paper does not bring up the question of a good or bad “copy” since, as Judith Butler (2004) exposes in a well-known idea of hers, gender is, after all, always a copy without an original.

therefore, those who do not identify with this model have the right to build their own explanatory model (Missé, 2014). For the depathologization movement, the plurality of paths and legitimacy of trans identities must be built into the social imaginary. An imaginary opposite to the one built by the biomedical model by which only medical tutelage confers legitimacy to trans identities (Platero, 2014). In this sense, states must implement policies that ratify the international declarations of human rights, recognizing and promoting access to health without pathologizing the individual, making this commitment to feminist principles and social justice (Carvalho, 2014).

According to Shannon Sennott (2010), professionals who have power over designations related to trans themes should immerse themselves in the trans population to make informed decisions about the future of “gender dysphoria”, recognizing that the arguments made by advocates for the removal of this disorder are based on the non-stigmatization of trans people. Such professionals should be based on feminist principles that have as a precept and idea that, in a socially just world, any type of sex/gender should not be pathologized.

Indeed, professionals should have the task of accompanying trans people through their self-determination, recognizing their experience as plural, not pathological, human beings (Jesus, 2012), embracing depathologization of gender as the most liberating and emancipatory path (Butler, 2009; Carvalho, 2014).

The critique of the model that pathologizes trans life experiences and paths is thus understood, in this paper, through the (re)cognition of the negative impacts that the adoption of this model has on the concrete lives of trans people (e.g., stigma, violence and lack of autonomy) (Platero, 2014). We recommend the importance of considering the work of health professionals in monitoring trans life paths, if people so wish, in opposition to the biomedical model that keeps the pathology of trans life paths and, through appreciation of the “institutionalization of normalization” of trans bodies and identities,

has become the “guardian” of the modifications of these bodies and identities (Coimbra, 1995; Platero, 2014).

References

- ALMEIDA, G. Reflexões iniciais sobre o processo transexualizador no SUS a partir de uma experiência de atendimento. In: ARILHA, M.; PISANESCHI, T.; CRENN, T. *Transexualidade, travestilidade e direito à saúde*. São Paulo: Oficina Editorial, 2010. p. 117-147.
- ANDÍA, B. *Fundamentación de la campaña contra la patologización de la identidad de género: alto a la patologización trans*, 2012. Bruselas: Secretaría Trans de ILGA, 2009.
- APA - AMERICAN PSYCHIATRIC ASSOCIATION. *Manual de diagnóstico e estatística dos distúrbios mentais*. 3. ed. Lisboa: Livros Técnicos e Científicos, 1986.
- APA - AMERICAN PSYCHIATRIC ASSOCIATION. *Manual of mental disorders*. 4. ed. Washington, DC, 1994.
- APA - AMERICAN PSYCHIATRIC ASSOCIATION. *Manual de diagnóstico e estatística das perturbações mentais*. 4. ed. Lisboa: Climepsi, 2002.
- APA - AMERICAN PSYCHIATRIC ASSOCIATION. *Diagnostic and statistical manual of mental disorders*. 5. ed. Washington, DC, 2013.
- ARÁN, M.; ZAIHHAFT, S.; MURTA, D. Transexualidade: corpo, subjetividade e saúde coletiva. *Psicologia e Sociedade*, Recife, v. 20, n. 1, p. 70-79, 2008. DOI: 10.1590/S0102-71822008000100008
- BENJAMIN, H. Transsexualism and transvestism as psycho-somatic and somato-psychic syndromes. In: STRYKER, S.; WHITTLE, S. *The transgender studies reader*. New York: Routledge, 1954/2006. p. 45-52.
- BENJAMIN, H. *The transsexual phenomenon*. New York: The Julian Press, 1966.
- BOCKTING, W. et al. Evaluation of a sexual health approach to reducing HIV/STD risk in the

- transgender community. *Aids Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, Abingdon-on-Thames, v. 17, n. 3, p. 289-303, 2005. DOI: 10.1080/09540120412331299825
- BRAZ, C. Eu já tenho nome: itinerários de homens trans em busca de respeito. *Habitus*, Goiânia, v. 16, n. 1, p. 162-176, 2018. DOI: 10.18224/hab.v16i1.6367
- BUTLER, J. *Undoing gender*. New York: Routledge, 2004.
- BUTLER, J. Desdiagnosticando o gênero. *Physis*, Rio de Janeiro, v. 19, n. 1, p. 95-126, 2009. DOI: 10.1590/S0103-73312009000100006
- CARNEIRO, N. S. *Ser, pertencer e participar: construção da identidade homossexual, redes de apoio e participação comunitária*. 2006. Tese (Doutorado em Psicologia) - Universidade do Porto, Porto, 2006.
- CARVALHO, I. Transexualidade: vivência do processo de transição no contexto dos serviços de saúde. *Acta Médica Portuguesa*, Lisboa, v. 23, n. 6, p. 1001-1010, 2010.
- CARVALHO, N. S. Gênero e sexualidade: intersecções em disputa. In: JESUS, J. G. *Transfeminismo: teorias e práticas*. Rio de Janeiro: Metanoia, 2014. p. 69-84.
- CASTEL, P.-H. Algumas reflexões para estabelecer a cronologia do “fenômeno transexual” (1910-1995). *Revista Brasileira de História*, São Paulo, v. 21, n. 41, p. 77-111, 2001. DOI: 10.1590/S0102-01882001000200005
- CAULDWELL, D. O. Psychopathia transexualis. In: STRYKER, S.; WHITTLE, S. *The transgender studies reader*. New York: Routledge, 2006. p. 40-44.
- COIMBRA, C. (Org.). *Guardiães da ordem: uma viagem pelas práticas psi do Brasil do milagre*. Rio de Janeiro: Oficina do Autor, 1995.
- COLEMAN, E. et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, Abingdon-on-Thames, v. 13, n. 4, p. 165-232, 2011. DOI: 10.1080/15532739.2011.700873
- COLL-PLANAS, G. Introdução. In: MISSÉ, M.; COLL-PLANAS, G. *El género desordenado: críticas en torno a la patologización de la transexualidad*. Barcelona: Egales, 2010. p. 15-25.
- DEVOR, A. H. Reed Erickson and The Erickson Educational Foundation. *The Erickson Educational Foundation*, [s.l.], 2013. Disponível em: <<https://bit.ly/3uQXi2M>>. Acesso em: 20 ago. 2020.
- DOCTER, R. F. *Becoming a woman: a biography of Christine Jorgensen*. Philadelphia: The Haworth Press, 2008.
- FERNÁNDEZ-FÍGARES, K. Historia de la patologización y despatologización de las variantes de género. In: MISSÉ, M.; COLL-PLANAS, G. *El género desordenado: críticas en torno a la patologización de la transexualidad*. Barcelona: Egales, 2010. p. 97-111.
- FISK, N. Gender dysphoria syndrome: the how, the what, the why of a disease. In: LAUB, D. R.; GANDY, P. *Proceedings of the second interdisciplinary symposium on gender dysphoria syndrome*. Palo Alto: Stanford University Medical Center, 1973. p. 7-14.
- FREIRE, L. Em defesa da dignidade: moralidades e emoções nas demandas por direitos de pessoas transexuais. *Mana*, Rio de Janeiro, v. 26, n. 2, e262205, 2020. DOI: 10.1590/1678-49442020v26n2a205
- GARAIZABAL, C. Transexualidades, identidades e feminismos. In: MISSÉ, M.; COLL-PLANAS, G. *El género desordenado: críticas en torno a la patologización de la transexualidad*. Barcelona: Egales, 2010. p. 125-140.
- HAMMARBERG, T. *Derechos humanos e identidad de género*. Estrasburgo: Council of Europe, 2010.
- HOYER, N. (Ed.). *Man into woman: the first sex change: a portrait of Lili Elbe*. London: BlueBoatBooks, 1933/2004.
- JESUS, J. G. *Orientações sobre identidade de gênero: conceitos e termos*. Brasília, DF: Jaqueline Gomes de Jesus, 2012.
- KING, D. Confusiones de género: concepciones psicológicas y psiquiátricas sobre el

- travestismo y la transexualidad. In: NIETO, J. A. *Transexualidad, transgenerismo y cultura*. Madrid: Talasa, 1998. p. 126-156.
- LEV, A. The ten tasks of the mental health provider: recommendations for revision of the World Professional Association for transgender health's standards of care. *International Journal of Transgenderism*, Abingdon-on-Thames, v. 11, n. 2, p. 74-99, 2009. DOI: 10.1080/15532730903008032
- LOURO, G. L. Heteronormatividade e homofobia. In: JUNQUEIRA, R. D. *Diversidade sexual na educação: problematizações sobre a homofobia nas escolas*. Brasília, DF: Ministério da Educação: Unesco, 2009. p. 85-93.
- MANCINI, E. *Magnus Hirschfeld and the quest for sexual freedom: a history of the first international sexual freedom movement*. London: Palgrave Macmillan, 2010.
- MCCARN, S. R.; FASSINGER, R. E. Revisioning sexual minority identity formation: a new model of lesbian identity and its implications for counseling and research. *The Counseling Psychologist*, Thousand Oaks, v. 24, n. 3, p. 508-534, 1996. DOI: 10.1177/0011000096243011
- MEYEROWITZ, J. *How sex changed: a history of transsexuality*. Cambridge: Harvard University Press, 2002.
- MISSÉ, M. *Transexualidades: outras miradas posibles*. 2. ed. Barcelona: Egales, 2014.
- NABAL, E. Entrevista a Raquel (Lucas) Platero. *BurgosDijital*, Madrid, 25 maio 2015. Disponível em: <<https://bit.ly/3wQde7j>>. Acesso em: 24 out. 2020.
- NIEDER, T.; RICHTER-APPELT, H. Tertium non datur: either/or reactions to transsexuality amongst health care professionals: the situation past and present, and its relevance to the future. *Psychology & Sexuality*, Abingdon-on-Thames, v. 2, n. 3, p. 224-243, 2011. DOI: 10.1080/19419899.2010.545955
- OLIVEIRA, A. L. Os homens transexuais brasileiros e o discurso pela (des)patologização da transexualidade. In: JESUS, J. G. *Transfeminismo: teorias e práticas*. Rio de Janeiro: Metanoia, 2014. p. 87-105.
- ORTEGA, E.; ROMERO-BACHILLER, C.; IBÁÑEZ, R. Discurso ativista y estatus médico de lo trans: hacia una reconfiguración de cuidados y diagnósticos. In: PÉREZ SEDEÑO, E.; ORTEGA, E. *Cartografías del cuerpo: biopolíticas de la ciencia y la tecnología*. Madrid: Cátedra, 2014. p. 521-572.
- PLATERO, R. L. (Org.). *Trans*sexualidades: acompañamiento, factores de salud y recursos educativos*. Barcelona: Bellaterra, 2014.
- PLATERO, R. L.; ROSÓN, M. De “la parada de los monstruos” a los monstruos de lo cotidiano: la diversidad funcional y sexualidad no normativa. *Feminismo/s*, Alicante, n. 19, p. 127-142, 2012. DOI: 10.14198/fem.2012.19.08
- RODRIGUES, L. *Viagens trans(gênero) em Portugal e no Brasil: uma aproximação psicológica feminista crítica*. 2016. Tese (Doutorado em Psicologia) - Universidade do Porto, Porto, 2016.
- SANMARTÍN, O. R. El gobierno pedirá a la OMS que no vea la transexualidad como una enfermedad. *El Mundo*, Madrid, 14 maio 2010. Disponível em: <<https://bit.ly/3djFLdH>>. Acesso em: 24 out. 2020.
- SENNOTT, S. Gender disorder as gender oppression: a transfeminist approach to rethinking the pathologization of gender non-conformity. *Women & Therapy*, Abingdon-on-Thames, v. 34, n. 1-2, p. 93-113, 2010. DOI: 10.1080/02703149.2010.532683
- SOLEY-BELTRAN, P. (Org.). *Transexualidad y la matriz heterosexual*. Barcelona: Bellaterra, 2009.
- STOLLER, R. Biological substrates of sexual behavior. In: STRYKER, S.; WHITTLE, S. *The transgender studies reader*. New York: Routledge, 1960/2006. p. 53-57.
- STP 2012 – STOP TRANS PATHOLOGIZATION 2012. *Comunicado da campanha STP 2012: reflexões sobre despatologização trans e direitos de saúde*. [S.l.], 2011.

- STP 2012 - STOP TRANS PATHOLOGIZATION 2012. *Reflexiones sobre los SOC-7*. [S.l.], 2012.
- STP 2012 - STOP TRANS PATHOLOGIZATION 2012. *Desarrollos recientes relacionados con el proceso de revisión del DSM y de la CIE*. [S.l.], 2013.
- STP 2012 - STOP TRANS PATHOLOGIZATION 2012. *Día Internacional de Acción por la Despatologización Trans*. [S.l.], 2015.
- STRYKER, S. *Transgender history*. Berkeley: Seal Press, 2008.
- STRYKER, S. Prefacio. In: BALZER, C.; HUTTA, J. S. (Ed.). *Transrespeto versus transfobia en el mundo: un estudio comparativo de la situación de los derechos humanos de las personas trans*. Berlín: Transgender Europe, 2013. p. 12-17.
- SUESS, A. Análisis del panorama discursivo alrededor de la despatologización trans: procesos de transformación de los marcos interpretativos en diferentes campos sociales. In: MISSÉ, M.; COLL-PLANAS, G. *El género desordenado: críticas en torno a la patologización de la transexualidad*. Barcelona: Egales, 2010. p. 29-54.
- TEIXEIRA, F. *Dispositivos de dor: saberes-poderes que (con)forman as transexualidades*. São Paulo: Annablume, 2013.
- VIÑUALES, O.; GUASCH, O. (Org.). *Sobre el futuro de la identidad*. Madrid: Reverso, 2000.
- WHO - WORLD HEALTH ORGANIZATION. *ICD-11 for mortality and morbidity statistics*. Geneva, 2019.
- WPATH - WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. *Normas de atenção à saúde das pessoas trans e com variabilidade de género*. East Dundee, 2012.

Authors' contribution

Rodrigues, Santos Carneiro and Nogueira cooperated in the writing of the entire manuscript with critical contributions and revision.

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Erratum

In the article “History of scientific, medical and psychological approaches to transsexualities and their critical approach”, doi 10.1590/S0104-12902021200768, published on volume 30, no. 2 of 2021 of *Saúde e Sociedade*, footnote number 1 was inserted on the first page:

It should read:

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