



Revisiting the “Wildcat Strike in the Gender Factory”: Material Effects of Classification

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ABSTRACT: Taking up a central metaphor of “the wildcat strike in the gender factory” from Dwight Billings and Thomas Urban’s formative 1982 article “The Socio-medical Construction of Transsexualism: An Interpretation and Critique,” I trace how trans*¹ lives are tied in with law and medicine, and how psycho-medical classifications affect material lives of trans* people. I question several core elements of contemporary gatekeeping to trans* healthcare. Next, I describe the material effects that classification discourse and medical practice have on the history and future of gender diversity. I argue that classifications serve among other things as a means to limit and control various genders and bodies. In the last part, I take a closer look on the struggle for liberation from these shackles. While Billings and Urban see the trans* phenomenon as a “wildcat strike in the gender factory,” resisting imposed gender categories, this essay explores how prophetic the authors were.

KEYWORDS: transgender, depathologisation, classification, medicine.

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Marxist (Marx & Engels, 1845) and feminist (Haraway, 1988) praxis recommends the author to position themselves and acknowledge how they situate their knowledge production practices. I embody the position of a longtime trans* and socialist activist who founded several trans* collectives in the Netherlands, such as *The Noodles* and *Principle 17*, to fight for the right to the highest attainable standard of trans* health. My agenda here is to tell a story that shows how classification means pathologisation of trans* identities, of identities *tout court*; how it affects trans* people; and how systems that deem them incapable or undesirable for decisional autonomy are detrimental to the right to life itself.

The Beginning

The history of modern transgender presence in the geopolitical Western world is considered to start in late 19th century. In 1897, a physician and sexologist Magnus Hirschfeld founded the *Wissenschaftlich-humanitäres Komitee* (The Scientific-Humanitarian Committee, *WhK*) in Berlin, today considered the first LGBT advocacy group in the (Western) world (see: Lauritzen and Thorstadt, 1995). In *Transvestites* Hirschfeld describes his first “cases,” he was also involved in the first transgender surgery – on Dora Richter, in 1931, in Berlin (Meyerowitz, 2002, p. 21). In those days the difference between trans* and homosexual was not yet canonized. In 1966, Harry Benjamin, Hirschfeld’s colleague at WhK, authored *The Transsexual Phenomenon* (1966), that for years functioned as the “Bible for Transsexuality.” Outside the Western world, gender diversity (that only from 19th century became fully binary) is known to have been recognised already for ages, with well-known examples like the South Asian *hijras*, pre-Columbian *travestis* in Latin America, *shaman* in North East Asia (see e.g. Feinberg, 1996). In many places, these non-binary gender systems were destroyed with the arrival of settler-colonizers. Philosopher Giuseppe Campuzano (2008) shows for Peru how pre-columbian genders disappeared through colonialism. Their destruction started already in the 16th century and was witnessed by Quechua nobleman Felipe Guamán Poma de Ayala (1978), who famously chronicled colonial violence inflicted on the indigenous peoples in the Andes. Similarly, contemporary decolonial philosopher María Lugones (2008) argues in *Heterosexuality and the Modern Colonial Gender System* how gender structures of the Yoruba in Nigeria and Native American tribes were subordinated by Western practices (p.196).

In many geographical contexts trans* people experience violence. In modern times, this continues in many places as evidenced by the “Trans Murder Monitoring Project,” issued by Transgender Europe (TGEU), a non-governmental organization advocating trans*gender and intersex rights.² In Europe, Turkey and Italy take the lead with respectively 43 and 36 killings since 2009, in the USA around 20 mostly trans* women of colour get killed yearly (see e.g. Kellaway & Brydum 2015; Advocate.com Editors 2016). There is no safe place for trans* people. Transphobia exists even among left wing and feminist organisations and theorists. One hugely important factor behind this is the Western classification system, as this essay will show. A formative article by Billings and Urban (1982) conceptualised trans* people’s existence as a “wildcat strike in the gender factory” (p. 282), and equated trans* people’s refusal to continue living their assigned gender or in an unaltered body, to a strike that is neither authorised nor legal, opposing the production of gender binary. I explore how far they were right.

Classifications

In this section I will explain what kind of classifications are imposed on the bodies of trans* people. The process of medically assisted gender transition is governed by two complementary classifications. The first one is the *Diagnostic Statistical Manual for Mental Health Disorders* (DSM), currently in its 5th edition (APA, 2013). Issued by the American Psychiatric Association (APA), DSM departs from a North American perspective. The DSM is in origin a American psychiatric manual and is rooted in the mores of US practitioners, though now with a more international team of experts. As the medical discipline, and psychiatry in particular, is very influential on what we think moves and ails us, we are considered psychiatric subjects. The second classification, with more authority worldwide, is the *International Statistical Classification of Diseases and Related Health Problems* (ICD, 1993) issued by the World Health Organization (WHO) that in essence is a human rights organization and a member of the United Nations family. The current ICD version is ICD-10, with ICD-11 in beta stage.³ The two classifications are different in aim and scope. The DSM is meant for psychiatry and the ICD is targeted at the whole medical field and contains far more somatic diagnoses than psychiatric. The character of the DSM is clearly helping with diagnosis, while only the Clinical Modification of the

ICD (ICD-CM) is meant for that, the ICD, as a classification, is mostly meant for morbidity and mortality statistics.

When looking at the two classifications, positive changes are visible. The current version of the DSM employs the word “gender” instead of “sex” and opts for “gender dysphoria” instead of “gender identity disorder.” These choices in nomenclature remain problematic as sex characteristics, corporeal/bodily phenomena that are not considered to have unequivocal influence on gender development, are still included in the DSM (Karkazis, 2000, pp. 47–62). The term “gender identity disorder” indicated that trans* identity itself is problematic, while “gender dysphoria” focuses on the issues people may have while living a trans* life. It seems that it was a close call that “gender incongruence” – a term preferred by many trans* activists – did not end up as the term of preference. The ICD is still in beta version for the coming edition, but chooses “gender incongruence” and more importantly, we also expect the new terminology to appear in a non-psychiatry related chapter about sexuality-related issues.

A psychiatric gatekeeping to access trans* health, often required on the basis of the classification, can be relatively swift, comprising a few sessions with a psychologist, to very intense and upsetting through a required stay of six weeks in a psychiatric ward, as has been the case in Ukraine⁴ and Belarus. France still requires health care recipients to see psychiatrists and endocrinologists who display little understanding and sensitivity towards trans* people and their needs. Denmark healthcare-wise also counts among the most regressive systems in Europe, notwithstanding the legal change made.⁵ Where some (mostly high-income) countries have simplified the legal gender recognition procedures, the majority of countries have no provision in gender identity recognition at all. Furthermore, their trans* and gender diverse inhabitants live in daily fear of discrimination and violence.

Trans* entanglements

When looking at legal changes towards fully free and self-determined gender change, it’s important to keep in mind that the healthcare and legal recognition are tied-in together. Most places offering legal gender recognition require drastic medical interventions, like castration, as criteria for approval. Just a few countries

disentangled this tie-in: Argentina, Malta, Ireland, Norway, and Denmark. Only the first two of them have also depathologized the access to transition care itself. Everywhere else, the requirements for legal change are mental health interventions and/or as full as possible physical approximation of the body to that of “the other sex;” underlaid by a genital focus of the clinic. In 2013, this interdependence was affirmed by the UN as “tantamount to torture or cruel, inhuman or degrading treatment or punishment” (United Nations Human Rights Council, par. 78). This is a good example illustrating that, despite the fact that rights-based discourse has its problems such as its top-down workings and its belonging to a liberal worldview, using human rights as the force of transformation is currently an effective tool.

Overall, basic tenets of medicine and psychiatry around gender, however shifting and changing, are still considered valid; genders may change to previously unfathomed diversity, sex however remains discrete and where not, it is diagnosed as a disorder of sex development. This is the rationale why sex characteristics and gender incongruence are going into one chapter in ICD-11. Gender is diverse, but sex must be fixed, as the basis of the psycho-medical worldview is to rest untouched. This way even the effects of declassification are limited, until also gender registration itself becomes irrelevant.

According to the United Nations, everyone has a right to the highest attainable standard of health (Preamble of the WHO Constitution, CESCR art. 12, GC 14, GC 20). This applies indiscriminately, with “only” economic development as a limiting factor. This includes health care related to gender transition. For trans* people, however, this right is undermined with many restricting procedures. In most countries that follow DSM, ICD, and/or the World Professional Association for Transgender Health’s (WPATH) *Standards of Care* (SOC, version 7 is current) having a referral letter that states conformity with DSM-code 302.85 (“Gender Identity Disorder in Adolescents or Adults”) or ICD-10 code F64.0 (“Transsexualism”), is a requirement before accessing gender transition related healthcare. That, in turn, constitutes a precondition to access legal recognition. In practice, often there is no right to health care for trans* people, but an obligation to undergo medical procedures in order to be able to change one’s gender marker on a passport or birth certificate.

Available gender transition procedures are mostly provided against a strong psycho-medical gatekeeping system. A psychiatrist first evaluates if the candidate complies with the diagnostic criteria for “gender identity disorder” or “gender dys-

phoria.” These are, among others, based on suffering caused by “incongruence” between one’s experienced gender and assigned gender (DSM-5 in: IFGE, n.d.). Because of these requirements in psychiatric or medical classifications, no one passes directly to a medical professional for access to hormones or surgeries. Also, not everywhere where there is a requirement of medical treatment, the resources to do that, such as a team of qualified professionals, are available. This way classifications, medical opinions and social norms become a warren of requirements to respond to.

An ontological fight for rights and agency

J. R. Latham (2016) signals in *Making and Treating Trans Problems* that the fight for trans* respect is also an ontological fight. Behind this statement lays a different idea about the production of reality. It is not the commonsense realism that assumes reality is objectively knowable and independent of the observer, but the idea that methods also make realities (Law, 2004 in: Latham, 2016), brought forward by scholars such as Bruno Latour, Annemarie Mol, or John Law. It matters how you see the world to define realities. According to Law reality is “not independent of the apparatuses that produce reports of reality” (2004, p. 31). Latham writes, “the systems designed to treat trans patients reiterate a specific trans ontology and trajectory of treatment [...] that does not reflect how many trans people experience their bodies and lives” (p.2). Latham argues that transsexuality, the psycho-medically defined sub-identity of transgender that is eligible for medical assistance, is produced by precisely the medical process, while it is assumed to precede intervention (Latham 2016, p.2). Medical interventions are based on politics that are opposed to this different ontology, of how trans* people imagine their lives, bodies and histories; one that is growingly rooted in autonomy and agency, stimulated by emancipation and activism as we will see towards the end of this essay.

Confronting the dominant idea, expressed by Selvaggi and Giordano in “Aesthetic Plastic Surgery,” that trans patients seeking gender confirmation surgery are clearly different from cisgender patients and need extra care, Latham examines “how clinical practices act in the making of trans realities, foreclosing particular iterations of what transsexuality (sic.) could be” (p.1). Latham dissects the assump-

tions and the reasoning of Selvaggi and Giordano as exemplary for mainstream reasoning. They use the main principles for medical intervention precisely to create trans people as a separate category. Riki Wilchins would call their attitude *genderpathophilia* (Wilchins, 1997, p. 225), an obsessive need to pathologize any kind of gender behavior that makes society feel uncomfortable. Latham shows how people with different gender identifications and/or expressions are treated differently from cisnormative population when seeking the same kind of health care interventions they may need: hormone replacement therapy, plastic surgery, facial feminization surgery (FFS), or genital surgeries. Morgan (2015), in “Self-determining legal gender: transgender right, or wrong?,” shows that medical professionals in Ireland and the UK also assume trans people need protection against delusions.

Intersex and trans* activist Mauro Cabral summarizes the strong entanglement of health classifications and legal gender recognition by saying that, on the one hand, the codifying of trans* identities and experiences in diagnostic terms confines them to a psychiatric ontology whose effects on life are negative – effects that do not only constitute trans* persons as less, but that also decidedly contribute to an institutionalized and normative reproduction of gender stereotypes. On the other hand, the same codification presents itself – and, in many cases, is also defended by these same trans* people – as a way to access rights. Particularly the right to surgically modify the sexed body and to the right of legal gender recognition (Cabral in: Suesch Schwend 2015, p. 418).

Material effects of pathological classification

Most literature on the effects of pathologization and mental health classifications concentrates on psychological effects thereof, minority stress, lack of wellbeing and the effects of medical treatment (such as e.g. hormonal effects on the body). Less is known from a sociological angle, how well people manage on the material, economic level and in labour market. Even less research is done on how this is connected with the idea that mental health classification of difference sets people back in society.

Pathological classification has very tangible material effects on trans* people. The first effect of identity disorder classification is stigmatization. Some people find the diagnosis comforting as they now have a recognition that what they expe-

rience is “real” somehow, that they are transsexual. Others refuse classifications, opposing the pathologization of trans* experiences overall. However, in both cases, they are all affected by discrimination and marginalisation, insofar as they are classified as having gender dysphoria.

Rampant discrimination and violence have always affected trans* people, but the psychiatric stigma adds an important new element to it (Cabral, 2016; Suess Schwend, 2016; Winter et al., 2015). As with homosexuality, trans* has not always been a psychiatric category. Homosexuality entered the DSM in 1952 and after a fierce struggle by activists and professionals it disappeared in 1974. However, in that same edition it was trans issues which entered the DSM. While scholars have shown how this is not a matter of causality (e.g. Zucker and Spitzer, 2005), it is clear that in both cases gender normativity is the common theme that brings them into the DSM and ICD (Valentine, 2007; Bernini, 2014). The DSM and ICD strengthen the stigma by confirming that trans* people have psychiatric mental health issues connected to their experience of gender. This fuels transphobic stereotypes that get picked up by media and popular culture: the stigma of a “man in women’s clothes”; and, to a lesser extent, “women dressed up as men” heightens the risk of trans* people being outlawed, refused a house, a job, or education. It also justifies violence, very often from police and security functionaries. Reported killings of trans* people keep on rising. According to TGEU’s Trans Murder Monitoring project (TGEU, 2016), we witness over 275 victims a year. For example the UK scores 65% on discrimination experience in the previous year (FRA, 2015, p. 21, p. 24).

The material effects of pathological classifications should be understood in intersection with other dimensions of discrimination: the lack of legal gender recognition that would enable trans* and gender diverse people to change their gender marker; the absence of regulations that protect trans* people from violence, discrimination, and even murder; and the inability to access affordable health care (both general and transition related) lead to socio-economic setbacks (NCTE, p. 125).

Another very important effect that pathological classification has is that it only allows for the production of certain bodies. The biopolitical effect of legitimation acknowledges only certain identities, for instance those labeled as “transsexual.” Therefore, other non-normative identities and bodies are delegitimised, declined recognition. In a system that upholds the biologicistic notion of only two “sexes,”

all sex/gender variances that diverge from it are exceptions to the rule, at best. In the DSM-5, and in discussions around the ICD-11 version, other genders are mentioned, but they remain an afterthought. Non-binary genders are still waiting in the wings to be “recognized.”

Nowadays non-binary trans* people have to go through intensive psychiatric evaluation for having a non-normative gender identity before being able to access health care (if any). This is not only a human rights violation,⁶ but it has strong material and psychological effects on people. However, although recognition for all trans* people is important, this cannot happen completely within a stigmatising framework such as the psychiatric diagnosis.

Resistance is fruitful

“The wildcat strike in the gender factory” has brought some positive results. The vision of the wildcat strike, as described by Billings and Urban, is that the marginalised who are a product of that same system would autonomously rise to overthrow its medico-capitalist ways of producing bodies and identities. Like activist workers, trans* people have organized, and still keep organizing, to fight the “class struggle of gender.” Years of activism have led to change in attitudes and legislations, although we need to add that these changes are not universally good and they do not work in the same way for different groups. As we saw earlier, advocacy and activism have led to changes in DSM and ICD and institutional practices such as the UN appointing an Independent Expert for “Sexual orientation and gender identity” (SOGI) issues, stepping up for intersex children’s rights, or Argentina adopting in 2012 the legal gender recognition law that is still considered the Gold Standard for trans* rights.

Protests against pathologization really took off from the change process from DSM-4 to DSM-5, that ended in 2013. In this process, the definition changed from gender identity disorder (making the identity disordered) to gender dysphoria that puts more emphasis on the problem, namely “dysphoria,” one has while being trans*. The diagnostic criteria have not changed much, and they remain rooted in universalised and naturalised Western understandings of gender roles, e.g. strictly gendered use of dolls or cars (needless to say, trans* activists react bewildered to this criterion). Despite all this, this shift in nomenclature can be meaningful in some more conservative settings.

The DSM has provoked resistance in trans* communities. The pro-depathologisation movement is an international movement. In their dissertation, Amets Suess Schwend (2015) focuses on the “Stop Trans Pathologisation” (STP) campaign, charting how multiple ways of resistance have formed in different places. Some examples of this resistance are the campaigns “L’autèntica malaltia és la transfòbia” (The real sickness is transphobia; that adopts a strategy of reversing the gaze), “Ni hombres, ni mujeres, el binarismo nos enferma” (not men not women, the binary makes us sick; criticism of a dichotomous system), “Por el placer de ser trans” (for the joy of being trans; about creating happy narratives). In the Netherlands continuing education through social media by trans* activists and the push towards legal change are slowly breaking the cultural hegemony of transphobic doctors.

Activists struggling for freedom and rising consciousness advocate for the recognition that trans* identities are valid in and of themselves and not through pathologization. The struggle involves more and more people with different non-normative identities. This struggle has centered, among other aspects, on showing that the dominant ideas in the medical profession are the product of heteronormative prejudices that do no justice to our lives. In result, the attitudes of professionals are slowly changing, making them consider different frameworks. By refusing for the psychiatric diagnosis to have the last say, this struggle creates room for wider visibility of different identities. Through the emancipation that is connected with the trans* movement, the power held by classifications and diagnosis is visibilized as a disciplining power that affects materially the lives of trans* people. Resistance proves to be fruitful. We are getting closer and closer to a non psycho-pathologising understanding of the ways in which access to health care should be provided to trans* and gender diverse people. The actions, oppositions and critiques to the medical committees that have the power to update relevant texts such as the DSM have contributed to this change, as Susan Stryker (2006) describes in her “Words to Victor Frankenstein” in relation to the protest action at the APA meeting. Also human rights declarations and activism are paving the way to relevant change. For example Transgender Europe (TGEU), Global Action for Trans Equality (GATE), International Campaign to Stop Trans Pathologization (STP), Centre of Excellence for Transgender Health (COE), European Union, United Nations; as is also a growing corpus of scientific literature that is more aware of trans* per-

spectives (see: *The Lancet*, series “Transgender health”, June 2016). This change is a contentious affair that should not be left to the medical discipline alone.

This strike is ours!

In this essay, I have given a short overview of how trans* and gender diverse people have for a long time been considered mentally disordered and thus their experiences have been forced into a psychiatric corset. Coinciding with a rising self-consciousness, a new militant trans* movement formed and the update of the DSM classification was taken as a moment to get involved and act up for access and availability of gender transition health care. Through multi-tier action the influence of this movement grows exponentially and can no longer be ignored.

Billings and Urban in their article express deep distrust towards the medical establishment and protest against transgender surgery as a solution for social discomfort. They reproach trans* people that they don't firmly and univocally reject the gender binary and fail to recognize that trans* people are as much of a product of heteronormative society as anyone else. But who are they to call for trans* disobedience? It's not their strike. Their myopic approach keeps heteronormative society blame-free, with contemporary researchers and practitioners still thinking that trans* people are “special” or suffer from a certain “disorder.” Billings's and Urban's blaming of trans* people is counterproductive, that is why in this essay I intercept the metaphor central to their paper and show its subversive potential. The wildcat strike in gender factory continues: while a disentanglement of legal recognition and medical assistance is one important aspect of it, without a model of informed consent granting us our agency, we are still a long way from home. Therefore, a unified action pressuring states and international bodies to adapt their laws and regulations coupled with the work of reclaiming our agency, will in the end lead to a societal transformation and get us there.

Endnotes

- ¹ Trans*, with asterisk, intends to include all forms of gender diversity on their own right. On its origins, see: Cabral, 2009, p. 14.
- ² See: [Trans Murder Monitoring](#) (n.d.); what is registered is considered only the tip of the iceberg as in many areas violence against trans* people is significantly underreported.

- ³ Approval is foreseen for June 2018, at the next World Health Organization assembly.
- ⁴ In 2017, Ukraine abolished the infamous Order 60 regulating access to trans-related health that imposed a mandatory 20–45 days of psychiatric internment. It remains to be seen how the updated rules will be implemented and what effect they will have.
- ⁵ Even though Denmark replaced the gender identity disorder criteria in the national classification of diseases with very friendly codes, medical practice is not prone to change yet.
- ⁶ It concerns most clearly The Yogyakarta Principle 18 on freedom from medical abuses – Yogyakarta Principles being a document concerning human rights in the areas of sexual orientation and gender identity prepared in 2006 by a distinguished group of international human rights experts in Yogyakarta, Indonesia. Principle 18 reads: “No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person’s sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed” (Yogyakarta Principles 2007).

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