Allegories of the “Ab/Normal”:
Transgressing Gender Norms on Medical
Reality TV

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Introduction

Today’s medical television situates the problems of around the world “normal” and “abnormal” behavior within a discourse of life-strategies, risk, mental health and medical norms. The ontological languages of pathology that once preoccupied medical experts have been replaced by biomedical languages of health and socio-cultural aspirations for well-being. A study of the participants and topics on reality shows reflects this shift. Cable programs like Intervention and Hoarders as well as network television—Dr. Phil, The Doctors, and Dr. Oz—have taken up the cause of governing our life and health. Collectively, these programs cut across major audience groups by race, age, sexuality and gender in order to convey a singular message: take care of yourself. By telling an array of unique, highly personal stories of health crises and triumphs, viewers of all racial, age, and cultural groups learn how to eat better, how to lose weight, techniques for detecting signs of illness and generally how to better plan and manage their lives. By virtue of our shared “humanity,” our common DNA, and our biology, social class, cultural differences and power differentials are bridged. Despite our differences, these shows seem to say, we are all the same.

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However, hidden behind this universalizing message, is a normalizing judgment, a critical attitude toward and, even, an ontological understanding, of difference. Through the deployment of science, medical evidence, and discourses of nature, social and cultural differences meld under the banner of a shared human nature. Those who trespass the boundaries of this essential human being are pathologized as categorically abnormal or “deviant.” This essay is about television’s place as a technology of governance shoring up social norms. Today’s medical reality television constitutes a popular forum where medical experts teach subjects how to care for themselves and where subjects also share their own personal stories of survival—cancer, addiction, mental illness—with the hope of helping others similarly struggling with disease. Within the rubric of health and wellness, however, these shows presume dominant social and cultural conventions.

The advent of medical television is associated with three overlapping interests: medicine, the state and the media itself. At a time when the life and health of citizens has simultaneously become the site of intense political debate among public officials as well as an object disavowed as a target of direct political power, new forms of authority capable of speaking about our health have emerged. Television’s medical personalities have taken up the helm of educating the public about all matters health related. These experts articulate medical principles as techniques of self, and life strategies, teaching viewers now only how to care for their bodies, prevent illness, reverse the signs of aging and so on, but also how to raise and educate their children and how to identify what is and is not normal.

The neoliberal imperatives of individual responsibility and self-governance are at the heart of television’s biopolitical project, with the American health care crisis, debates about health care reform and gay marriage looming in the background. The most revealing contradictions within television’s governing imperative emerge when the citizenship struggles of the LGBTI community enters the picture. After the 1990s’ heyday of tabloid talk shows and the consequent moral crusade led by William Bennett and others to “clean-up the airwaves” made talk of normal and abnormal behavior a matter of widespread social and political concern, a broad array of new talk and reality shows found expression in the culture of governing abnormalities by television. Instead of shows about husbands who cheat on their wives, wives who cheat on their husbands, women who are men, men who are women, surprise gay crushes (among other sensational topics covered by *Jerry Springer*, *Ricki Lake*, and *Jenny Jones*) today’s television experts—*Dr. Phil*, *Dr. Oz*, *The Doctors*, Dr. Sanjay Gupta of CNN and so
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on—rearticulate the question of normal and abnormal behavior by referencing medicine, science and nature and by deploying a language of health and wellness.

While such normalizing discourses reflect the economic and political relations between the medical establishment, on one hand, and the media on the other, the normalizing impulse of today’s medical self-help and reality television can also be traced to a certain anxiety in conceptions of American identity. This anxiety was articulated in the 1990s and early 2000s by officials across the political spectrum. The most notable examples are Senators Joseph Lieberman and Daniel Patrick Moynihan who, during a press conference delivered in 1995 to discuss the growing “problem” of tabloid programs, worried that these shows were “blurring the lines between the normal and the abnormal.” Massachusetts Senator Daniel Patrick Moynihan made the more dramatic claim that the popularity and ubiquity of tabloid shows demonstrated that “Americans [themselves] are getting used to a lot of deviancy, taking it for granted.” At this juncture, it was reported that Jerry Springer had higher ratings than even Oprah, the first talk show to do so in Oprah’s then more than ten year career. William Bennett, who had served as Ronald Reagan’s Secretary of Education and was the first head of National Drug Control Policy under George H. W. Bush, was one of the most vocal critics of talk shows in the 1990s. Bennett argued that shows like Jerry Springer and Jenny Jones reflected not simply the “low brow” or “lowest

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2 This idea about medicine and its application informed (and was thus subsequently reinforced by) the 1997 decision by the FDA to allow direct-to-consumer marketing for prescription drugs. For more, see Healy, David. Let Them Eat Prozac: The Unhealthy Relationship Between Depression and the Pharmaceutical Industry. New York: New York University Press, 2004. Print.


5 Qtd in Glynn, Kevin. 186 [“themselves” added for clarity]. Moynihan’s reputation for signaling the transmission of “pathology” --his 1965 report famously characterized the typical black family as a “tangle of pathology” because many were headed by single mothers —from one affected segment of the population to another in this sense registers the alarm with which public officials were beginning to receive the genre during this period. See Moynihan, Daniel Patrick. The Negro Family: The Case for National Action. BlackPast.org: Remembered and Reclaimed updated 2011. Humanities Washington. Accessed July 9 2011. Web.

common denominator” within American culture, but that they also predicted the demise of traditional American culture altogether.7

These moments of angst contribute to our sense of the period’s social and cultural shifts. At the height of tabloid television’s popularity, welfare reform, affirmative action, AIDS, “Don’t Ask, Don’t Tell,” and gay rights dominated the social agenda, pointing toward the connections between the public discourse of abnormality and social difference. These differences, I suggest, are maintained on today’s television through discussions of normal, healthy behavior and subjectivity. This is best evidenced on shows about sex, sexuality and gender identity.

Studying these rationalities of government does not imply their efficacy however. The analysis of the language and goals of today’s medical experts provides an opportunity for competing interpretations of norms. The discussion of norms articulated by Lieberman and others demonstrates the importance of contesting discourses that seek to cultivate “healthy “practices and” healthy” citizens. Specifically, these moments demonstrate the power of television to serve as a medium of power where programs that aim to rule merely “administer the lives of others in light of conceptions of good, healthy, normal, virtuous, efficient or profitable.”8 A study of this administration requires an attention to the material: the techniques, the discourse, the theories and the practices that come together under the banner of medical fact.

What is Normal?

In order to understand the preoccupation with norms on today’s medical television, we must come to grips with basic assumptions of normativity that have taken hold among those who seek to govern through television. First, we must ask what is normal? This is a vexed question since it can never be answered once and for all. The answer will always lead to further questions and demand further qualification. When we ask, what is normal, we must know what is being defined by the terms “normal” and “abnormal”? Do we speak of gender norms? Cultural norms? Norms in medicine? Even as we

look at these as separate questions, we must continually qualify what it is that we are talking about since the assumptions we make in one field, say, for example, about gender, will define what we mean by the term “normal” in another, in, for example, medicine.

The “normal” is a specter, a phantom in a never-ending search for a body. Yet, when we speak of norms, we give presence to, and, indeed, endow with power that which we address. Foucault claimed that a norm belongs to the arts of judgment, and that although a norm is related to power, it is characterized less by the use of force than by what the sociologist Francois Ewald calls an “implicit logic that allows power to reflect upon its own strategies and clearly define its objects. This logic is at once the force that enables us to imagine life and the living as objects of power and the power that can take ‘life’ in hand, creating the sphere of the biopolitical.”

The norm is thus a discursive tool. We use the terms normal and abnormal to describe and to judge. Through discourse, we create that which in and of itself has no meaning, no essential nature apart from that which we endow it with our language. Nevertheless, as Judith Butler shows in her analysis of gender norms, the language of norms is saturated with power, riddled with assumptions that carry with them the force of law, the sense of being natural, eternal and universal. Calling someone or something abnormal evokes ontological questions about their nature, their essence, that is, fixed and indefinitely broken, pathological or even dangerous. The power of these words to resonate in these ways has as much to do with what we don’t ask of their referents as it does with what we do.

Originally, the terms normal and abnormal were used to as modifiers; they were terms that described the state of other things and carried no internal meaning unto themselves. The idea of the normal as a self-defining term emerged in the late eighteenth century with the advent of modern statistics. The “law of errors” was developed for observational astronomy and other sciences and was later adopted for the study of human attributes. For instance, Adolphe Quetelet, the Astronomer-Royal of Belgium, determined that many biological traits have a distribution defined by a mean and standard deviation. Quetelet’s innovation was applying what had never been used for the study of humans—statistical data about such things as

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10 This section was inspired by Ian Hacking’s arguments in “Suicide is a Kind of Madness,” “Regimental Chests,” “The Normal State,” and “As Real as Cosmic Forces,” chapters 8, 13, 19 and 20 respectively in *The Taming of Chance.* Cambridge: University of Cambridge Press, 1990. Print.
height and hair-color—to articulate a new “mean.” On Quetelet’s normal
distribution, the mean was not a real quantity—error makes no sense when
speaking of human traits. Rather, the mean or the normal referred to a
concept Quetelet invented. This was the concept of “the average man”\footnote{Hacking 112-113}
theorized descriptively as an intermediate type determined on the basis of
physical characteristics.

The idea of the average man made its leap into medicine with the
discovery of genetic inheritance and the advent of Darwinian evolutionism.
In the hands of Francis Galton, the concept of the average man became the
basis for improvement. Francis Galton, the father of eugenics, was the first
to use the idea of the normal to explain what he believed were curious
phenomena of a regular and law-like sort among human beings—the
distribution of hereditary genius in gifted families for instance. For Galton,
the abnormal represented that which was extraordinary rather than ailing.
Through the idea that the “best breed the best and the worst breed the
worst,”\footnote{Hacking 183} Galton theorized that the abnormal may be the healthiest stock of
the race. For Galton, then, the normal represented what was typical and the
abnormal was called pathological.

The association between abnormality and pathology took hold again with
the statistical sociology of Emile Durkheim. Durkheim’s idea of anomic, of
social and moral decline, was conceptualized through the analysis of suicide.
Society’s with higher than average (or abnormal) rates of suicide were
considered pathological. Suicide, as an abnormal or unusual means of death,
allowed Durkheim to transfer the notion of pathology as a kind of disorder
or dysfunction to the state of a population. Durkheim’s study of suicide thus
not only reestablished the nominal links between the abnormal and the
pathological but did so by linking abnormality to conduct, in this case, the act
of suicide, which served, in aggregate, as a gauge of a society’s moral
development. In this way, the normal came to signify not only that which
“is”, that is to say, to describe a current state, but also to infer how things
should be.\footnote{Hacking 163}

By linking the moral and ethical development of a population to an
aberrant act, Durkheim’s theory of suicide also opened the way for
conceptualizing a new kind of human problem—the problem of abnormal
acts and abnormal individuals. Here, the abnormal took on a nature of its
own. The abnormal assumed a body. Jean-Étienne Dominique Esquirol, the nineteenth-century student of mental imbalance, argued that suicide was a kind of madness and that, as such, should be placed under the province of medicine.\textsuperscript{14} Thus in the late nineteenth-century, suicide, along with criminality and sexual anomalies would become the purview of a new psychiatry concerned no longer with madness or alienation, per se. Rather, the psychiatry of the nineteenth century would become preeminently preoccupied with the question of norms.

Amidst the industrial revolution, the growth of a burgeoning middle-class and the development of the modern welfare state, late nineteenth-century psychiatry found itself assuming an extrajudicial role in the prevention of crime, the regulation of society and the promotion of public health. Measured against an optimum level of development and drawing on the social conventions of the growing middle-class, psychiatry produced figures of abnormality who were not quite mad and yet not quite criminal.\textsuperscript{15} Rather, the abnormal emerged as that which did fit not the paradigm of conventional conduct. According to Foucault in his lecture on the \textit{Abnormal}, these figures of pathology were produced through shift in the perception of reality. Placed under a kind of constant psychiatric surveillance, the abnormal was produced through of observations of the body in relationship to itself. The confessions of the body—its impulses, desires and satisfactions—revealed the secrets of nature hidden within the individual. Since those who fell under the category of the Abnormal did not break any laws, the role of expert psychiatric opinion in this context was to allow the offense, as defined by the law, to be doubled by other things—forms of conduct or ways of being that were not quite regular. In the hands of psychiatric experts, irregularities in conduct served as the cause, origin, motivation or starting point of offense. Abnormality became figurative of the pathological and predictive of the criminal.

Abnormality and psychiatric power go hand in hand. They exist in a mutually reinforcing relationship with one another. This is best illustrated through the multiple expansions of the \textit{Diagnostic Statistical Manual (DSM)}, the handbook published by the American Psychiatric Association listing by type and severity the various types of mental disorder recognized by mental health professionals. Many of the \textit{DSM}’s newest categories are vague and refer to

\textsuperscript{14} Hacking 65
rather generalized states that seem difficult to isolate as “illnesses” in and of themselves. In most cases, the newest diagnostic addictions to the DSM include aspects of subjectivity, emotion and behavior that present problems by exceeding the social, largely class based, expectations for civil conduct emphasizing self-control, self-discipline and productivity. Yet extremes of this model are also problematic. For example, addiction is defined against a normative moderation of behavior typical of a middle-class ethos, while Obsessive Compulsive Disorders (OCD) represent the middle class preference for order and regimentation taken to its extreme—that is, too much control leads to an abnormal inflexibility.

The conflation of social norms with vital norms in these diagnostic categories suggests what Georges Canguilhem argues is the consequence of the pathologization of everyday life by psychiatry that leads to confusion between normality and normativity. For Canguilhem, life adheres in the distinction between “environment and the living thing,” a distinction that determines what is normal in nature and what is normal in the environment. On this reading, difference, a “normal” part of life, itself becomes pathological. Considering this in the context of the expansions of the DSM, the medical treatment of nonconformity to dominant conventions not only confirms the status quo but also disallows the opportunity to reconfigure the normal through differences in subjectivity and identity practices.

For Canguilhem and others, diagnosing “normal” differences as medical conditions results in a situation in which neither the environment—the social and cultural contexts in which we live—nor the living thing—individuals themselves—can “vary without compromising the viability of [life].” This situation gives rise to the paradox in which “the apparent normality of adaptation” becomes pathological.

If the implications of psychiatry’s multiple expansions—since first published in 1952, the DSM has seen five expansions and has ballooned from a 130 page manual listing 106 mental disorders to an 886 page tome in 1994 listing 297 disorders—are read in light of Canguilhem’s argument, then labeling differences in subjectivity as forms of disease results in a situation wherein we lose sight of the meaning of what it is to be different, to suffer, to be human and to be alive and further, lose the opportunity to redefine the normal. Still, it must be noted that from the point of view of the diagnosed--

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17 Canguilhem, 354 cited in Fraser 70.
18 Canguilhem, 354 cited in Fraser 70.
for instance, those diagnosed with Obsessive Compulsive Disorder (OCD)—there is a sense in the self that things are not quite right. Those who are diagnosed with OCD or Depression experience their lives through the prism of their mental illness conditions and consider their effects to be not “normal” to themselves. Subjects of OCD are said to suffer from the inability to align their conduct—their habits, laborious rituals and disabling routines—with their desire to live a “normal” life that includes flexibility and a less rigid relationship to order. For some, the illness also presents a physical hazard to patients as is evidenced in those who manifest the condition through hoarding—a tendency common among some diagnosed with OCD to collect and save voluminous amounts of useless items sometimes to the point of the physical destruction of homes, the loss of employment, the break-up of families and threats to health.

While the diagnoses of certain conditions may provide relief in the form of offering a non-castigatory explanation for “abnormal” behavior and extending the promise of treatment, other diagnoses are more problematic. For instance, trans-genderism is problematically classified as a mental illness defined not by the experience of psychic pain (although living openly as a transgendered person may result in the traumas of rejection and pathologization that can lead to depression, suicidal ideation and drug and alcohol addiction) but rather by the experience of being differently male or differently female. Such diagnoses as mental illnesses are open to debate as examples of the sorts of pathologizations of “normal difference” Canguillhem talks about. At the same time it is also important to note how the the language of normal and abnormal development and behavior also opens a space of contestation about gender norms and identity practices. This, I argue, can be seen on today’s medical self-help television programs which aim to help viewers help themselves.

Between the description of social norms and rules and the prescriptions of medicine and health, today’s medical self-help talk and reality television shows identify abnormal individuals and abnormal conduct in order to help

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19 I draw this conclusion from watching a number of self-help TV shows focused on forms of OCD in which subjects confess to wanting to change their behavior but feel that they cannot for fear that giving up some control will produce chaos in their lives. I demonstrate this tension in the constitution of mental illness in chapter one. In Chapter two, I illustrate how some classified mental illnesses do indeed blur boundaries between “vital norms” and “social norms,” but, in such situations, in turn open rather than close down debate about what is and is not normal, natural and/or pathological. I demonstrate this point with an episode from Dr. Phil focused on trans-gendered children.
troubled individuals improve their lives. In doing so, I argue, the language of norms and the discourses of health we see on these programs shore up dominant cultural conventions and repeat social hierarchies by rendering them both natural and healthy, on one hand, and fixed and universal on the other. As Foucault demonstrates in his lectures on psychiatric power and abnormality, the norm brings with it a principle of both qualification and correction, it is always linked to a positive technique of intervention and transformation, to a sort of normative project Today’s medical self-help and reality television takes up this project under the banner of health and wellness.

**Gender Trouble: Nature Vs. Nurture**

The confusion between medicine and culture on today’s medical reality television emerged most obviously on a number of Dr. Phil episodes dealing with gender identity and sexuality. On these episodes transgender identification was represented variously as: an abnormal condition read against the male-female dichotomy based on biological sex, a normal condition read against the male-female dichotomy based on socialization; and, last, a normal condition within a spectrum of identity positions based on fetal exposure to sex hormones. Read through this matrix we come up with the following possible scenarios when considering the question of transgenderism: Cross-gender identification is a pathology that can be corrected in one of two ways. Individuals who identity as MTF or FTM can undertake the process of transitioning to the opposing gender. In order for this to take place, they must submit to a battery of psychological tests the results of which will be determined by psychological professionals attesting to the tenacity of the individual’s desire to transition. This is the method of “treatment” the American Psychiatric Association takes in resolving the problem of gender dysphoria. The second way transgendered individuals are normalized is through strategies of reform. The National Association for the Research and Treatment of Homosexuality, for example, treats cross-gender identification as a mental illness that, like other psychiatric conditions, can and should be treated through various forms of psycho-therapy.

The medical opinions about the issue are of two basic types. Proponents of the hormone theory of gender identity argue that gender is determined by exposure to male or female hormones while in the mother’s womb and has little or nothing to do with either genotype or culture. On this view a child

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of either male or female genotype exposed to an abundance of testosterone in utero will be more likely to identify as a male. The same is not true with the exposure to estrogen. The sex theorists of gender argue that gender and biological sex are “normally” coincident and that cross-gender identification among children is abnormal, the consequence of improper gender socialization. In cases of MTF identification, the absence of the father is often blamed. Both biological theories—the hormone theory and the sex theory—present irresolvable paradoxes.

Psycho-medical discussions framing normal gender identification are complicated by the language of experience and desire. Speaking from their own experiences, many in the transgendered community have contested the pathologization of cross-gender identification by taking an essential position on gender. Gender identity, on this view, is an indispensable part of one’s being and is thus, as such, determined not by an arbitrary choice but rather by the force of nature. Taking this position paradoxically contradicts and reinforces the “truth” of each of the opposing medical explanations of cross-gender identification. The difference between the two sides of the debate ultimately amounts to whether or not cross-gender identification is in fact a pathology, an example of nature run amok by improper nurturing, or if cross-gender identification is a part of nature, the consequence of the normal, biological development of the human brain.

The conundrum opened up by medical versus sociocultural explanations of gender has been taken up by today’s medical television experts. In 2008, Dr. Phil aired the first of a handful of episodes dealing with the topic of cross gender identification among children. On an episode called “Gender-Confused Kids” Tim, Melissa and their eight-year old transgendered child were presented as a case study for answering the following questions posed by the show: “What do you do if your son wants to wear dresses and play with dolls? Or if your daughter tells you she wants to be a boy?”21 For the parents, the answer to these questions was clear: nurture the child’s desire, even if it does not conform to social norms. Both Tim and Melissa were clear about their stance regarding their son’s desire to be a girl. Citing the child’s early avocation of wanting to be a girl and their attempts to introduce the child to masculine paraphernalia, Mellissa and Tim defend their decision to support their son’s transition. “At age 3,” Melissa explains, “he stated that ‘he’ was a ‘she.’” Similarly Tim admits that though he was reluctant to accept

21 All quotes are taken from the show notes for this episode. See “Gender-Confused Kids.” Dr. Phil. 28 October 2008. Peteski Productions Inc. Web. 29 January 2012. n. pag.
his son’s feminine qualities, saying "I thought maybe it was just a phase because of the age. He was only 3, and maybe he hung around his mom a lot and liked girl things, and maybe in time, when he gets a little older, he'll grow to like boy things," Tim says it was only after seeing the happiness on his son’s face when dressed as a girl that he was convinced that his son’s desire would not fade:

I've kept on trying to push her on jerseys and boots, and she would not want anything to do with that. She was getting depressed. On Halloween, her mom allowed her to wear a princess outfit to her kindergarten Halloween dance. That was the first time where she actually wore women's clothes in public. They did it without telling me. She was happy. You could see the glow in her. My heart just dropped. I felt like I'd been a bad dad, keeping her from how she really feels.

From the beginning of this episode, it was clear that Tim and Melissa’s story was not meant by the show to be instructive to other parents. Rather, Tim and Melissa’s story was presented as problematic, their decision to nurture their son’s female identity explicitly and implicitly questioned throughout the show. These questions were introduced through the episode title, “Gender-Confused Kids,” which immediately framed the discussion in terms of a problem—the child who is “gender-confused” and the equally perplexed parents—rather than as an open engagement with difference. Instead, Tim and Melissa’s position was set up as part of a debate in which their parenting was directly subject to scrutiny and in which their son’s “gender-confusion” formed the foundation for the psycho-medical discussion about normal and abnormal child development in the remainder of the program. The show’s implicit indictment of the parents first became evident when Dr. Phil himself, usually careful in his presentation of what he terms “controversial topics,” directly asked the couple: "Are you aware that less than 20 percent of transgender children grow up to be transgender adults?" "How do you feel about that? Does that mean that this is a phase?"

On its face, this seems like an honest question. It cites an overwhelming statistic, and thus appears to be asked in the interest of informing the parents about the possibility that their son may revert to identifying as male later in life. Further, it ends with the question rather than the claim that the child’s cross gender identification is a phase, suggesting that it may be and that it may not be. However, there are several other things going in this particular question—and the other types of questions similar to it posed throughout the episode. For instance, Dr. Phil later asks Tim and Melissa whether or not they “are concerned that an 8-year-old child doesn't know, and that you're
turning the steering wheel over to an 8-year-old child?" Such questions, I suggest, reveal the show’s normalizing bent. In other words, by presenting Tim and Melissa’s story as essentially abnormal, the program effectively relayed the message that prevailing social norms are not only right, but also “natural” and “healthy.” Further by giving the pretense of engaging with difference while in actuality continually subjecting those who are different to questioning on the basis of prevailing gender norms, Tim and Melissa’s case is offered up not as an instructive model of good parenting or “what to do when your son wants to wear dresses and play with dolls.” Rather, their story is, at most, presented as “food for thought,” an opportunity for the “normal” world to contemplate the life of the “abnormal” and, at least, a counter-example of what “good” parents should do when confronted with a similar issue.

The show’s preference for prevailing gender norms and thus its implicit indictment of Tim and Melissa’s decision to nurture their son’s cross-gender identification was revealed through the line of questioning the show posed about gender. In footage taped prior to the episode itself, Dr. Phil meets with Tim and Melissa’s child and asks a series of questions that seem designed to “test” the child’s commitment to her identity:

**Dr. Phil:** Is there anything that's special about you that you want me to know?

**Child:** That I used to be a boy and now I'm a girl.

**Dr. Phil:** When did you become a girl?

**Child:** When I was in first grade. I had short hair, and I used to wear boy clothes, like dragons and dinosaurs and all that, and I just wanted to be a girl.

**Dr. Phil:** OK. Transgender. What does that mean?

**Child:** When a boy or a girl wants to be a girl or a boy.

**Dr. Phil:** Where did you learn that word?

**Child:** My mom. I went in her room, and I was like, 'Is there a word for the way I feel because I was a boy, and now I'm girl?' and she was like, 'It's called transgender.'
What is the purpose of this interrogation, we might ask? From the point-of-view of the Dr. Phil show’s overall instructive ethos, we can read this exchange as an attempt at a disinterested dialogue. From this perspective, the interview can be seen as an attempt to open up discussion about gender norms and the boundaries between “nature” and “nurture,” “normal” and “abnormal” human development. Dr. Phil appears to have the child’s best interest in mind. His questions are neither probing nor leading. Dr. Phil’s concern for the child is also evident in the fact that the interview takes place behind the scenes and the child’s face is never shown. Indeed, that the interview is of a child gives the appearance of genuine engagement with the issue since children are the target of so many of the debates and lessons on the Dr. Phil program. To hear the words “I am girl,” from the child and to listen as the child accurately defines the term “transgender” provides convincing evidence that she is neither confused nor abnormal and that the goal of the program is, as Dr. Phil suggests, to “tackle the sensitive topic of children who identify more with the opposite sex.”

If we look at the language used throughout the program, the line of questions Dr. Phil asks and the fact that he asks them not from his position as a talk-show host as (as is often the case when celebrities or other well-known figures appear on the show to tout a new film or television show) but rather in the pose of an expert, we can see that the child and transgenderism more generally are actually being presented with a framework of pathology. Looking at Dr Phil’s interview with this child, we can see that the child is being depicted as thoroughly confused and prematurely experienced with the discourse of gender. To begin, the depiction of the child as victim comes across in the way the interview is set-up. Sitting across from Dr. Phil in the style of the therapy session, her face never shown and only quick shots of her hands (ostensibly to showcase her polished fingernail and her arms covered in pink, clearly girl’s clothing), the child appears as a patient suffering from an entrenched case of gender dysphoria. Dr. Phil’s first question to the child—“Is there something special about you that you want me to know?”—sets up the child’s female identity as a problem. The word “special” can be read within the discourse of medical pathology that assigns “special needs” to those suffering from various forms of mental and physical defect. In this case, given the setting and Dr. Phil’s professional background, the problem with this child clearly appears psychological.

The child’s answers to Dr. Phil’s questions ironically provide the evidence for the show’s normalizing claims. When the child admits—“I used to be a boy, but now I’m a girl,” we are to see a clear point of demarcation in
the child’s history. The child once identified as a boy in the same way that the child now identifies as a girl. The question we are meant to ask is, what happened? Why the shift in identity? And the more the child speaks, the more certain we become not only that the child is confused, but that she has been misled by her equally confused parents. For instance, when the child specifies that it was in first grade that her transition began and recalls that prior to this time period she had “had short hair,” “used to wear boy clothes,” and “like[d] dragons and dinosaurs and all that,” viewers are left to wonder at the seeming arbitrariness of the change. Why in the first grade? Was the child distressed by her masculinity? Was the child’s desire for dragons and dinosaurs genuine or did she desire other toys more commonly associated with little girls?

However, rather than continue in this direction by asking whether or not the child behaved in typically boyish ways out of a desire to do so or if these behaviors were merely attempts to conform to the expectations of others, a line of questioning that could provide more clarity about the child’s sense of self, Dr. Phil asks where the child learned the word “transgender,” an odd and abrupt shift in the line of questioning meant to suggest undue adult influence on the child and ultimately leading viewers to wonder whether all of the child’s speech and behavior isn’t in fact the consequence of improper socialization by the parents. And as the question itself anticipates, the child’s answer once again provides evidence for Dr. Phil’s case: the child learned the word “transgender” from her mother.

While the show was careful not to pathologize the child, the pathologization of cross-gender identification was evident throughout the episode. This was brought into focus when Tim and Melissa’s story was counterbalanced by experts. On one side of the debate was Dr. Dan Siegel, UCLA professor and a clinical psychiatrist, who argued that gender identity and biological sex can and often do conflict. From Dr. Siegel’s perspective, Tim and Melissa’s decision to allow their son to identify as a girl was not only responsible and exemplary of good parenting, but also medically sound: "The basic thing we need to realize," says Dr. Siegel,

is there is something called a gender identity, which isn't the same as the genitals you have. So your genes determine whether you have male genitals or female genitals, but the exposure to the fetus’ brain as it develops in the womb, we think, determines the identity. And it's on a spectrum, so you could be feeling fully male or fully female, or somewhere in between, and in your case, the child we're talking about, she feels that her brain.
On the other side of the debate was Glenn Stanton, director of Focus on the Family and research fellow at the Institute of Marriage and Family in Ottawa, Canada. Stanton vehemently argued against Dr. Siegel’s spectrum theory of gender, saying:

We always identify with either a boy or a girl, we can always determine OK, that's girl behavior or boy behavior. For my little boy wanting to go to art museums, for me wanting to go to art museums, is that feminine behavior? For you being interested in ballet, is that a feminine behavior? No. It could be done in a very masculine way.

Although it was clear throughout the show that Stanton was approaching the discussion from the point-of-view of a traditionalist, taking up the Christian narrative of nature and God’s laws as the grounds for his claims that Tim and Melissa’s child had been “led astray,” he was presented on the show as a kind of authority whose purpose for appearing on the program was to offer his expert opinion. When directly asked by Dr. Phil if he thought Tim and Melissa were wrong to nurture their son’s cross-gender identity, Stanton suggests that they were because they ostensibly didn’t know better. Speaking to Melissa, Stanton says: “From what I understand, you've taken an entry level psychology course in college, you gave your child a test on the Internet about what it means to be transgendered, and your child mimics, really, as I see it, some very adult concepts that she got from somewhere, and so I'm wondering who's leading and who's following?"

While Tim and Melissa often defended themselves with a similar recourse to “facts” and scientific evidence—for example, Melissa responds to Stanton’s suggestion that she and Tim were allowing their son to “assume the driver’s seat” in the parent-child relationship by citing several statistics showing the higher rates of depression, suicide and prostitution among transgender teens and adults who are not supported by their family and friends, evidence that could be read in support of Stanton’s position that cross-gender identification is a type of pathology—their most common line of defense rested with their experience. You don’t know what it is like. You don’t have a transgendered child.

Stanton’s indictment of Tim and Melissa’s parenting was underscored in the last segment of the episode, called “coming full circle.” During this segment Dr. Phil introduced Mary. Like Tim and Melissa, Mary also identified signs of her son’s transgenderism at a young age. She says that he “would wear girl's clothing. He would get wigs, and bras, and old prom
dresses and dance around. He was fascinated with mermaids and dolls. He played more with the girls than in the sandbox with the boys.” By age five, Mary says, he preferred nail polish, dolls and dresses to the typical boy toys of trucks and transformers and affirmed at age eight that “he felt like a girl inside.” Also like Tim and Melissa, Mary says that she nurtured her son’s desire to be female. She allowed him to identify as a girl, which included letting him take on a female persona, wear female clothing and enroll in ballet. However, unlike Tim and Melissa, Mary is now ambivalent about her decisions. Now that her son is sixteen, Mary says she is not sure she did the right thing. Her purpose for appearing on the show is to warn Tim and Melissa, as well as the other parents for potentially transgendered children in the audience, against making the same mistake.

According to Mary, allowing her son’s transition effectively destroyed his life. She describes several episodes at school when her son was bullied and physically assaulted by the other children. After being dismissed from Catholic school, Mary says that her son experienced even worse harassment at public school where he was ridiculed for wearing earrings and feminine clothing and often feigned illness so that he could avoid being around other children. Mary also says that her son’s cross-gender identification created a wedge between her husband and her son, leading the husband to alcoholism as the way to cope with “losing a son. Finally, Mary says that her son, now sixteen, no longer identifies as a female and has fully overcome his gender “confusion,” saying “he has evolved back to more male interests,” “feels straight, not gay,” “has a girlfriend,” and “identifies with the masculine side of things.” The early childhood experiment in gender-bending, apparently, had not only come to naught, but had left much destruction in its wake.

Towards the end of this segment, however, a question: Mary wonders whether her son is’ being totally honest with himself,” and worries that he’s not. Yet Mary’s uncertainty is glossed over; in the rush to end with show with a neat conclusion, Mary’s story is left in its original form: Her son was never transgendered but was merely experiencing a phase of gender confusion, just as Dr. Phil implied earlier in the show. Mary’s mistake was that she had tried to track her son into a transgender identity by allowing him to identify as a girl. In doing so, it is suggested, she did more harm than good. The lesson viewers are to learn from this narrative: Don’t make the same mistake.

Of course missing from the discussion was the force of something hinted at in Mary’s open question: what about the ridicule, intolerance and
Maryam El-Shall

ostracism her son suffered as a result of his attempt to transition? Did that have any impact on his decision to revert to identifying as a boy? Mary's very clear uncertainty about her son's identity suggests that, in fact, it may indeed have seemed easier and, further, that it would have made life simpler for everyone else, if he just gave in to the pressure and identified as a boy. Questioning whether or not her son now “knows who he is,” Mary says that she does not believe that he does. But the show’s programmatic mandate for easy answers does not allow for this complication, thrown in as it was at the end of the show. Instead, the discussion would have to be deferred to another show, passed on to another set of experts and another group of parents wondering what they should do with their “gender-confused kids.” For now, the debate should end weighing heaving in favor of the Stanton position.

Yet the irony of this episode, as is it with other episodes dealing with the question of gender identity, is that both Melissa and Tim’s story as well as Mary’s story confirmed and undermined both sides of the argument. Their stories and experiences could easily be and, indeed, were, co-opted by one “side” or the other of the debate about whether or not cross-gender identifying children suffer from a form of mental disorder. Mary’s once transgendered son is presented as “evidence” that gender, as Glenn Stanton maintained, is in fact biologically determined and that transgenderism is an aberration of nature caused by inappropriate nurturing. Consequently, Stanton’s theory that transgendered children can be “normalized” back to their biological sex represents as proof of the socialization theory of gender which says that the environment and, particularly parents, are instrumental in children’s gender development. Yet the contradiction in this logic rests on the idea that gender and biological sex are one, or at least should be, a point which reveals the ideological rather than “factual” nature of gender.

On the other side of the debate, Tim and Melissa’s story offered support for Dr. Siegel’s hormonal theory of gender identity, which says that gender identity and biological sex do not necessarily always coincide. Dr. Siegel summarized this argument by saying that gender is determined by what is between the ears rather than what is between the legs. But in insisting that their son, who now indentifies as a girl, is firmly anchored in the gender norms of the opposite sex, Tim and Melissa shored the very presumptions of normativity that mandates certain ways of doing gender. In fact, where Dr. Siegel advocated for a theory of gender on a spectrum that could open up the possibilities of life and living for a multitude of people who identify as neither male nor female, Tim and Melissa were proponents of an “either/or”
view of gender. One identifies as either male or female; there is nothing in between. Perhaps it was the case that Tim and Melissa perceived that taking this position would ultimately undermine their attempts to help their child develop into a recognizable, reasonably adjusted adult. Perhaps they also understood the way that lending their support to Dr. Siegel’s spectrum theory of gender could be used by their opponents, who could use the malleability of the theory to argue that, if indeed gender is this flexible attribute that can shift and conform to different identities, why not simply help children who identity across gender feel more comfortable with their biological sex? Wouldn’t that be an easier and ultimately, given the ridicule and abuse transgendersed children and adolescents, healthier solution? Unfortunately, the only way, it seemed, that Tim and Melissa could counter the simplistic, dogmatic approach of Focus on the Family and other organizations is to offer one just as streamlined: For Tim and Melissa, while gender and biological sex are disentangled from one another, the sex binary of male and female remained the only intelligible gender identity options. And so as femininity and masculinity are disassociated from the body of sex, they are once again attached to the body that actively takes on the qualities of sex.

Indeed, both the medical authorities and the transgendered guests featured on the show spoke in the language of norms. Both groups required a clear gender dichotomy between male and female, normal and abnormal subjectivity and behavior and used science as the truth of this rule. What was being contested is whether or not those who identify across gender are in fact normal or abnormal. As we saw in the preceding discussion, however, how the normal is defined, is largely determined by how the question of norms is asked. Every answer will be riddled with contradictions. The difficulty produced by the diagnosis of gender dysphoria is that in focusing on the individual as abnormal, it does not question prevailing gender norms. Nor does it ask whether the strictures of prevailing norms produce distress, whether they impede one’s function or whether they generate sources for suffering or “dysphoria.” This was evidenced in Glenn Stanton’s focus on the trauma parents of “gender-confused” children necessarily inflict on their children by not considering “what’s going to happen to them” when they go to school. This tack suggests that in fact child-bullying is the natural or normal response while cross-gender identification is unnatural or abnormal.

Indeed, the discourse of gender confusion showcased on this episode of Dr. Phil set out to establish criteria by which a cross-gendered person might

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22 Butler 95.
be identified by solidifying prevailing gender norms as biologically given. Conforming to this logic then becomes a sign of mental health or “what’s normal.” Failing to live up to this norm not only renders one pathological, mentally ill or deficient, but also totally unintelligible. This was demonstrated by the sheer absence of those who might argue for a position of gender autonomy. At the end of the show, Dr. Phil tells Melissa and Tim, "I really hope you don't consider hormone therapy at this point, but you continue to let this evolve. That would be a wrong, wrong, wrong thing to do in my opinion." Lesson learned.

“Little Boy Lost” and the Regulatory Power of the Norm

In order to situate the discourse of normal and abnormal gender identification on another episode of Dr. Phil focused on transgendered children, it is useful first to consider the language used in the DSM to diagnose abnormal gender identifications. Gender Identity Disorder is a medically recognized mental illness diagnosed on the basis of two chief criteria. The first is that “there must be strong and persistent cross-gender identification,” defined as “the desire to be” the other sex, “or the insistence that one is.” These two aspects of this criterion do not have to emerge together. Desire, especially among young children, can be determined on the basis of behavior, for example, through play. The second criterion for diagnosis of GID is the presence of “persistent discomfort” about one’s assigned sex or a sense of “inappropriateness.” The evidence of distress comes in the form of other mental illness conditions such as Depression and impaired function.

In order to make sense, the GID diagnosis must intertwine socio-cultural gender norms and medical norms of health to the produce the notion of Gender dysphoria, the sense of “not getting it right” in the area of gender. In Judith Butler’s apt analysis of the DSM-IV classification of Gender Identity Disorder she shows how the criteria for diagnosis operate on a number of assumptions that are themselves contestable. For instance, Butler discusses the diagnostic presumption of two genders, a masculine and a feminine; that sex and gender are “normally” coincident; and that identity inheres in one, once and for all. Butler cites as one example of the inculcation of gender norms in the diagnosis the requirement that there be “persistent discomfort about one’s assigned sex.” In order for this criterion to make sense, Butler argues, one must take preexisting gender norms as

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23 I am indebted to Butler’s reading of the DSM criteria for GID for much of my analysis in this section. See Butler 75-101.
axiomatic. The assumption is that gender categories are universal and fixed and that conforming to a different gender norm will alleviate the individuals’ distress.

The problem with this logic, Butler points out, is that it presumes as natural or given that which is, in fact, artificial, or, at least, discursively constructed. Butler demonstrates this by pointing out the DSM’s own use of the word “assigned” to designate an individual’s “original” gender identity, showing that sex, rather than being an innate quality, is a socially produced and relayed concept. In this way, Butler suggests, we can see how one understands being the “right” or the “wrong” gender not through what Foucault might call a “pure contemplation” but rather though the social categories, discourses and cultural memes relaying sex to self and others. This leaves cross-gender identifying groups little choice but to submit to a pathologization of identity in order to garner the rights and entitlements of illness—insurance benefits, legal right and protections and, most of all, a certain intelligibility—or resist the diagnosis and remain beyond the pale of recognition, unable to complete a transformation of identity and yet continuing to find oneself in a perpetual state of disharmony with one’s self.

Many diagnosed with GID reject their diagnosis. In many cases this is because, rather than psychic pain or behavioral disturbance, the question of mental illness upon which the diagnosis rests emerges when subjects’ behavior surpasses medicine’s own capacity to determine what is or is not normal or healthy. In cases of gender dysphoria, notions of normal or abnormal behavior or desire are not clearly defined by medical authorities largely because they are so complicated by cultural expectations. Because of this, many physicians have shied away from dictating how children should grow up and how parents should raise them and avoid predicting children’s future possibilities on the basis of either biology or childhood. 24

In the case of gender identity, then, it is fair to say that the concepts of normal and abnormal are ideological to the extent that they function like so much “common sense,” relying on the force of convention and the tyranny of conformity rather than scientific proofs or medical consensus. In this regard we can redefine the terms of norms. The normal is that which passes unnoticed and is presumed to be right, while the abnormal draws attention to

itself and, depending on one’s point-of-view, it can be “wrong,” deviant, pathological or dangerous.

The regulatory power of norms was illustrated on a January 2009 episode of *Dr. Phil* called “Little Boy Lost.” On this episode, Dr. Phil featured Toni, the mother of a transgendered adolescent, and Dr. Joseph Nicolosi, a psychologist specializing in the field of adolescent gender identity. The way this episode was framed saw Toni defending her decision to allow her nine year old son to identify as a girl. Toni attested to allowing her son to dress in girl’s clothing, play with girl’s toys and to adopt a girl’s name. Dr. Nicolosi argued against Toni’s decision and promoted the idea that cross-gender identification is a treatable mental condition that, if properly recognized as such, could be overcome.

The show framed the discussion between Toni and Dr. Nicolosi as a debate between a “layperson” speaking from experience and an “expert” speaking from ”twenty-years of practice,” a framing that signaled not only that Toni may not only have made the wrong decision in supporting her son’s gender transformation, but that she might also have played a role in bringing it on in the first place. The ensuing discussion between Toni and Dr. Nicolosi supported this idea as it focused almost exclusively on Toni’s parenting skills and what Dr. Nicolosi referred to as her “over-attachment” to her son. When Dr. Nicolosi asked Toni if she ever got therapy for her son, she says yes, when he was 8. Here is their exchange:

**Toni Dartmouth:** My child was transgender the minute she walked in the room.

**Dr. Nicolosi:** Yeah, we would start much earlier. The important age is around 2 or 3. That's when we begin the work. That's when we establish the gender identity, at that point.

**Toni:** Well, at 2 or 3, all little boys play with girl things at some point.

**Dr. Nicolosi:** Not necessarily.25

This discussion was interrupted when Dr. Phil asked Dr. Nicolosi how patients who come to his clinic for this “disorder” are treated. Dr. Nicolosi argued for a gender-nurturing strategy that emphasized the role of the father

in the family. The way to address the problem, according to Dr. Nicolosi, is to address its cause, which was the parents.

In his practice, Nicolosi argued, cross-gender identification among children was the result of improper role modeling. His therapy thus drew on techniques focused on supporting what he called proper gender roles by working with both the children who identify with the “wrong” parent and with the parents who over-attach to children of the “wrong” gender. Parents’ therapy involved teaching parents the proper strategies for managing the child’s “problem.” For instance, parents learn how to put limits on their children’s exposure to the opposite gender and its culture—toys, clothing and other gender-identifying accessories. The child’s therapy involved the creation of appropriate gender identification reattachments by strengthening the bonds between fathers and sons and mothers and daughters and acclimating the child to the culture, behavior and expectations of their “correct” gender.

A quick online study of Dr. Nicolosi’s practice reveals that his position on the show was more ideologically informed than viewers might have been led to believe. In the “Special Thanks To” note on the bottom of the Dr. Phil webpage for this episode, Nicolosi’s name is listed along with an abbreviated title of his organization. A study of the organization, which appears as narth.com on the Dr. Phil webpage, shows that the organization is the Christian-based facility focused on the treatment of homosexuality, called the National Association for Research and Therapy of Homosexuality, of which Nicolosi was once President. In the time period since this episode aired, Nicolosi left NARTH and has since become director of the Thomas Aquinas Psychological Clinic, where he specializes in the treatment of “unwanted same-sex attractions.”

However, based on Dr. Nicolosi’s comments on the show as well by the way the show staged the discussion, viewers could draw the conclusion that both homosexuality and cross-gender identification are forms of mental disorder. Given the professional title attached to Nicolosi’s position, viewers could also conclude that the basis of normal gender identity and sexuality are defined within a hetero-normative notion of human subjectivity and development. Read through this matrix, heterosexuality becomes the healthy, normal state against which homosexuality is pathologized as deviance and cross-gender identification becomes the basis for the diagnosis of GID. Treating the abnormal child in this context signifies a technology of normalization based in regulation. For Dr. Nicolosi, the path back to healthy
norms involves a long process of correction, education and making the right choices. The guiding force behind this process is tradition.

According to Dr. Nicolosi, fathers should not only embody masculine qualities, but they should also be close to their sons in order to nurture the same masculine qualities within them. At the same time, mothers should avoid becoming overly involved with their male children for fear that they will nurture feminine qualities in them before they have fully developed their male identities. The ultimate goal of this dynamic is the heteronormative reproduction of traditional society with the moralized family at its center. This ostensibly Oedipal process seeks as its object the perpetuation of the family unit with the patriarch at its head and the children and wife in supporting roles. Thus the debate between Toni and the Dr. Nicolosi centered not so much on whether or not her son was suffering from GID, a point Dr. Nicolosi took for granted, but rather on Toni’s involvement in her son’s life. For instance, Dr. Nicolosi continually suggested that Toni had an “abnormally” close relationship with her son because she is separated from the child’s father. Referring to the cases he’s worked on, Dr. Nicolosi then explained that that Toni’s case was typical of “certain patterns” in which children identify across gender. These typical patterns included:

[A]n over-involved mother, where the mother and son have a symbiotic relationship. It’s very close, their identities are merged, and the father is out of the picture, and the work that we’re doing is to get the mother to back off, get the father more involved, get that boy to dis-identify with the mother and bond with the father, and in the bonding with the father, he develops that masculine identity.

Nearly two-thirds of the way into the program, the debate between Toni and Nicolosi ended when Toni expressly contested Nicolosi’s diagnosis that her son was suffering from a mental disorder by telling him, in appropriately laymen’s terms, that his “theory sucks.” Complicating the discussion further, Dr. Siegel, a neurobiologist whose work focuses on the biology of the brain, defended Toni. Dr. Siegel argued the hormone exposure theory, saying 1) gender and biological sex are two separate issues 2) gender identification is a complex process centered in the development of the human brain at the fetal stage. Yet, throughout the discussion, Toni’s anger toward Nicolosi registered her own ambivalence about her son’s gender-transformation. She repeatedly countered Dr. Nicolosi’s language of norms by pointing out that in all other aspects of their lives she and her daughter were “perfectly normal.”
Close to a year after this episode aired, Toni posted several comments on the show’s message board in a similar vein. On her last post dated October 2010, Toni addresses viewers’ questions about her on-stage rancor toward Dr. Nicolosi and follows up on her commitment to support her son’s cross-gender identification:

I first would like u to take a look at the 2 photos of my transgendered child tell me does she at 15 years old look like she doesn't know who she is. I do recognize that my response to those two gentlemen on the show was harsh. But there were things going on on stage that people could not see the smirks and sly smiles that they were directing at me. This has not been an easy transition in my life. I was very clear with the Dr Phil staff that I would not go on a show and debate my child. I was promised that that would not happen the show was suppose [sic] to be about the loss in our family. Clearly none of that was touched on. And I certainly was not going to allow them to blame me for my child's brain disorder i ama [sic] good mom. I never drank, smoked, or did drugs during my pregnancy it could of happened to anyone including you and ur family. And than [sic] maybe if someone was on stage accusing [sic] u of being to close to ur child maybe u also might not have been to nice. My objective of going on the show was to educate people that we were just a normal family and sometimes we just have to accept what we get and do the best we can. If u believe what those men said that they could cure someone from being homosexual or lesbian than [sic] please I have a bridge I want to sell u Thank you for taking time out of ur day to comment on something u can't possibly understand [sic].

Sincerely,
Toni Ugalde

First, Toni riffs on the episode title “Little Boy Lost” by heading her message with the same title corrected, calling her post “Little Boy Lost”(Little Girl Found).” Next to the title, Toni has posted two-photographs of her son—now fifteen years old and fully transformed—looking happy and well-adjusted in her female identity. In the body of her message, Toni continues her critique of the show for misrepresenting the issue and suggests that the show used her to generate dramatic footage by having her debate with Dr. Nicolosi about whether or not her child suffered from a pathology. More importantly, Toni says that her main objective in writing is the same as her objective in appearing on the show: to remind viewers that cross-gender identification is not an abnormal condition in any

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psychological or biomedical sense but is rather, as evidenced by her (now) daughter who is happy and well-adjusted, totally “normal.”

This is how Toni would have liked to talk about her experience on the show, words that she was prevented from speaking by the way the show was framed. Turning the question of truth on its head, Toni pits the experiential truth of motherhood against the weighty arguments of experts. Yet, in doing so we can see a movement toward a position that solidifies normative thinking. Here, we have a description that is saturated with norms—gender-identity, gender roles, biological and scientific languages of health, risk and the “normal.” They are written in the context of a complicated debate that has still to be settled by science and in wake of a growing social consciousness among not only queer communities, but also among non-queer groups that neat, ostensibly scientific distinctions between gender, gender-identity, sexuality and biology are in fact neither neat nor at all clear. The questions of culture, politics, and power continually intrude and shape the way we think and act gender, sex and identity.

What we see in Toni’s message however is an attempt to tease out these issues by reversing the boundaries between social and medical norms. While she defends her decision to support her son’s gender transition, she does so by referring to her son’s “brain disorder,” relying on the pathological language of the GID diagnostic criteria to justify her decision. Further, we can see a recourse to the same “scientific” arguments that presume a sex binary to prop up the equation of norms and health. Toni insists that she’s a good mom and her (now) daughter is thoroughly female. They’ve both lived up to the expectations of prevailing gender norms—she through motherhood and her daughter by adopting a thoroughly feminine persona.

Yet Toni’s references to her healthy pregnancy—“I never drank, smoked or did drugs”—and her warning that “it [transgenderism] could of happen to anyone including you and ur family” suggest her own ambivalence about what is or is not normal. Her reference to her pregnancy implies that had she used drugs, drank alcohol or smoked cigarettes her child’s “disorder” would be a disorder in the medical sense, a clear-cut case of abnormality as pathology. Given that she had a healthy pregnancy her son’s desire to become a girl is not abnormal in the pathological sense, but is merely an unspoken part of what it is to be normal, a part that doesn’t collide with science but rather with convention. We can perhaps see the greatest ambivalence in Toni’s response when she protests her family’s normality by positioning her son’s transgenderism as a kind of obstacle that, like any other
obstacle that families must learn to overcome, must be accepted and dealt with. On this reading, her son’s transgender identification is a problem, chronic and perhaps permanent, and thus must be tolerated like any other illness condition.

In these twists and turns in Toni’s post, we can also perhaps see an opposite attempt on Toni’s part to normalize the “abnormal.” On this understanding, the normal is not that which is dominant or supported by conventions, but that which is visible and recognizable as categorically a part of our social and cultural consciousness. Toni wanted to make the “abnormal” normal by placing it within the realm of the everyday—through television. This is evident in her repeated statements about her goal for appearing on the show—“my objective of going on the show was to educate people that we were a normal family.” Although reader’s might be confused by Toni’s use of the past tense here, her prior statements in the posting as well her criticism of the psychologists who appeared on the show with her—“If u believe what those men said that they could cure someone from being homosexual or lesbian than [sic] please I have a bridge I want to sell u”—as well as the fact that she posted the message close to a year after appearing on the show, support a reading of normalizing the abnormal in reverse. In this sense, Toni’s goal is to normalize the abnormal—here her transgendered daughter—by making the abnormal “normal” through a reframing of normality away from “science” toward personal experience. Yet, what it means to “be normal,” as we see in Toni’s language, ultimately depends on prevailing gender binaries and heterosexist assumptions.

What we see in “Little Boy Lost” and Toni’s online message on the Dr. Phil website calls attention to a certain paradox in her position. Defending her son’s decision to become a girl as normal solidifies the very gender binary that Dr. Nicolosi defends as natural, proper and “normal.” At the same time, it allows for a transgression of the concept of what it means to be normal that establishes a new way of thinking about prevailing notions of gender and sexuality. In this sense, to quote Butler, “individual agency is bound up with social critique and social transformation. One only determines ‘one’s own’ sense of gender to the extent that social norms exist that support and enable that act of claiming gender for oneself.”27 In this light, we can read Toni’s message as a call for what Butler calls justice—justice as a matter not only or exclusively of how persons are treated or how societies are constituted, but also as concerns “consequential decisions about what a person is, and what

27 Butler 58
social norms must be honored and expressed for ‘personhood’ to become allocated.”

I would like to end by considering the implications of Butler’s vision of justice for thinking about how we engage in the politics of identity.

We know that prejudices are prejudices precisely for their longevity. Entrenched belief systems and traditional logics exist in form and content because at some time and on some level, they worked. By worked, I mean they gave shape and meaning to ways of living. Importantly, they worked because they remained, for much of modern Western history, just what they seemed: the mere mechanics of the social order churning beneath the surface. They needn’t be scrutinized or inspected for possible malfunctions and to attempt to adjust them would be to throw the entire system into chaos.

Today, however, we recognize that social change—the language we use, the conventions we observe, the identities we recognize—is necessary for the survival of society. The question we face now is how fast we are willing to change. The political Right argues that we are moving too fast while the many on the Left suggest that change is best undertaken incrementally. We cannot afford to be too idealistic, by hoping for too much, too fast. This attitude, though not explicit, is reflected in the recent “It Gets Better” project launched to give support and hope to LGBTI youth. Created by Dan Savage to spread the message that “it gets better”—that the bullying, ostracism and pathologization of LGBT youth and teens is endurable? Will eventually go away?—the project promises LGBTI teens that the pain produced by social intolerance will not last forever. It asks them to hold on to hope and to endure. In this respect, the project speaks to the sector of LGBTI youth most likely to commit suicide, engage in dangerous or risky behavior, including drug use and prostitution, or otherwise place themselves in danger as a way to cope with society’s intolerance. From this perspective, the project is admirable and direly needed. But is it just?

Is it just to advise struggling youth that “it” gets better without addressing the “it” in question? This “it” is the social, political and cultural life we experience and shape through media, social interaction, civic and political engagement. It is the “it” that makes the lives of minority groups intolerable. “It,” to put it simply, is us and encompasses the words we use, the social and cultural institutions we support, the politics we endorse. We as

28 Butler 58
a society are responsible for the pain LGBTI youth experience. From this perspective, “it” will not get better until we as a society make it better. In this respect, shows like Dr. Phil are instructive, for while critics worry that many of the guests who appear on the program are being exploited, that their personal problems are being used by savvy producers and clever hosts to create cheap but highly popular forms of entertainment, it is also important to note the way many guests also exploit the show for their own ends.

Toni on “Little Boy Lost,” and Tim and Melissa on “Gender-Confused Kids,” are examples of this. Unlike the guests who appear on the program seeking advice and help from Dr. Phil, this group of guests came to point out our problems—namely our intolerance and lack of understanding of the LGBTI community. They used our assumptions and our terms of intelligibility to question how we think about gender and sexual norms. Their goal was to make things better not just for themselves, but for others facing similar difficulties. They came to educate us about our prejudices, not to share their problems. Yet they did so by speaking from experience, opening the way for more dialogue and deeper thought about identity and social norms. Their claims were couched in the language of daily life and were circumscribed by the specifics of their own circumstances rather than through the confines of “science” or medicine. With this said, shows like Dr. Phil are important not simply because they are popular, but also because they provide a space for rethinking and reshaping our notions of normativity, identity and justice. We as scholars can help open the discussion by bringing attention to the work these shows do.
Works Cited


