Adam Smith

DOI: https://doi.org/10.56315/PSCF3-25Smith

Gender Incongruence and the Question of Medicalization

Adam Smith

How should Christians in science engage in the gender debate? Much of that debate is about matters of empirical fact: the causes and consequences of what is called "gender incongruence," and the benefits and harms of various interventions. On the other hand, some thinkers and activists who accept the reality of such facts also deny their relevance, and insist that what matters is simply how a person feels and what a person wants. Neither the "appeal to facts" nor the "appeal to feelings" are legitimate grounds for debating the question of whether gender incongruence is, in some sense, a medical problem to be fixed, or whether it is an identity to be celebrated. Only by making "ethical judgments"—fallible claims about objective values—can we address that question coherently and faithfully.

Keywords: gender, gender incongruence, medicalization, naturalism, normativism

How should Christians in science engage in the gender debate? Much of that debate is about matters of empirical fact: the causes and consequences of gender incongruence, and the benefits and harms of various interventions. Writing in these pages, Tony Jelsma has ably presented much of what is currently known.[1] Christians in science can and should follow Jelsma's lead and help people to tighten what is often a loose grasp of the subject.[2]

But the gender debate at its heart turns on questions that empirical facts cannot resolve, regardless of what the facts may be. Even if the known facts may have recently shifted in favor of those who argue, for example, that puberty blockers do more harm than good,[3] the debate itself seems to be shifting toward those deeper questions, and toward what the trans writer Andrea Long Chu calls "a stronger demand": one grounded in a worldview according to which puberty *itself* is the kind of thing that can do more harm than good, and should perhaps be prevented from occurring until a child is old enough to consent to it.[4]

Christians in science will have to grapple with such claims, not as scientists, but as Christians. The deeper questions and their competing answers are not empirical, they are ethical. At issue is not how the human body works, but how to be a human being. And this ethical question is ultimately theological: any answer to it will always be rooted in a broader vision of human flourishing in which claims about God are decisive.[5]

I am neither a scientist nor a theologian. The argument I make here cannot get at the facts, and it cannot get into the theology. What it can do, I hope, is to make plain *why* empirical facts are not sufficient to resolve the gender debate, and why theology is necessary. I think Christians in science are in a unique position to speak to the controversy, but I think their voice will be clearer if they can appreciate the limits of what they can say as scientists, and the significance of what they can say as Christians. So my purpose here is not to advance my own conclusions about

Adam Smith *is professor of political philosophy and director of the Honors Program at the University of Dubuque, in Dubuque, Iowa.*

gender incongruence; rather, it is to make an argument about the kinds of reasons we can and cannot use to draw any conclusions whatsoever, including those opposite to mine. I am talking about the ground for the debate itself.

I am going to make my argument by considering the gender debate as one example of a type of controversy that includes many similar cases. One of the key points of contention is whether gender incongruence is, in some sense, a medical problem or whether it is better understood as an identity. Thus the gender debate is partly a controversy about "medicalization"—the social process by which certain phenomena get defined in medical terms. If we want to know whether the phenomenon called gender incongruence does or does not count as a medical problem, we need to know how (or if) we can know what counts as a "medical problem" in general. In particular, we need to know which kinds of answers are relevant to this question of medicalization—and which kinds are not.

Both popular and scholarly discourse about medicalization tend toward two competing answers. The first is the one I have already hinted at here, which I will call the "appeal to facts." This is the claim that empirical knowledge about how the body works can tell us what is and is not a medical problem. The second is what I will call the "appeal to feelings." This is the claim that subjective preferences—attractions and aversions, pleasures and pains, likes and dislikes—can tell us what is and is not a medical problem. While they may seem to be rivals, both answers are wrong in the same way. Neither facts nor feelings by themselves can tell us what counts as a medical problem, because neither facts nor feelings alone can tell us what counts as a *problem*, per se. Controversies about medicalization are not debates about whether a certain problem should or should not be treated medically; they are debates about whether or not something is a "problem" in the first place. My thesis is that only by making ethical judgments—fallible claims about what is objectively good and bad for human beings, in which "objective" means "what is good or bad whether you like it or not"—can we offer legitimate answers to the question of medicalization in any particular case, including the case of gender incongruence.

Ethical judgments are neither observations of fact nor expressions of feeling, though they have connections to both. They are similar to claims about empirical facts, in that they are claims about what is objectively the case. But the "case" in question is the moral realm, the realm of values. And they are relevant to claims about feelings, in that they are claims about what we ought to feel. But the question of what we "ought" to like and dislike is very different from the question of what we happen to like and dislike. The latter is a question of subjective values, while the former is a question of objective values. Thus I am arguing from what philosophers broadly call a "moral realist" position.[6]

In this paper I use the term "fact" to refer specifically to empirical facts, of the sort pursued by science (mainly natural sciences such as biology, in this context, but also including social sciences, such as psychology) because my argument is directed against the widespread tendency to treat such facts as if they are *in themselves* evidence for or against certain answers to the question of gender incongruence. I am not suggesting that empirical facts are the only kind of fact—indeed, my argument for the priority of "ethical judgments" over empirical facts and subjective values is an argument for the priority of claims about what moral realists often call *moral* facts. "Moral fact" is another term for "objective value." I use the latter term because I hope it will be less confusing to non-philosophers, to whom this paper is primarily addressed.

I want to emphasize that facts *are* relevant to the question of whether gender incongruence is a medical problem to be fixed or an identity to be respected. So are subjective feelings. My argument is *not* that facts and feelings do not matter here; my argument is that *how* they matter is a question that can be answered only by making an ethical judgment, a claim about what is objectively good and bad for someone. The point is that this judgment is often the hidden assumption on which arguments about gender incongruence in particular and medicalization in general depend, and that this occlusion has consequences. Logical error is the least of these consequences: my claim is that what is centrally at stake in questions of medicalization is our capacity to respect one another as images of God, and that in disputes like this we cannot fully respect one another without treating one another as makers of fallible ethical judgments.

I also want to emphasize that there may be more than one legitimate answer to the question of gender incongruence. Again, I am not arguing for a particular conclusion: I am making an argument about how

to argue. But I do not want to be evasive, and I will state for the record that, in my view, gender incongruence is a (very complicated) problem, and that in some respects the problem may be medical. I believe it is a condition to be lamented and compassionately treated, not an identity to be celebrated. I also suspect that shifting the ground for the debate from empirical facts and subjective feelings to objective values might have the effect of making views like mine more persuasive. Still, it may be possible to coherently defend the contrary position, that gender incongruence is an identity, by making ethical judgments.

Among those who do hold that contrary position, the question of medicalization has long been divisive. I want to start by considering Chu's argument about medicalization, and by emphasizing that Chu is right to insist that medicalization is fundamentally about *respect*.

Medicalization and the Demand for Respect

Trans activists have often based their requests for medical interventions on Judith Butler's familiar contention that not only gender but sex itself is a social construction.[7] For Butler, biological sex is not an empirical reality. It is an illusion of facticity conjured by the repeated "performance" of gender. What follows is the now-familiar demand for the right to change one's sex so that it matches one's gender: since sex was always a social construction, individuals have the right to reconstruct it as they see fit. Among other things, reconstruction may involve drugs and surgeries.

The problem with Butler's view, as Chu points out, is that "[i]f gender really is an all-encompassing structure of social norms that produces the illusion of sex … why would the affirmation of someone's gender identity entail a change to their biology?"[8] This problem has often led trans activists toward an alternative argument, according to which medical interventions are justified by a diagnosis of gender incongruence (the currently preferred term) or gender dysphoria (now used to designate the stress that may or may not accompany gender incongruence itself). The problem with this alternative, for Chu, is that it medicalizes what should be understood as an identity. It turns difference into pathology.[9]

Against both positions, Chu contends that "any comprehensive movement for trans rights must be able to make political demands at the level of biology itself." Chu thinks we should accept that biological sex is a fact, while insisting that the desire to change this fact is not pathological. On the contrary: "justice is always an attempt to change reality." Chu's "stronger demand" is therefore for a universal right to change sex *without* needing to justify it by referring to any facts at all.

> We will never be able to defend the rights of transgender kids until we understand them purely on their own terms: as full members of society who would like to change their sex. *It does not matter where this desire comes from*. (emphasis in the original)[10]

It does not matter, in other words, whether the desire comes from "non-normative exposure to hormones in the womb," or to "unconscious parental conflict," or perhaps to "the obsessiveness and rigidity of patients with ASD [Autism Spectrum Disorder]."[11] It does not matter if it generally has "a complex etiology with hormonal, genetic, epigenetic disruptors, and immunological mechanisms that cause a specific neuropsychological profile," or if it is caused specifically by "a different sexual differentiation of the brain, not concordant with natal sex or sex assigned at birth, as a result of changes in the DNA sequence of the estrogen receptor α- β genes (ESR1 and ESR2) and the AR androgen receptor gene, as well as the CYP19A1 and the CYP17A1 genes."[12] It does not matter if it comes from endocrine-disrupting pollutants,[13] or, in particular, from phthalate esters.[14] It does not matter if it has a "rapid onset" and comes from "social influence, maladaptive coping mechanisms, parental approaches, and family dynamics,"[15] or if papers advancing that hypothesis have been retracted.[16]

All that matters, for Chu, is whether a person desires to change their sex, full stop. Chu assumes that desires themselves are neither good nor bad; what is morally right is the freedom to pursue our desires, so long as they harm no one else, and what is morally wrong is any restriction on that pursuit that is not justified by the need to prevent harm to others. At the same time, Chu also assumes that what counts as "harm" itself depends on what a person desires. Thus, even if she regrets it later, a woman who wants to remove her breast cannot be morally "harmed" by that removal, precisely because it was what she wanted.[17]

Chu's argument is an explicit rejection of any "appeal to facts" that might be made by or on behalf of people with gender incongruence, and an explicit "appeal to feelings" in defense of their absolute right to medical interventions. Chu clearly thinks it is possible to

divorce the need for a medical intervention from the idea of medical need: one need not be understood to have a medical *problem* in order to be given *medicine*. Medical care is for treating problems, but the "problem" in this case is an unsatisfied desire to change sex. There is no possibility for Chu that the desire itself could be the problem (in which case the desire's satisfaction would cause harm) and that this problem might in some respects be understood in medical terms such as those laid out by Jelsma and others.[18]

Chu's argument is admirably coherent—more coherent than Butler's—and it precisely identifies the crux of the matter. Even to label the desire "gender incongruence" (which replaced the older term "gender identity disorder") is still to pathologize it in some sense, and the question is whether the desire is pathological.[19] Thus Chu supports medical intervention to satisfy the desire, but opposes the medicalization of the desire itself. And Chu has a keen sense for what is really at stake in this question: not "health care" but *respect*. To pathologize the desire itself is to show disrespect for people (including children) who must be understood "on their own terms" and recognized as equals.

Chu is right: this is about respect, in that any case of medicalization is always fundamentally about respect. If we think—as we often do—that medicalization is instead about compassion, we fatally misunderstand what we are doing when we define something as a medical problem. Calls to relieve a person's suffering are predicated on claims *that* the person is suffering, and such claims are profoundly implicated in our attempts to recognize one another, in Chu's words, "as full members of society."

To see why medicalization is about respect, it is useful to consider what we are actually *doing* when we define something as a medical problem. In the next section I want to explain in simple terms how the process of medicalization works. The main point is that medicalization is a moral process, not an empirical one.[20]

How Medicalization Works

Note first that we define a great number of human experiences as "medical problems," and that controversy arises in only a few cases. Strictly speaking, common colds and broken bones are all "medicalized," but we take such cases for granted. There are no social movements for or against the medicalization of the flu.[21]

Those cases that do generate controversy can show us what we are doing even when no controversy occurs. Homosexuality, for example, was defined as a medical problem for much of the twentieth century. The medicalization of homosexuality was originally proposed, often by gay people themselves, as a compassionate alternative to its moralization and criminalization. But other gay people were insulted by having their orientation defined in this way. They did not object to the claim that sexual orientation has a biological basis, but to the claim that this biological fact was also a biological problem. Medicalization is normally consensual and occasional conflictual precisely because of this power to *problematize*. We take the medicalization of the flu for granted because we take for granted that the flu is a problem for people with the flu. If we disagree about the medicalization of homosexuality, it is because we disagree about whether homosexuality is a problem for people who are gay, an obstacle to their flourishing.[22]

Whether it is consensual or conflictual, medicalization is therefore always a moral process. Even if science may play a role in it, medicalization *per se* is not a scientific process of empirical discovery. After all, scientific discoveries need not be translated into medical applications. Rather, it is a process by which certain empirical facts, including those discovered by scientists, come to be understood as *mitigating* facts. Medicalization is about blame and excuse. When we "treat" a person's experience in a certain way (as a medical problem), we necessarily "treat" the person herself in a certain way. If you stay home from your job and spend the day swimming, I might treat you as "lazy," in which case I *blame* you. But if you stay home from your job and spend the day vomiting, I might treat you as "sick," in which case I give you an *excuse* for missing work. And as a sick person, you will feel well treated. Likewise, if you pursue relationships with the same sex and I perceive this as a choice, I might treat you as "perverted" and blame you. If I perceive it as natural, I might treat you as "diseased" and excuse you. But you may still feel ill-treated, because while you agree with me that your behavior is "natural," you may not agree that it is a "disease." The question of medicalization is never whether something can be excused; the question is always whether something needs an excuse.[23]

While the case of sexual orientation may be less settled among this readership than it is in the broader society, for better or worse there is now a fairly solid consensus that whether or not gay people are "born

this way," being gay is not a problem to be suffered and, if possible, solved, but is rather an identity to be celebrated. To emphasize the genuine difficulty of determining whether something needs an excuse, it may therefore be helpful to consider a case that is perhaps more challenging to most people's intuitions.

Those of us who are not deaf may be surprised that anyone would object to defining *deafness* as a medical problem. If anything is an obstacle to human flourishing that should, if possible, be removed or ameliorated by medicine, surely deafness is. It seems obviously bad for a person to lose one of her senses; or at least it seems obviously better to be able to hear than otherwise. On the basis of this ostensibly common sense, medical researchers have developed cochlear implants, so that deaf children could hear. Yet many Deaf[24] persons passionately resist this intervention, by which they feel disrespected. They believe that sign language is not a poor substitute for speech, but a unique alternative to it. It is as expressive and sophisticated as any oral language, and it forms the basis for a special culture whose members flourish as well as in any other. On their view, cochlear implants are not a way for Deaf people to overcome natural obstacles; rather, they are unnatural obstacles to the formation of a uniquely Deaf form of life. If you get a cochlear implant at a young age (when the implants are most effective), you are less likely to learn sign language. Some say that such interventions are a form of "ethnocide."[25]

Cases such as sexual orientation and d/Deafness show why medicalization is not only a moral but also frequently a political process. The treatment of certain experiences as problems, and then as problems of a certain kind, involves the treatment of persons in certain ways. These treatments can take the force of law, as when we guarantee sick leave or determine insurance coverage. When people feel insulted by the way they are treated, they may form a shared identity around this experience of disrespect. They may organize against the existing policies which define as a "problem" something they believe is not. Or, they may organize in support of policy changes that would define as a medical problem something not currently understood as such.[26]

Exactly the same moral and often political controversies unfold around a number of other cases. Is obesity a medical problem, or is it an occasion for "fat pride"?[27] Is anorexia something people suffer, or can people legitimately embrace a "pro ana" lifestyle?[28] What about autism—should we describe it as a disability or as a "neurodivergence"?[29] Can the concept of neurodivergence go so far as to embrace conditions like schizophrenia—can we have "mad pride" in the same way we have "fat pride," which is the same as "gay pride"?[30] Or consider the phenomenon of "body integrity disorder," or BID, which is the case that is probably most similar to that of gender incongruence. Just as some people with gender incongruence want to change their body in order to bring their biology more in line with their identity, so some people with BID identify as a disabled person and wish to amputate or paralyze healthy arms, legs, or other body parts in order to "become what they are."

For many people, the rhetorical weight of many of these examples might lend itself to the intuition that gender incongruence is a pathology rather than an identity, and that the morally appropriate response is compassion that aims to resolve a pathology, rather than respect that aims to honor an identity. As I have said, that is indeed my own view. BID in particular may seem more straightforward than cases like d/Deafness, and those sympathetic to the claim that gender incongruence is an identity rather than a pathology might suspect that any attempt to draw an analogy between gender incongruence and BID is probably a spurious argument made in bad faith by gender skeptics.[31] But it is worth noting that Body Dysmorphic Disorder is listed by the NIH as a differential diagnosis for gender dysphoria.[32] It is also worth noting that some clinicians and medical ethicists now justify amputation or paralysis as a legitimate treatment for BID, on precisely the same grounds that are used to justify gender-affirming care.[33] And it is especially worth noting that some people with BID embrace it as an identity, referring to themselves as "transabled."[34]

Yet the examples themselves do not show that my view is correct. If BID is a pathology rather than identity, and if BID is exactly analogous to gender incongruence, then gender incongruence is a pathology. But this is merely a formal argument, and leaves the substantive question unanswered: *is* BID a pathology? And my own question lies behind it: what kinds of answers to such a question are legitimate? Can we answer by pointing to facts about the body, to causes and consequences of BID? Or can we answer by pointing to the feelings of the person with BID, to her preference for being disabled?

To further explore this question, I want to consider one case of medicalization in more detail. The strange case of "drapetomania" dramatizes the blame/excuse structure of medicalization and makes it easier to understand why neither empirical facts nor subjective feelings are enough to tell us what is and is not a medical problem. In particular, it makes plain why Chu's own appeal to feelings cannot secure the respect that Chu rightly believes to be at stake in the debate about gender incongruence, and shows why such respect is actually a matter of making and contesting ethical judgments about what is objectively good or bad for human beings, given some substantive vision of human flourishing. At the same time, the case lends rhetorical weight to the proper concern of people like Chu, which is that medicalization, far from securing compassion for people with problems, can produce the most extreme forms of disrespect: in this case, justification for chattel slavery. This helps to check the passions of those of us who believe, as I do, that to treat gender incongruence as a (medical) problem, and to pursue an accurate empirical understanding of that problem in hopes of developing effective interventions, is to show compassion for people who are suffering. While I believe it is worth taking, there is indeed a real risk that our "compassion" may be a cover for something else.

The Disease Causing Negroes to Run Away

Dr. Samuel Cartwright coined the word "drapetomania" and introduced the concept in 1851, in an article for *DeBow's Review* on "Diseases and Peculiarities of the Negro Race." Slaves suffering from this "disease of the mind" were driven against their best interests to run away from their masters. To attempt an escape was to display the symptoms of drapetomania, and to indicate the proper course of treatment, which under some conditions included "whipping them out of it." In this same article, he also introduced "dysaesthesia aethiopica, or hebetude of mind and obtuse sensibility of body—a disease peculiar to negroes—called by overseers, 'rascality.'"[35]

Cartwright's first move in "Diseases and Peculiarities" is to describe an action taken by another human being ("running away") as a "symptom." Under this description it is no longer an action at all, but a behavior, something which is "induced" and is therefore "curable." That which induces the symptom is revealed as the disease, and specifically as a "disease of the mind." Cartwright invites us to accept the initial plausibility of his diagnosis by claiming that it is as much a mental disease "as any other species of mental alienation."[36] If we believe there is any such thing as mental illness, then we cannot reject the idea of drapetomania out of hand, but must consider it on its merits.

By describing the runaway's action as a behavior which is a symptom of a disease, Cartwright establishes from the outset that the runaway is a certain kind of human being: one who lacks the capacity to decide to run away. A human being who has this capacity does not need the protection offered by slavery. It is this need, this particular lack, which establishes the action as a symptom, and the person as a slave. The logic is internally quite consistent. If the runaway is a "natural slave," someone who lacks a certain capacity for free action that masters have, then running away can only be explained as a malfunction. That Cartwright depends on the assumption, and that the idea of drapetomania reinforces the assumption, does not itself render the assumption wrong. There is no logical problem of circularity here—although there is clearly a moral one, in the sense that we suspect Cartwright is moved to introduce this disease not by empirical curiosity, nor by moral concern, but by the need to prove the assumption right.[37]

Immediately after describing the runaway's action/behavior as a medical problem with a medical solution, Cartwright situates the problem and the solution in a particular moral context. The morally correct relation of the master to the slave is the paternalistic non-moral relation. This paternalistic relationship may be required by the moral law which determines relations between non-equals (for Cartwright, this law is established or at least supported by divine revelation in scripture). But it is not itself a moral relationship, which can only occur between equals. So it is possible for Cartwright to introduce the slave's escape as a medical problem, but only because the moral problem has already been solved.

This paternal relationship prohibits both abuse and respect. Just as children are not "respected" as equals by their parents, but are rather cared for and guided, so, for Cartwright, slaves are not respected as equals by their masters, but are directed and protected. Crucially, the claim that respect is not justified absolutely does not justify abuse: for Cartwright, the prohibition on equal respect and the prohibition on abuse are two sides of the same conceptual coin. The proper relation of master to slave requires *detachment*,

an attitude which makes possible punishment without anger. The presence of punishment (rather than vengeance) and the absence of anger are equally necessary to this attitude. To respect the slave would therefore be to damage him or her, because by definition respect is not what a slave needs.

Rather, the natural need of the slave is only for material goods and "kindness." Kindness must be expressed "without condescension."[38] Of course this prohibition on condescension is not about equal respect. It is not a prohibition on a patronizing attitude. Rather, it prohibits the master from lowering himself. Lowering oneself as a master to the level of one's slave would be wrong because it would be an inaccurate reading of the facts of nature. The white person is not the equal of the black, but is rather the natural superior, and their moral relations must reflect this fact. To be right in our relation to another, we must know what is already true about that other's nature.

If the slave develops a desire for respect, then this manifests a mental disorder. After all, mental disorders are at least in some respects disordered desires—they involve felt needs which if met would harm the person who feels them. Again, there is an implicit invitation to consider the diagnosis as plausible: if you believe in the possibility of disordered desires, you must entertain the logical possibility that the slave's desire for freedom is disordered.

Cartwright argues that the most common cause of the slave's disordered desire for freedom is a failure by the master to maintain a properly paternalist attitude. Paternalism is a virtue that balances between two vicious extremes: familiarity or a pretense to equality, and cruelty (stringency, neglect, "blustering manner of approach").[39] So the cause that motivates attempted escapes is not the slave's passion for respect, for that passion itself is a symptom, something with an environmental cause. Rather, the cause of disordered passions for equal respect is a circumstance which is under the master's control, and for which he is therefore responsible. The master must supply material needs; the master must punish hubris, which is bad for the slave because it will lead him or her to act against his or her own best interests. When circumstances, including material circumstances and the motivational structure of rewards and punishments, are properly arranged, then black people are "easily governed."[40] In modern parlance, there is a "social determinant" for this particular health problem.

And that is what Cartwright does: he defines the slave's desire for freedom as a health problem. For him, it is a health problem as opposed to a moral problem. A health problem is an excuse. A moral problem invites blame. Now we think that Cartwright was wrong about this: the desire for freedom is not a health problem. It is not a moral problem, either. But it is a moral matter, as opposed to a health matter. As a moral matter it is the opposite of a problem. We think the desire for freedom is praiseworthy. Two different mistakes were possible here. One was to blame the slave for desiring freedom. That would be a mistake because the desire for freedom is good, not bad. Another was to deny that the slave's desire for freedom is the sort of thing that can be blamed or praised. Cartwright avoided the first mistake by making the second. Cartwright never blames the slave for running away; rather, he denies that the slave is worth being blamed for any such thing.

Now, the second mistake is what we call an act of medicalization. Cartwright medicalizes the desire for freedom, turning it from a moral problem (in which a master might blame a slave for the attempted escape, call her "foolish" or "ungrateful," disparage his "character," etc.) into a health problem (which provides an excuse for such behavior, which would otherwise invite blame). We know without doubt that this is a bad case of medicalization. But many other cases of medicalization we call good, and for the same reason: they prevent blame by providing excuse.

It seems then that what we need is a critical perspective that can distinguish appropriate from inappropriate cases of medicalization. Presumably, medicalization is appropriate when it is appropriate to define something as a health matter, and inappropriate when the matter so defined is actually not (just) a health matter but (also or otherwise) a moral one. Thus we might consider whether it is more appropriate to define an inability to pay attention in class as "ADHD," for which a student may be prescribed some kind of medicine, or whether it is more appropriate to understand such inattention as a kind of character flaw, for which a student may be held responsible and prescribed some kind of discipline. Among philosophers of medicine, there is a long-running debate between two positions on this question, which are generally known as "naturalism" and "normativism." Naturalism and normativism are simply the technical versions of what I call here the appeal to facts and the appeal to feelings, respectively. I want to briefly summarize the naturalism-versus-normativism debate,

not only to connect my argument to a large literature that some readers may profit from exploring, but also to further clarify the problem with both the naturalist appeal to facts and the normativist appeal to feelings, by noting what naturalists and normativists have to say about the case of drapetomania in particular.[41]

Naturalism and Normativism

A naturalist concept of health supposes that health matters are matters of fact. From this approach, the distinction between health and illness can appear to us before we have the chance to conflate either phenomenon with the feelings we have about it. Although the difference between what we happen to like (health) and what we happen to dislike (illness) tends to match up with the natural distinction, it does not supply the distinction. Naturalist concepts are fairly straightforward. They are what we call "common sense." Cancer is an illness, and we do not like cancer, but our not liking cancer does not render it an illness. In philosophy of medicine, the leading naturalist is Christopher Boorse, who has been defending this approach for decades. Boorse defines health as an absence of disease, and he says that "disease judgments are value neutral … if diseases are deviations from the species biological design, their recognition is a matter of natural science, not evaluative decision."[42]

A normativist concept of health supposes that health matters are projections of values onto facts. From this approach, the distinction between health and illness appears only as the result of that projection: health is something we like, illness is something we don't. Now there are many things we like or dislike that we don't consider matters of health or illness. So the claim that something is a health matter isn't provided by biological facts, but by the way we categorize our values, which tells us which "facts" are "biological" and which are "social" or whatever. And this changes over time, across cultural boundaries. Often, though, to claim that something is a health matter is to pretend that the claim is not a projection of subjective preferences, but a neutral statement about the facts. And this is often in the service of power, which likes to conceal itself. The normativist concept is more often a critique of naturalism than a positive approach in its own right. You can see the critical edge in Sedgwick's assertion,

> All sickness is essentially deviancy [from] some alternative state of affairs which is considered more desirable … The attribution of illness always proceeds from the computation of a gap between presented behavior (or feeling) and some social norm.[43]

It is easy to see how each approach would dispense with the problem of drapetomania. Naturalists would say that drapetomania is a bad case of medicalization because there is no such thing as drapetomania: the facts do not support it. They would also say that drapetomania is an easy test for the naturalist perspective, because the science, in this case, is so obviously bad. Norman Daniels says that cases like drapetomania, where "a departure from a norm clearly was classified as a disease," are evidence not for normativist suspicion but for the naturalist conclusion that "societies sometimes make grievous errors about diseases or egregiously abuse disease classifications." And these examples actually show that "a normative approach to disease carries grave risks: it fails to let us say that these were errors that recognized methods of public reasoning, including the biomedical sciences, helped us expose."[44]

Normativists would say that drapetomania is a bad case of medicalization because it imposes a value (by using the language of "fact") onto people who would otherwise project other values onto their own experience of their bodies and environments. Slaves value their desire for freedom, while masters disvalue it. So drapetomania is not, for the normativist, a scientific mistake which, if avoided or corrected, would have decided the matter for the slave and against the master, and undermined the "social norm" of slavery. Drapetomania is "their view"—the view of white supremacists in the nineteenth century. As Harold Mersky puts it: "*For them*" it was a disease. "*For us* it is not. We cannot escape such relativism."[45]

Without getting too much into the conceptual weeds,[46] I simply want to lay out the decisive problem with each approach. The problem with naturalism—with the notion that the distinction between good and bad medicalization can be drawn entirely with reference to facts which are neutral regarding values—is that the moral question is never what the facts are, but how the facts matter. Now in the case of drapetomania, it is obvious that the facts are not what Cartwright said they were. So, in a sense, the moral question does not arise here, because there is nothing to ask a question about. But this is not evidence for the capacity of naturalism to distinguish good from bad medicalization. Consider the hypothetical. If Cartwright had had access to some advanced MRI machine that fulfilled all the often overblown promises made for that technology and allowed him to locate the "mania for

freedom" inside the slave's skull, we certainly would not accept that as medical evidence for the theory of natural slavery. The "facts" would not sway us here. The whole question is about the meaning of the facts: this is a moral question, and the political question arises because we can disagree about the meanings of facts. Naturalism simply avoids the question altogether. We can sense the problem with naturalism if we ask ourselves whether any set of facts should ever be able to persuade us that racialized slavery is justified.

Naturalism, then, is vulnerable to the objection raised by normativism, not because there are no such things as facts, but because the questions that concern us in a case like this—moral and political questions about human relationships, rather than scientific questions about physical reality—are questions about how the facts matter, not questions about facts themselves.

The problem with normativism, on the other hand, is that, having exposed this flaw in naturalism, by exposing the ineliminable role of values in giving facts their significance, and thus exposing the operations of power in the supposedly neutral discourse of facts, it remains inert in its relativism. Normativism is "critical" in that it exposes pretensions to neutrality, but it is uncritical in that it proceeds on the assumption that the values which are "projected" onto facts can only be subjective values. If the values in question—the meanings of facts—are based only on the preferences of individuals, then there is no sense in which the slave's valuing of their desire for freedom (a desire which certainly could be correlated, by the best science, with biological facts like brain states) is the correct value, while the master's desire for control, concealed behind the pretense of medicine, is the incorrect value. There is only the struggle for power between master and slave, in which we align ourselves retrospectively with the slave because his values happen to be "our" values. The relativism of normativism leaves us unable to say what is wrong with drapetomania: all it can say is that naturalism is just as ill-equipped to make the judgment, and that "our" judgments conflict with "theirs."

With all this in mind, let us return to the case of gender incongruence.

Medicalization and Gender Incongruence

Medicalizing gender incongruence involves isolating a phenomenon in order to describe and explain it with greater precision, here using biological and psychological discoveries available for medical use. We make observations which indicate causal relationships: prenatal hormones, environmental pollutants, social influence, or other factors. We learn how a gender-incongruent person's body works. With this kind of knowledge we may be able to develop interventions that mitigate or even eliminate the incongruence.

None of this requires reacting or responding to the gender-incongruent person *herself* in any particular way. In the scientific attitude, I can learn to "see" how gender incongruence works physiologically or psychologically—I come to understand, with increasing precision, why this person desires to change their sex, why they behave in certain ways—without thereby "seeing" the person herself. An empirical understanding of gender incongruence does not logically entail any moral obligation to the gender-incongruent person, or any moral limit on the pursuit of my own purposes toward her. Knowing how to medically treat the condition called gender incongruence is not the same as knowing how to morally treat the gender-incongruent person. The question is whether the same scientific attitude in which we try to explain the mechanisms of gender incongruence can confirm the claim that gender incongruence, understood as a biological and/or psychological condition, is also a biological and/or psychological *problem*—a "pathology" rather than a "normal variation." My answer is that it cannot.

To medicalize gender incongruence is not only to explain how the gender-incongruent body works: it is also to claim that it works badly for the gender-incongruent person. This is the moral structure of medicalization. To characterize a person's experience as a problem is to take up a certain kind of relationship to the person himself. To treat the person's problem *as* a problem, and as a problem of a certain kind, is to treat the person in a certain way. If we treat the person's experience as a medical problem, we treat him as if the behavior associated with the problem needs an excuse. If something is a problem for a person, it is an obstacle to that person's good. It is "bad for" the person. To say that gender incongruence is a problem, medical or otherwise, is therefore to make a judgment about what is good or bad for people: it is to say, for example, that it is good to be satisfied with your natal sex.[47] In the same way, to say that the flu is a problem, medical or otherwise, is to say that having the flu is bad for you. The difference between these cases is not whether we are able to

describe the "problem" in medical terms (a scientific achievement) but whether we are able to describe it as a problem, period. It is easy to agree that the flu is a problem, but not because we all have the same solid grasp of how influenza works. Likewise, it is hard to agree that gender incongruence is a problem, but the dissensus is not due to a lack of empirical knowledge, even if there is much that we still lack. Rather, it is due to conflicting judgments about what is good for individual people and for human beings.

These judgments cannot be eliminated from debates about medicalization, and it is precisely when we *try* to eliminate them—when we act as if facts (as in naturalism) or feelings (as in normativism) alone can determine what does or does not count as a medical problem—that we disrespect our interlocutors. The reasoning behind the above idea is that what we respect in persons is what Philip Pettit calls their "fitness for responsibility"[48]—their capacity to act intentionally. To define a person's experience as a medical problem is to claim that they do not endorse this experience in that responsible capacity, but rather that their bodies simply suffer it. If they claim to the contrary that their experience (such as their desire to change their sex) is not a problem which excuses their behavior, and that their behavior (such as their visit to the gender clinic) is something which they endorse because they have reason to believe it is good for them, then our empirical grasp of the biological facts which explain their experience is not enough to counter their judgment about that experience. For what we respect in others (and in ourselves) is precisely this natural human capacity to make fallible judgments about what is objectively good and bad for people, judgments which cannot be reduced to statements of empirical fact and so cannot be certified by empirical discoveries. If we wish (as I do) to counter their claim because we think that they are wrong, that this really is bad for them, then we must give them ethical arguments about what is good and bad for human beings, not facts about how their bodies work.

Of course, the gender debate is not usually a contest between naturalists who believe that facts alone can tell us whether gender incongruence is a medical problem and those (like myself) who believe that only objective values can distinguish pathology from identity. The other side of the debate is usually the normativist position that is so perfectly captured by Chu's argument, which is that a person's subjective feelings are enough to decide the matter—even if the person is a child. So it is important to emphasize that the moral structure of medicalization means that normativists are wrong for precisely the same reason as naturalists are wrong. That is, the normativist actually treats his subjective preferences in the same way that the naturalist treats her empirical facts: as "value-neutral." Thus, for Chu, whatever the causes of the desire or the consequences of its satisfaction, it cannot be bad for a person to desire a sex change. All desires are valid in themselves.[49]

But we cannot respect someone by "validating" their desires. Rather, what we respect as personhood is the capacity to make judgments about desires, to determine whether our subjective feelings are objectively good or bad for us. A person, as opposed (perhaps) to an animal acting purely on instinct, does not just subjectively "like" or "dislike" things. A person has likes and dislikes, and also has the capacity to reflect on whether his likes and dislikes are good or bad for her, given the kind of creature she is. A person is always making these judgments, whether implicitly or explicitly. And judgments—unlike desires—can be contested.[50]

What Chu misses is that the transitioner does not simply desire to change sex; he makes a judgment, implicitly or explicitly, that his desire to modify or change his sex is good for him. This is precisely parallel to the slave, who did not simply desire to escape, to "be free," but judged that his desire for freedom was itself a healthy desire, rather than being the symptom of a mental illness. If the master had argued with the slave, if he had tried to persuade him that he was suffering from a problem called "drapetomania," then the master would surely have failed. But by arguing he would also have shown the slave the respect due to an equal in an exchange of respect—this, of course, is precisely what he could not do, because a slave is by definition unworthy of such respect. To contest the enslaved person's judgment would have been to admit that the person was a *person*, not a "natural slave."

No doubt it is because our judgments can be contested that we like to pretend we are not making them—often by appealing to "the facts," as Samuel Cartwright did, or conversely to our feelings, as Andrea Long Chu does, and in many cases by declaring that the one thing we cannot do is to "impose our values," when of course that is the one thing we are always doing, although "imposing" is usually the wrong word for it. The gender debate, like

many other controversies in which the question of medicalization is front and center, is full of this evasion. But the gender debate is also full of demands for respect. And you cannot respect people without making your own ethical judgments and contesting the ethical judgments that others make.[51]

Christians are not all on one side of the gender debate. There is disagreement amongst ourselves. But I think Christians should be able to agree that the proper ground for this debate is the ground I have mapped out here. The fundamental Christian belief about human beings is that they are made in the image of God, and to be made in God's image surely means to be made with the capacity for ethical judgment. We cannot respect others as images of God without respecting them as judges of what is good and bad, as creatures who can be held responsible for their actions precisely because the moral significance of their actions is not fully determined by the subjective feelings that individuals express, or by the empirical facts that science investigates.

Such facts only become morally relevant in light of these judgments, and Christians in science have the opportunity to put empirical knowledge in the context of the Christian vision of human flourishing. Let me emphasize again that nothing I have argued here should be taken to imply that facts are *not* morally relevant. The point is that they do not carry their moral relevance within themselves, so to speak. But facts (and feelings) are vital: we cannot responsibly engage the gender debate *without* taking stock of the relevant facts and feelings. It is true that on my account, facts in themselves cannot tell us whether gender incongruence is a problem. Strictly speaking, we must make an ethical judgment independently of the relevant empirical facts, precisely because we only know which facts are "relevant" *after* we have made the ethical judgment. And this judgment must be connected to a larger vision of flourishing. However, we cannot (and, in practice, do not) make such a judgment behind some veil of scientific ignorance. If we find, for example, that gender incongruence is caused in part by an underdeveloped mind-body connection (as Jelsma suggests), that fact might count as one piece of evidence for the judgment that gender incongruence is a problem rather than an identity—*assuming* we have also made the judgment that an underdeveloped mind-body connection is itself a problem, in the sense of an "obstacle to flourishing" (as indeed we would have, simply by using the loaded term "underdeveloped"). Facts thus establish connections between distinct ethical judgments, and those judgments must be connected if they are to cohere into (or out of, depending on our theories of how this works) a comprehensive vision of human flourishing.

That vision, as I have suggested, is a theological matter, and I will let the theologians explore it.[52] But all of us who are Christians, whether we are scientists or theologians or laypersons, can benefit from being clearer about what the debate is really about, and I hope I have made some contribution toward that work of clarification.

Notes

[1]Tony Jelsma, "An Attempt to Understand the Biology of Gender and Gender Dysphoria: A Christian Approach," in *Perspectives on Science and Christian Faith* 74, no. 3 (2022): 130–48, https://doi.org/10.56315/PSCF9-22Jelsma.

[2]The work of psychologist Mark Yarhouse is especially notable in this regard. See Yarhouse, *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture* (IVP Academic, 2015).

[3]Hilary Cass, "The Cass Review: Final Report," NHS England, 2024, https://cass.independent-review.uk/home/publications/final-report/. Cass's findings have, of course, been widely disputed. See Dori M. Grijseels, "Biological and Psychosocial Evidence in the Cass Review: A Critical Commentary," *International Journal of Transgender Health*, June 2024, 1–11, http://dx.doi.org/10.31235/osf.io/wjafd; Chris Noone et al., "Critically Appraising the Cass Report: Methodological Flaws and Unsupported Claims," *OSF Preprints*, June 11, 2024, https://doi.org/10.31219/osf.io/uhndk; and Cal Horton, "The Cass Review: Cis-Supremacy in the UK's Approach to Healthcare for Trans Children," *International Journal of Transgender Health*, March 2024, 1–25, http://dx.doi.org/10.1080/26895269.2024.2328249. While it had some important effects on health policy in the UK, the review largely "failed to land" in the US. See Jennifer Bock, "Gender Medicine in the US: How the Cass Review Failed to Land," *The BMJ*, May 23, 2024, https://doi.org/10.1136/bmj.q1141.

[4]Puberty, after all, is a traumatic and potentially damaging experience that no one signs up for. On these grounds, Florence Ashley argues that far from being banned or restricted, puberty blockers should be freely available. See Ashley, "Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth," *Clinical Child Psychology and Psychiatry* 24, no. 2 (2019): 223–36, https://doi.org/10.1177/1359104519836462. Emma Colton quotes activist Zinnia Jones, who put it like this: "An inability to offer informed consent or understand the long-term consequences is actually an argument for putting every single cis and trans person on puberty blockers until they acquire that ability." While conservative critics (including Colton) pounced on the presumably absurd suggestion that everyone should be forced to take puberty blockers, Jones was actually pointing out the logical consequences of the consent-based argument against puberty blockers (Emma Colton, "Transgender Activist

Makes Argument for All Children to Be Put on Puberty Blockers Until They Can Determine Identity," *The Washington Examiner*, December 14, 2020, https://www.washingtonexaminer.com/news/1672921/transgender-activist-makes-argument-for-all-children-to-be-put-on-puberty-blockers-until-they-can-determine-identity/). Ashley's argument for making puberty blockers "readily available" is quite serious, but Jones is offering a *reductio ad absurdum* and, in my view, quite an effective one. One important implication of my own argument is that when it comes to the gender debate, arguments about "consent" often miss the point. Jones shows why.

[5]As Oliver O'Donovan puts it, "The ultimate questions of ethics are theological. The penultimate questions are not always so, but to comprehend what moral reason is about, and how it must proceed in a way that satisfies our need for fulfilled lives, ethics must be set in the context of the human relationship to God" (Patricia Paddly, "A Conversation with Oliver O'Donovan," *Wycliffe College Blog*, November 28, 2017, https://wycliffecollege.ca/blog/conversationodonovan). See Oliver O'Donovan, *The Disappearance of Ethics* (Eerdmans, 2024) for O'Donovan's most recent argument for the rootedness of ethics in theology.

[6]On moral realism and the availability of "moral facts," see, for example, Russ Shafer-Landau, *Moral Realism: A Defense* (Oxford University Press, 2003); and Paul Bloomfield, *Moral Reality* (Oxford University Press, 2001). My use of the terms "ethical judgments" and "objective values" is influenced especially by Hans Joas, "Values Versus Norms: A Pragmatist Account of Moral Objectivity," in *The Hedgehog Review* 3, no. 3 (2001): 45, https://hedgehogreview.com/issues/pragmatism-whats-the-use/articles/values-versus-norms-a-pragmatist-account-of-moral-objectivity#:~:text=While%20norms%20refer%20to%20the,to%20only%20one%20of%20them.

[7]"If the immutable character of sex is contested, perhaps this construct called 'sex' is as culturally constructed as gender" (Judith Butler, *Gender Trouble* [Routledge, 1990], 9).

[8]Andrea Long Chu, "Freedom of Sex: The Moral Case for Letting Trans Kids Change Their Bodies," *New York Magazine*, March 11, 2024, https://nymag.com/intelligencer/article/trans-rights-biological-sex-gender-judith-butler.html.

[9]This is the essence of medicalization: turning what had been considered a moral deviation into a medical pathology, or moving, in Conrad's classic formulation, "from badness to sickness." See Peter Conrad, *Deviance and Medicalization: From Badness to Sickness* (Mosby Press, 1980). The intention, often explicit, is to remove the stigma of deviance. Chu's argument is that gender incongruence is *neither* a moral deviation *nor* a medical pathology, which after all is another kind of "deviation"—a deviation from a biological rather than a moral norm, which can carry its own stigma. Thus the puzzle, as the American Psychiatric Association puts it, is "how best to preserve access to gender transition-related health care while also minimizing the degree to which such diagnostic categories stigmatize the very people that physicians are attempting to help" (Author Unknown, "Gender Dysphoria Diagnosis," *Psychiatry.Org*, November 2017, accessed September 4, 2024, https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis#:~:text=Criteria%3A%20Gender%20Dysphoria%20in%20Adolescents%20and%20Adults,-1&text=A%20strong%20desire%20to%20be,the%20anticipated%20secondary%20sex%20characteristics. At the same time, some push the argument further and suggest that *de*pathologizing gender incongruence (as Chu does) comes with its own risk. Thus Max Thornton says that while "it is important to refute the idea that being trans is a disease," it is also important to avoid the "ableism" that this often presumes. He explains,

> On the surface, it may seem compelling to defend transness with statements along the lines of: "I'm not CRAZY, I'm transgender!" Yet to attempt to destigmatize transness by further stigmatizing mental illness is a losing proposition … It concedes to the unjust priorities of an ableist society, with its unspoken corollary: "if I WERE crazy, you would be justified in mistreating me …" (Max Thornton, "Gender Pandemic?," *Queer Disability Studies Network*, October 31, 2021, https://queerdisabilitystudies.wordpress.com/gender-pandemic/)

[10]Chu, "Freedom of Sex."

[11]Juan Pablo Rojas Saffie and Nicolás Eyzaguirre Bäuerle, "Etiology of Gender Incongruence and Its Levels of Evidence: A Scoping Review Protocol," *PLOS ONE* 18, no. 3 (2023): e0283011, https://doi.org/10.1371/journal.pone.0283011.

[12]Rosa Fernández et al., "The Biological Basis of Gender Incongruence," in *Human Sexuality*, ed. Dhastagir Sultan Sheriff (*IntechOpen,* 2022), https://www.intechopen.com/chapters/80813.

[13]Steven David Holladay, "Environmental Contaminants, Endocrine Disruption, and Transgender: Can 'Born That Way' in Some Cases Be Toxicologically Real?," *Human & Experimental Toxicology* 42 (September 2023), https://doi.org/10.1177/09603271231203382.

[14]Jieyu Liu et al., "Long-Term Exposure to Exogenous Phthalate, Masculinity and Femininity Trait, and Gender Identity in Children: A Chinese 3-Year Longitudinal Cohort Study," *Environmental Health* 22 (November 28, 2023): article 81, https://doi.org/10.1186/s12940-023-01031-5.

[15]Lisa Littman, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLOS ONE* 13, no. 8 (August 16, 2018): e0202330, https://doi.org/10.1371/journal.pone.0202330.

[16]Suzanna Diaz and J. Michael Bailey, "Retraction Note: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases," *Archives of Sexual Behavior* 52, no. 3 (June 14, 2023): 1031–43, https://doi.org/10.1007/s10508-023-02576-9.

[17]Chu writes,

> The freedom of sex does not promise happiness … where there is freedom, there will always be regret … it is one thing to regret the outcome of a decision, but it is a very different thing to regret the freedom to decide … If we are to recognize the rights of trans kids, we will also have to accept that, like us, they have a right to the hazards of their own free will … if children are too young to consent to puberty blockers, then they are definitely too young to consent to puberty, which is a drastic biological upheaval in its own right. (Chu, "Freedom of Sex")

[18]An especially clarifying parallel example of this appeal to feelings in debates about medicalization comes from Alyson Spurgas, writing on the promise of "female viagra." It is worth quoting in full.

> As I examine this sexual marketplace and these debates wear on, I often wonder … why women's desire is constantly being dissected, examined, and worked upon, but never stimulated, enlivened, and aroused *on our*

own terms. Even more so than women's desire, it seems that women's *pleasure* has been almost forcibly shut out of the clinic and the bedroom in too many times and places, or negated in lieu of someone else's pleasure, and that this is still the case today. In this vein, we ought to remember that sexism and misogyny are still prevalent in a variety of insidious forms—within and outside of clinical medicine and scientific laboratories, and with or without prescription drugs. The medical and scientific climate around sexuality and proposed and prescribed treatments are, rather, *effects* of a widespread and willful ignorance of women's pleasure, and thus they represent a larger social lacuna. This is why it seems so imperative to shift the debate from the drugs themselves to the larger medical, scientific, social, cultural, and political milieu in which gender differences are configured and disseminated—configurations that have real consequences for how people experience their own bodies, other people's bodies, and their sex lives. If taking a drug will make women feel the desire that they desire to have, and that is satisfying and pleasurable to them, then, by all means, we should have it! But let's not stuff too many pills down our throats before seriously considering what we want, why we want it, and what we could potentially want for our futures (sexual and otherwise). There are many trajectories to that place of pleasure—if "sexual" pleasure is what we *choose* to pursue. (Alyson K. Spurgas, "We've Come A Long Way, Baby? Pink Pills, Blue Pills, and False Equivalences in the Medical Treatment of Sexual Dysfunction," *SIUE Women's Studies Program*, February 12, 2016, https://siuewmst.wordpress.com/2016/02/12/weve-come-a-long-way-baby-pink-pills-blue-pills-and-false-equivalences-in-the-medical-treatment-of-sexual-dysfunction/)

In my doctoral dissertation, I wrote,

> What then is the test that distinguishes good from bad medicalization, and determines whether "taking a drug" will in this case indicate either care or control, liberation or repression? For Spurgas it is clear: the test is simply "the desire that they desire to have," the pleasure women "choose to pursue," desire "on our own terms." Medicalization went well for men not because it included masculine desires which are objectively good for men, but because it included their desires, period. Men made medicalization work for them by disguising those desires as objectively good. Spurgas rips away this disguise and proposes that medicalization will work well for women when it helps them to pursue their subjective desires as effectively as men can. What better description of a "subjective value" than "the desire we desire to have"? (Adam Smith, *Democratic Medicine: Recognition, Citizenship, and the Politics of Medicalization* [PhD diss., Brandeis University, 2017], 104)

Note that Spurgas's formulation can also sound strangely similar to the way that a theory like Harry Frankfurt's (mentioned below, in note 49) would lead us to think of *objective* values, which are (in Frankfurt's terms) "desires about desires." The difference is that Spurgas does not seem to believe that one can have better or worse "desires about desires," whereas Frankfurt's "second-order desire" is rationally contestable.

[19]The WHO in 2019 updated its diagnosis manual by removing gender incongruence from the list of mental disorders, but the term "gender incongruence" itself is still included (it denotes "a marked and persistent incongruence between a person's experienced gender and assigned sex"); this inclusion, for some activists, is still offensive. "Language, especially when it comes to gender, matters. It is the incongruence part—defined "out of place"—that makes some activists feel the WHO is not as progressive as this move would initially appear," *BBC News* staff, "Transgender No Longer Recognised as 'Disorder' by WHO," *BBC News*, May 29, 2019, https://www.bbc.com/news/health-48448804.

[20]This article, the next two sections in particular, draws freely on my PhD dissertation. See Smith, *Democratic Medicine*. The dissertation does not take up the question of gender incongruence, except in passing, but it does include discussion of many of the other cases mentioned here, and develops in detail the argument that I apply to the gender question in this article.

[21]Peter Conrad notes,

> While much writing, including my own, has been critical of medicalization, it is important to remember that medicalization describes a process. Thus, we can examine the medicalization of epilepsy, a disorder most people would agree is "really" medical, as well as we can examine the medicalization of alcoholism, ADHD, menopause, or erectile dysfunction. (Peter Conrad, *The Medicalization of Society* [Johns Hopkins University Press, 2007], 5)

[22]See Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in Modern Society* (University of Chicago Press, 1999), chap. 2.

[23]This is Talcott Parsons's insight about the "sick role." See Parsons, *The Social System*, 2nd edition (Routledge, 1991).

[24]The capital letter is used to distinguish a condition (deafness) from an identity (Deafness).

[25]See, for example, Owen Wrigley, *The Politics of Deafness* (Gallaudet University Press, 1997). For the specific claim that cochlear implants are a form of "ethnocide," see Robert Sparrow, "Implants and Ethnocide: Learning from the Cochlear Implant Controversy," *Disability and Society* 25, no. 4 (2010): 455–66, https://doi.org/10.1080/09687591003755849.

[26]See Phil Brown and Stephen Zavestoski, eds., *Social Movements in Health* (Wiley-Blackwell, 2005). See also Phil Brown et al., *Contested Illnesses: Citizens, Science, and Health Social Movements* (University of California Press, 2011).

[27]Esther Rothblum and Sondra Solovay, eds., *The Fat Studies Reader* (NYU Press, 2009), write in the foreword,

> Calling fat people "obese" medicalizes human diversity. Medicalizing diversity inspires a misplaced search for a "cure" for naturally occurring difference. Far from generating sympathy for fat people, medicalization of weight fuels anti-fat prejudice and discrimination in all areas of society. People think: If fat people need to be cured, there must be something wrong with them … The pretense of concern for fat people's health wards anti-fat attitudes against exposure as simple hatred. Belief in a "cure" also masks that hatred. It is not possible to hate a group of people for our own good. Medicalization actually helps categorize fat people as social untouchables. It is little surprise, then, that when fat people do fall ill, we get blame, not compassion. We receive punishment, not help. Medical cures are inappropriate when applied to social ills. Such a misdiagnosis can be very dangerous. (xiii–xiv)

Virginia Sole-Smith, author of the widely feted *Fat Talk: Parenting in the Age of Diet Culture* (Henry Holt, 2023), explicitly compares being fat to being gay or being black.

> The solution to racism is not to make everyone white. The solution to homophobia is not to make everyone straight. This is not how we as a culture want to be

proceeding on [anti-fat bias]. (Audio interview with Tonya Mosley, "Diet Culture Can Hurt Kids. This Author Advises Parents to Reclaim the Word 'Fat,'" Fresh Air, *NPR Health*, April 25, 2023, 34:33, https://health.wusf.usf.edu/npr-health/npr-health/2023-04-25/diet-culture-can-hurt-kids-this-author-advises-parents-to-reclaim-the-word-fat)

[28]Unlike "fat pride," "Pro Ana" is no longer much of an active movement, but many Pro Ana advocates took the appeal to feelings to what may be its furthest logical conclusions. On their websites and message boards, the appeal to feelings became a full-throated embrace of a pure will-to-power. The anonymous writer at a site called *Pro Ana Lifestyle Forever* offered a long list of reasons for "why I starve myself," including "because I can," "because I want to," "because I have wanted to be these way forever" and "because it's me." (Author Unknown, "Ana Religion & Lifestyle," *The Pro-Ana Lifestyle Forever* (blog), May 4, 2013, https://theproanalifestyle00.wordpress.com/about/)

Another anonymous writer describes her website as

> a gathering point for sentient individuals who are working to cause changes to occur in body in conformity to will. There are no victims here. This is not a place for the faint-hearted, weak, hysterical, or those looking to be rescued. This is not a place for those who bow to consensus definitions of reality or who believe in the cancerous fallacy that there is any other authority on earth besides their own incontrovertibly self-evident, inherent birthright to govern themselves.

The writer goes on to contrast "rexies" (those who are "pro" ana) with "anorexics."

> You may already know the difference between us rexies and anorexics! If u [sic] want sympathy for your "disease," you are anorexic. If you want respect and admiration for your lifestyle of choice, you are a rexie. Anorexics die. Rexies don't. Have we understood the difference? This site is for us rexies, who are proud of our accomplishments, and the accomplishments that lie ahead. We will never die.

Passages are from a defunct website (Ana's Underground Grotto) quoted in Author Unknown, "The Rise of Pro-79 Anorexia and Pro-Mia Websites," Social Issues Research Centre. Texts are also reproduced at "Ana's Underground Grotto—Original Texts Reproduced from the First Home of Project Shapeshift," Project Shapeshift: ProACTIVE Pro-Ana Positively Alive and Optimally Well!, http://project-shapeshift.net/anas-underground-grotto.html.

[29]As the title of one article puts it: "Autism Is Not a Disease. Stop Trying to 'Cure' Us and Learn to Understand Us." See Jodie Hare, "Autism Is Not a Disease," *Novara Media*, November 25, 2012, https://novaramedia.com/2021/11/25/autism-is-not-a-disease/.

[30]Joseph Straus writes,

> In recent years, a new concept of madness has emerged, one that rejects the medical model … in favor of an appreciation of the diversity of human embodiments, both mental and physical. Under the banner of slogans like "the dangerous gift" (with reference to bipolar disorder), "neurodiversity" (with reference to autism), and "psychocrip" (an in-your-face re-appropriation of a stigmatized category, modeled on "crip" and "queer"), activists are arguing that madness, so long medicalized as "mental illness," may be better understood as part of the natural diversity of human minds, with a claim for acceptance and accommodation rather than normalization and cure. (Joseph Straus, *Extraordinary Measures: Disability in Music* [Oxford University Press, 2011], 34)

Cydney Heed reflects on (and endorses) these developments in "Our Brains Are Not Broken: Mad Pride, Neurodiversity and How Diversity Becomes Disease," *The Michigan Daily*, May 28, 2024, https://www.michigandaily.com/statement/our-brains-are-not-broken-mad-pride-neurodiversity-and-how-diversity-becomes-disease/.

[31]The same reaction has accompanied the similar suggestion that being transgender is analogous to being "transracial," as Rebecca Tuvel argued in her (in)famous *Hypatia* article, "In Defense of Transracialism," *Hypatia: A Journal of Feminist Philosophy* 32, no. 2 (Spring 2017), 263–278, https://doi.org/10.1111/hypa.12327, which prompted demands for retraction (the demands were not met, though the journal did issue an apology, which was itself controversial).

[32]Garima Garg et al., *Gender Dysphoria* (StatPearls Publishing, 2025), https://www.ncbi.nlm.nih.gov/books/NBK532313/.

[33]Rianne M. Blom, Raoul C. Hennekam, and Damiaan Denys, "Body Integrity Identity Disorder," *PLOS ONE* 7, no. 4 (2012), https://doi.org/10.1371/journal.pone.0034702.

[34]Jenny L. Davis, "Narrative Construction of a Ruptured Self: Stories of Transability on Transabled.org," *Sociological Perspectives* 55, no. 2 (2012): 319–40. Consider the way that one person with BID (here called BIID—body integrity identity disorder) approaches the question of whether BID is itself a pathology.

> Some people might well conclude that having BIID causes disease. There is a lot of pain and unhappiness expressed about having BIID. But I would suggest that the pain and unhappiness is not from the BIID. It is from the response of the world to our BIID, or from our inability to get our amputations, paralysis, or whatever done. I actually enjoy my fantasies of being one-legged, and I enjoy my pretending. It is when these crash down in the face of reality that I become distressed. Well, irrespective, if BIID leads to unhappiness, doesn't this make it a disease? Not unless you want to say also that being black in a racist society or being gay in a homophobic society is a disease. The distinction here is important. If there is "disease," then we should look for a treatment to change the condition that leads to the disease. If the condition that leads to the disease is intolerance or failure to understand, this is what we should work to change—not the condition that is not tolerated or misunderstood. I would assert that lack of understanding or intolerance of BIID is a "disease of society," and that that is what we should be trying to treat and cure. (Michael Gheen, "Is BIID an Illness?," *Overground*, accessed November 9, 2016, http://www.overground.be/features.php?page=THE&article=390&lan=en)

Gheen's argument mirrors Chu's: it is not the desire to transition itself that is and causes problems, rather the problems are caused by other people's refusal to accept that the desire is legitimate.

[35]Samuel Cartwright, "Report on the Diseases and Peculiarities of the Negro Race," *DeBow's Review* 11 (1851).

[36]Cartwright, "Report on the Diseases and Peculiarities of the Negro Race."

[37]In my doctoral dissertation, I wrote,

> There is some debate among historians about when and to what extent there appeared in the South an argument that slavery was not a necessary evil but a "positive good" (which is an argument for natural slavery). For a long time it was accepted that the positive good argument was a new development in the South,

arising in the 1820s and responsible for the Garrisonian abolitionist backlash. Larry Tise, in an exhaustive study, challenges the traditional thesis and argues that the notion of slavery as a positive good has a much longer history, and was not unique to the South. See Tise, *Proslavery: A History of the Defense of Slavery in America, 1701–1840* (University of Georgia, 1990). I find Tise convincing, and his argument matters because it indicates that Cartwright's argument was not an aberration, but part of a long-standing way of thought with extensive and (I would suggest) lasting influence. (Smith, *Democratic Medicine,* 121, n. 70)

[38]Cartwright, "Report on the Diseases and Peculiarities of the Negro Race."

[39]Cartwright, "Report on the Diseases and Peculiarities of the Negro Race."

[40]Cartwright, "Report on the Diseases and Peculiarities of the Negro Race."

[41]To be sure, the debate is more nuanced than a brief summary can suggest, and includes various alternative positions that try to reconcile naturalism with normativism, or to carve out a third way. See, for example, Elselijn Kingma, "Health and Disease: Social Constructivism as a Combination of Naturalism and Normativism," in *Health, Illness and Disease: Philosophical Essays,* ed. Havi Carel and Rachel Cooper (Routledge, 2014), 37–43. See also Kingma's "Naturalism about Health and Disease: Adding Nuance for Progress," *Journal of Medicine and Philosophy* 39, no. 6 (December 2014): 590–608, https://doi.org/10.1093/jmp/jhu037. For a similar approach, see Juha Räikkä, "The Social Concept of Disease," *Theoretical Medicine* 17 (December 1996): 353–61, https://doi.org/10.1007/BF00489680.

Some revise the naturalism/normativism debate for more "practical" reasons. George Khushf argues that the value-neutral/value-laden dichotomy becomes less useful in an age when institutions of medicine have so obviously encompassed social and political (thus, value-laden) aspects of life ("An Agenda for Future Debate on Concepts of Health and Disease," *Medicine, Health Care and Philosophy* 10, no. 1 [March 2007]: 19–27, https://doi.org/10.1007/s11019-006-9021-7).

My own view is that the naturalist/normativist dichotomy conceals a deeper consensus, which I too would reject in favor of a third way. I am sympathetic to Richard Hamilton's Aristotelian defense of a "naturalistic ethics," which accepts the naturalist claim that disease is not just a projection of disvalue onto a value-neutral world, but insists against naturalism that value is itself a natural quality (Richard Hamilton, "The Concept of Health: Beyond Normativism and Naturalism," *Journal of Evaluation in Clinical Practice* 16, no. 2 [April 2010]: 323–29, https://doi.org/10.1111/j.1365-2753.2010.01393.x). At the same time, I am also sympathetic to the more Humean approach developed at much greater length by Paul Davies in *Norms of Nature: Naturalism and the Nature of Functions* (MIT, 2001). While I cannot develop such a claim here, I think we need not presume that Aristotelian and Humean approaches are incompatible (for a suggestive argument to this effect, see Jessica Spector, "Value in Fact: Naturalism and Normativity in Hume's Moral Psychology," *Journal of the History of Philosophy* 41, no. 2 [April 25, 2003]: 145–63, http://dx.doi.org/10.1353/hph.2003.0020.) The point is that my own "third way" between naturalism and normativism would feel most at home with those who hold that values come "first," without supposing that values must also be "non-natural."

[42]Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44, no. 4 (1977): 542–43, https://www.jstor.org/stable/186939.

[43]Peter Sedgwick, *Psychopolitics* (Harper & Row, 1982), 32.

[44]Norman Daniels, *Just Health* (Cambridge, 2008), 40.

[45]Harold Merskey, "Variable Meanings for the Definition of Disease," in *Journal of Medicine and Philosophy* 11 (1986): 223, https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=df2777f28a612b40dc1b38ed45e13cfb51ded7cc. Emphasis in the original. Merskey is talking here about masturbation, not drapetomania, but the logic of his argument applies.

[46]In my doctoral dissertation, I wrote,

> Naturalist critics of normativism tend to proceed by finding counterexamples that cast doubt on the coherence of normativist concepts, and normativist critics of naturalism do the same. The game is to show that a concept must count as diseases, things that are obviously not, or that it fails to count as diseases, things that obviously are. Even those who seek a middle ground or higher synthesis often follow this strategy. Kingma, for example, supports her synthetic concept by claiming that Boorse's naturalist concept cannot account for paracetamol poisoning, which is what Boorse calls a "malfunction" but is also statistically normal, and thus escapes his definition of malfunction as statistical abnormality. But it is worth noting that, in my view, conceptual success does not work as a standard for deciding between naturalism and normativism, and the strategy of conceptual analysis used by both normativists and naturalists is a dead end.
>
> Maël Lemoine shows the limits of conceptual analysis by distinguishing descriptive from stipulative definitions: to describe is to show how a term is used, while to stipulate is to say how a term should be used. Naturalists and normativists both tend to understand their project as descriptive. Naturalists say that when we call something a disease we are observing a fact, while normativists say that we are expressing a value. Both aim to describe what we are doing when we call something a disease. A descriptive definition produces a concept which renders existing usage more logically coherent, while a stipulative definition produces or implies an account of a concept's appropriate use. Conceptual analysis, as a descriptive project, seems to rule out stipulation, but Lemoine argues that stipulation must precede the analysis itself. While conceptual analysis may exclude "extensional" stipulation (asserting that an existing concept should extend to cases not normally covered—like insisting that pregnancy is a disease), it cannot rule out "intensional" stipulation. Intension means choosing between two different conceptualizations that both capture the same universe of cases but in different terms. For Lemoine, naturalism and normativism are two different intensions: conceptual analysis cannot decide the dispute between them, since the dispute is not about what fits into our concept, but about which concept we should use. If every case of "practical" disease (where disease is defined in normativist terms) is also a case of "theoretical" disease (where it is defined in naturalist terms), then the difference lies in meaning, not in extension … [t]he criterion that could decide which "take primacy" or is "more fundamental" obviously cannot come out of conceptual analysis. (Maël Lemoine, "Defining Disease Beyond Conceptual

Analysis: An Analysis of Conceptual Analysis in Philosophy of Medicine," *Theoretical Medicine and Bioethics* 34, no. 4 [August 2013]: 320)

For his proposed alternative to conceptual analysis, see Lemoine's later essay, "The Naturalization of the Concept of Disease," in *Classification, Disease, and Evidence: New Essays in the Philosophy of Medicine,* ed. Philippe Huneman, Gérard Lambert, and Marc Silberstein (Springer, 2015), 19–41. For a good overview of this emerging critique (and of Lemoine's contribution to it), and for another proposal for an alternative to conceptual analysis, see Jonathan Sholl, "Escaping the Conceptual Analysis Straightjacket: Pathological Mechanisms and Canguilhem's Biological Philosophy," *Perspectives in Biology and Medicine* 58, no. 4 (Autumn 2015): 395–418. The point is that theory (which produces a concept) cannot ground practice (which puts a concept to use), because we must make an ethically loaded choice about which concept to use. This choice cannot be certified by the coherence of the concept itself, since the alternative concept may be just as coherent.

Naturalists and normativists both suppose that their approaches capture what we are doing when we call something a disease: observing a fact or expressing a value. Their concepts of a "medical problem" are then supposed to help us to do this more coherently, so that we do not label as "disease" something which their concept determines is not, or vice versa. The upshot of Lemoine's argument is that naturalists and normativists both misunderstand the activity of defining something as a medical problem, whether we do so with or without the benefit of their conceptual tool. We are not just describing; we are stipulating. We are making claims about how something ought to be described, and our descriptions, whether we describe facts observed or feelings expressed, cannot authorize these claims. Rather, these claims authorize (or fail to authorize) our descriptions. On this point, see Steeves Demazeux, "The Function Debate and the Concept of Mental Disorder," in *Classification, Disease and Evidence: New Essays in the Philosophy of Medicine,* ed. Huneman et al., 80. Demazeaux sums up the point: "entrusting science with settling contentious issues is not enough to make it capable of doing so" (p. 89). See also Valérie Aucouturier and Steeves Demazeux, "The Concept of Mental Disorder," in *Health, Illness and Disease: Philosophical Essays,* ed. Carel and Cooper, 75–89. (Smith, *Democratic Medicine*, 155–58)

[47]It is worth noting at this point that while I have focused on Andrea Long Chu's non-Butlerian version of the pro-trans argument, there are other, perhaps more nuanced, positions that my argument would apply to equally. Danièle Moyal-Sharrock and Constantine Sandis, for example, join with Chu against Butler in acknowledging the empirical reality of biological sex, but they depart from her (and from Butler) by insisting that gender is *also,* in some important sense, empirically real, such that people can be "born trans," precisely because their natal sex does not match their natal gender. Thus they make an "appeal to facts," and include gender among the relevant empirical facts (as opposed to classifying it, as is the more common approach, as a "social construct"). My response to this kind of argument is the same: even if gender is "innate," and people are born with a certain gender (one that either matches or does not match the sex they are born with), that fact does not by itself tell us what to *do* about it. Moyal-Sharrock and Sandis's argument in favor of the right to transition (and to have one's transition acknowledged) depends not on the purported empirical fact of gender, but on the ethical judgment that if there is a conflict between one's natal sex and one's natal gender, it is good to change one's sex to match one's gender. But if there is both natal sex and natal gender, then it would seem equally legitimate to make the opposite judgment: that it is good to change one's natal gender to match one's natal sex; Moyal-Sharrock and Sandis would certainly condemn this as "conversion therapy." The point, again, is that the empirical facts, such as they are, do not themselves tell us which judgment is correct. The facts, as Moyal-Sharrock and Sandis understand them, could not even rule out the possibility that we might be under some moral obligation to *induce* gender incongruence, supposing that were technically possible: why, after all, do we assume that it is better for sex and gender to match than to diverge? See Danièle Moyal-Sharrock and Constantine Sandis, *Real Gender: A Cis Defense of Trans Realities* (Polity, 2024). Thanks to an anonymous reviewer for alerting me to their argument.

[48]See Philip Pettit, *A Theory of Freedom: From the Psychology to the Politics of Agency* (Oxford University Press, 2001).

[49]The idea that desires themselves are morally neutral, and that only *acting* on a desire can be wrong, is central to some of the most radical arguments about sex and sexual identity. Allyn Walker's controversial book *A Long Dark Shadow: Minor-Attracted People and their Pursuit of Dignity* (University of California Press, 2023) is predicated on this distinction: Walker argues for destigmatizing the attraction *as opposed to* the behavior. But radical arguments like this only show what is, in fact, the dominant common sense of our culture.

[50]There are many versions of this claim, both classic and contemporary. Aristotle says in Book I of the *Politics* that whereas animals can express their desires by making cries of pleasure and pain, human beings can, by means of language, call some pleasures "bad" and other pleasures "good." This capacity for making judgments—and for making *different* judgments—about our desires is what makes us, not animals, but *rational* animals (to use the later formulation of Aquinas). A more recent example might be Harry Frankfurt's well-known argument about what he calls "second-order desires"—that humans distinctly have what we call "free will" because they can have not only desires (first-order desires), but desires about desires (second-order desires). Thus I can want a cookie, and wish that I didn't want it (because the cookie is bad for me, meaning that *desiring* the cookie is bad for me). See Harry Frankfurt, "Freedom of the Will and the Concept of a Person," *The Journal of Philosophy* 68, no. 1 (January 14, 1971): 5–20, https://doi.org/10.2307/2024717.

[51]I develop this argument in detail in "The Populist's Feelings, the Expert's Facts, and the Citizen's Peculiar Virtue," in *Engaging Populism: Democracy and the Intellectual Virtues,* ed. Gregory R. Peterson, Michael C. Berhow, and George Tsakiridis (Palgrave Macmillan, 2022), chap. 13.

[52]See Fellipe do Vale's *Gender as Love* (Baker Academic, 2023) for a rigorous and nuanced approach to the theology of gender. Do Vale is particularly good at showing how serious theology helps us escape the dichotomy between "biological essentialists," on the one hand, and pure "social constructionists" on the other. Or, perhaps more precisely, do Vale shows that when we escape that dichotomy, we find ourselves in far more complex territory, in need of far more serious theology.