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“THEY NEED LABELS”: CONTEMPORARY INSTITUTIONAL AND POPULAR FRAMEWORKS FOR GENDER VARIANCE

by

OPHELIA D. BRADLEY

Under the Direction of Dr. Jennifer Patico

ABSTRACT

This study addresses the complex issues of etiology and conceptualization of gender variance in the modern West. By analyzing medical, psychological, and popular approaches to gender variance, I demonstrate the highly political nature of each of these paradigms and how gender variant individuals engage with these discourses in the elaboration of their own gender identities. I focus on the role of institutional authority in shaping popular ideas about gender variance and the relationship of gender variant individuals who seek medical intervention towards the systems that regulate their care. Also relevant are the tensions between those who view gender variance as an expression of an essential cross-sex gender (as in traditional transsexual narrative) and those who believe that gender is socially constructed and non-binary. I finally argue that the standards of treatment for gender variant individuals pertains more to the medical legitimization of their identities than with necessarily improving outcomes.

INDEX WORDS: Gender, Identity, Anthropology, Gender identity, Transsexuality, Transsexualism, Gender identity disorder, Harry Benjamin Syndrome, Transgender, Hormone replacement therapy

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by

OPHELIA D. BRADLEY

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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“THEY NEED LABELS”: CONTEMPORARY INSTITUTIONAL AND POPULAR FRAMEWORKS FOR GENDER VARIANCE

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for the activists

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PREFACE

If the intent of anthropology can be described as reaching a better understanding of humanity, a problem of definition presents itself: how does one define that which is human, and do all humans indeed share a fundamental nature? Even if one is to assume that a single humankind does exist, what feature or combination of features creates such a unique creature to which we assign the label of 'human?' The answers to these questions have varied considerably over the course of the life of anthropology as a discipline, and will no doubt continue to change; what I am mainly concerned with here will be the impact that the inquiry into the limits of humankind has for those whose humanity is called into question.

In her search to delineate a standard of humanity, Evelyn Keller posits that "human bodies have a structural commonality....They walk erect, they have a distinctive body plan, they are equipped with five senses, linguistic capacity, and so on. These properties are human universals" (2007:352). Recognizing that not all humans share these "universal" features (for example, in the case of deafness, cognitive ability, etc.), Keller goes on to state that "none of these variations compromise our ability to recognize a member of the human species as such" (353). I believe that such a claim is inherently false, given the history of racism that found refuge in the validity of mainstream science up until the mid–20th century and the continuing difficulties faced by those whose lives call into question the meaning of "normal." However, Keller's central argument—that those considered to be lacking certain features of the human body have "less than whole bodies" (353)—is insightful, for it demonstrates the unease that many feel towards those with different abilities or bodily configurations. If as Keller says, "we do not want to claim possession of a full set of human universals as prerequisite to human rights" (353), these differences would be of little import, since all bodies would be "read" as entirely

human. Unfortunately, far too many instances show that this is not and has not always been the case.

One really need look no further than the oft-cited example of the Nazi Holocaust to appreciate the logical outcome of a discourse that focuses on the differences (both phenotypical and cultural) among bodies. When a whole or ideal body is posited as the standard for humanity, it is far too easy for a semantic shift from "dissimilar" to "undesirable" to take place (the irony here being that the standard for humanity will always be different according to the time and place where it was conceived, whether it be the Aryan or the man or the warrior, etc.). When a given body fails to meet the standard to which it is held, its elimination becomes a question of tidiness, perhaps even vitality, in order to maintain the health of the human body as a group. If Mary Douglas's proposition that "any structure of ideas is vulnerable at its margins" (1966:121) is correct, then those who find themselves at the fissures of the binary gender system are vulnerable to the effects of an orthodoxy that seeks to maintain that system. Jean-Paul Sartre reminds us that the fear of difference, however illogical, remains a deep-seated reaction. In *Anti-Semite and Jew*, he mentions the sudden and complete sexual dysfunction of the Gentile following the revelation that he is making love with a Jew (1948:10). Such a reaction might seem to many liberal, contemporary readers to be shocking and obscene; in a context where Jewishness is understood as a racialized identity, the anecdote makes more sense. Could one not imagine a similar scenario playing out between a white American man who discovers that his female lover is half black (or Muslim? or had been born a boy)?

Contrary to the currently-held mainstream concept of a unitary humankind, the phenotypical (and largely visually-determined) differences between people were formerly used as evidence for the gradation of humanity by type. Carl Linnaeus's famous system of taxonomy

classified humans separately in his *Systema naturae* on the basis of race (Gould 1996:66). Keller would have us take as common sense that phenotypical variation does not "compromise our ability to recognize a member of the human species as such" (Keller 2007:353); this same common sense approach, a reliance on self-evidence, produced Nott and Gliddon's 1854 treatise on the *Types of Mankind*, in which drawings of Africans and apes were placed side-by-side for the reader to appreciate their inherent similarity. It was not until the early 20th century when Franz Boas, the father of American anthropology, found substantial changes in the cranial measurements of second-generation immigrants to America compared to their first-generation immigrant parents (Gravlee et al. 2003) that the human body began to be understood as highly adaptable to environment and the myth of biologically-determinable race began to be questioned. Indeed, it has only been with *systematic* research that many folk models for human difference have been negated. As a species that relies heavily on visual cues for making meaning, a common sense approach is not only invalid but it would unfortunately also not tend to favor the concept of a single humanity (perhaps this ability to create categories and then separate people into them should be considered a feature of humanity, for as Sartre writes, "If the Jew did not exist, the anti-Semite would invent him" [Sartre 1948:12]). Being regarded as lacking a 'whole body' is itself a determination based both on visual cues and cultural norms, and clearly has an impact that shapes their interactions; to assume that their humanity remains unquestioned is to have never been in the place of such individuals.

The base requirements for recognizing a human cannot be taken for granted. Just as the definition of humanity shifts based on social context, so do the standards by which that determination is made. Marcel Mauss states that "The body is man's first and most natural instrument" (Mauss 2007:56), for even without the use of an externalized apparatus, no two

bodies can be said to function exactly alike (though one may perceive patterns within a given culture that affect most individuals raised within it). One of Mauss's best examples is that of walking: “The positions of the arms and hands while walking... are not simply a product of some purely individual, almost completely physical arrangements and mechanisms....There exists an education in walking” (52-53). Mauss compared the gait of the British to those found in other nations, as well as noting a particular manner of walking shared among women in both New York and Paris, an emulation which he attributed to the American film industry's influence. If Keller's argument that the ability of humans to walk erect is a structural commonality is to be considered correct, then that argument must be tempered by the acknowledgment that walking is merely a human *potential* (i.e. not prior to culture) which will be expressed differently based on enculturation practices.

Similarly, in discussing the role of the sexed body within the framework of feminist epistemologies, Judith Butler has criticized the “presumption of the material irreducibility of sex” (Butler 2007:164). Sex, though molded in many cultures to be represented inside of a binary framework of male and female, contains multiple dimensions (hormonal, chromosomal, assigned at birth, legal, social, externally morphological, internally morphological, self-identified, etc.) and can be more complex than meets the eye. The legitimization of a male/female binary establishes the criteria for a “whole body,” creating pathology in the many natural variations of sex that humans exhibit, often in ways that appear shockingly comparable to old race “science” and the then-dominant theory of non-Caucasians as less perfect (read: human) physiologies. While anthropologists have documented numerous expressions of non-binary gender identities (cf. Nanda 2000), their near-absence in the West is associated with a strong

belief in sexual binarism[1]. So firmly entrenched in the Western understanding of biology is this belief that transgender bodies are inherently suspect; violating the sex binary effectively calls into question the legibility of the subject as human. Popular illustrations of this phenomenon are easy to find, be they in the form of a dramatization or a cartoon. One episode of the series *Californication* features an argument between two friends, one of whom has just hit a woman he had been making out with at a party prior to discovering that she has a penis. "You can't do that, that's a human being," replies his friend, "you can't be throwing punches at people!" In another instance, the father in the animated cartoon series *The Oblongs* encounters his son who is both cross-dressed and hanging laundry; "Steady, man, he's still a human being" he tells himself calmly. These examples lend credence to the claim that the legibility of transgender bodies as human is undermined, otherwise there would be no need to reaffirm it. The treatment of those at the interstices of gender at the hands of researchers also reveals a profound discomfort that may rise to the level of dehumanization.

Writing about the display of intersexed persons' body parts in jars suspended in formaldehyde, Alice Dreger points to a lack of empathy for their situation that allows them to be "othered" in the eyes of society. She writes, "To recognize the subject as who we might be—even who we might want to be—is to dissolve all the glass that separates us and let the monster out of the jar" (Dreger 2007:485). Rather than working from a presumption of a non-culturally "flavored" human standard, an approach that sees commonality in the varying morphologies of human bodies engages the researcher to actively empathize with those that they study and may help to avoid relying on the often unreliable "common sense." Appreciating that the "Other" is the same as "Us"—a humanizing appeal—goes a long way in breaking down the stigma

[1] Whether the lack of culturally-sanctioned gender variant roles are to blame for strong sex binarism or the inverse is hard to say, though I think the case could be made that the Abrahamic religions have had a strong influence on its solidification and maintenance.

associated with difference, and is usually an essential part of the process in any movement to recognize the civil rights of an oppressed group. Discussing when she started to speak with real intersexed people over the course of her research, Dreger admits that she "didn't mind writing about them as 'other,' but when they started to step up off the page and [on] to the phone, that made me nervous." Dreger's engagement with a group that has been typically regarded by researchers as objects of study rather than as participants and her discomfort with doing so highlights not only the traditional assumption of scientific detachment of the researcher, but also its failure, as the inability to empathize with one's research participants prevents one from seeing the problems that they face from their point of view. If one day the social sciences are able to view the other as ourselves we might then properly address the concerns of the populations that we study, and we'll have no need to be nervous when faced with the individuals that we purport to understand and have the privilege of speaking for in institutional and policy-shaping settings, for they will be speaking in the same voice as we do.

In the case of transgender individuals, such a humanizing discourse is unquestionably missing. This study is intended to be an examination of the realities that transgender people face in a world where their dignity and respect for their humanity is implicitly, and sometimes explicitly, questioned. The circumstances in which those whose gender identities defy heteronormative standards often find themselves are inconsistent with the principles of individual equality of opportunity to which Western democracy purports to adhere. If we wish to rectify the conditions that dispute the humanity of transgender people, an important first step will be to listen to opinions and experiences of transgender people themselves. I hope that this study may achieve that lofty goal.

CHAPTER 1 – INTRODUCTION

This thesis addresses the complex issues of etiology and conceptualization of gender variance in the modern West. I argue that gender variant individuals have a highly ambivalent relationship with medical authority. Those individuals who use hormonal and surgical interventions to more closely align their bodies with an internal sense of gender (commonly known as "transsexuals") must accept medical authority in order to actualize their transitions in sex, most often through the psychological diagnosis of "gender identity disorder" as a prerequisite to medical interventions. However, not all gender variant individuals (including those who are not transsexual) accept the utility or the legitimacy of psychology in determining the eligibility of individuals for medical intervention, which led to the formulation of "transgender" identity in the late twentieth century as a non-pathological way of understanding gender variance. The unresolved questions surrounding the role of psychology in categorizing gender variance as a mental disorder, determining medical eligibility, and the differential access to medical interventions based on the acquisition of the "gender identity disorder" diagnosis create a precarious dynamic between transsexual individuals and health care professionals.

I also argue that the requirement of the "gender identity disorder" diagnosis creates significant strain within gender variant communities, as the authority that psychology possesses in endorsing certain forms of gender variance aggravates the tendency of some transsexual individuals to attempt to frame their institutionally-validated identities as more legitimate than other forms of gender variance. This is illustrated in the enthusiasm of some transsexual individuals for the brain-sex theory of transsexuality, which holds that transsexuality is the result of a form of intersex condition of the brain. This theory can be used both to legitimate the cross-sex identities of transsexual individuals, but also to delegitimize the identities of other gender

variant individuals who would supposedly not truly possess the brain of their self-identified sex. The availability of different frameworks of gender variance—be that in the psychological paradigm of "gender identity disorder," the community-oriented "transgender," or the medicalized brain-sex theory—are appropriated and used to understand one's own gender identity within a culture that views gender transgressions as suspect and in need of explanation. The attempts to parse out different forms of transsexuality—be they in the form of Blanchard's "homosexual" or "autogynephilic" transsexuality, Benjamin's older "primary" ("true") or "secondary" transsexuality, or the theories of cross-sex neuroanatomy—are found to be repeating themes within the discourse among gender variant individuals, and all are highly disputed. A major feature of these discourses is in the disagreement over the authenticity of different forms of gender variance, with those who seek to uphold the male/female binary at one end and those who wish to subvert it at the other extreme. I demonstrate how these respective competing discourses can potentially be harmful to individuals' understandings of self, either in the negation of transsexual individuals' claims to inherent cross-sex identity or in the devalorization of the identities of gender variant individuals who do not adhere to the transsexual orthodoxy of an innate cross-gender identity. The goal of this study is to bring these competing discourses of gender variance—the medical, the psychological, and the popular—together in a single analysis, since these different conceptualizations are often prone to speaking past one another within both the academic and nonacademic realms. In the course of my research, I used ethnographic methods through my participant observation in gender variant spaces online and through the subsequent use of a questionnaire to better understand the relationship of gender variant individuals with medical authority and gender variant communities and their self conceptualizations of gender and identity.

Background

Of particular importance in understanding the foundations of contemporary gender variant identities in the West are the medical and psychological discourses that have historically laid claim to the understanding and treatment of gender variance. The earliest (or at least best-known) articulation of gender variance as identity was made by German jurist and social activist Karl Heinrich Ulrichs (1825-1895). Ulrichs, who "as a young child […] wore girls' clothes, preferred playing with girls, and in fact expressed a desire to be a girl" (LeVay 1996) and who was sexually attracted to men, would grow to identify himself and those like him with the term *Urning*, or "Uranian" in English, in 1864. His self-identification as a male-bodied individual with a female psyche (which would probably categorize him as transsexual in contemporary discourse) established the first instance in modernity of sexual desire or behavior being repackaged into a form of identity (he is also generally regarded as the first openly "gay" man). The connection between cross-gender identity and same-sex attraction would continue with the popularization of the term "homosexual," coined by Karl-Maria Kertbeny in 1869 and included in Richard von Krafft-Ebbing's *Psychopathia Sexualis* (1886) to describe a "sexual inversion" in the brain. Homosexual identity, as we know it today, is very different from these early attempts at theorization. In America, the LGBT movement has espoused a culture of gender equality, where gender identity is separate from sexual orientation. Explicit removal of homosexual gender-normative identity from the discourses of pathology can be found in the deletion of homosexuality in 1973 from the Diagnostic and Statistical Manual of Mental Disorders (DSM), the handbook published by the American Psychiatric Association. Meanwhile, in 1980, the APA added the new diagnosis of "transsexualism" to the DSM, defined as "a persistent sense of

discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex" (APA 1980:261-262).

The participant population for my study comprises those individuals who either subscribe to a "transgender" identity or who have some history as a gender variant individual. According to Susan Stryker (2006:4), it is generally believed that the coinage of the term "transgender" took place sometime in the 1980s by Virginia Prince (born 1913), a prominent figure in heterosexual male cross-dressing circles. Prince used the term as a noun to describe a person who adopts the social role of the opposite sex, including dress, but who does not have their genitals surgically altered to reflect that role, as in the case of transsexual individuals. A "transgender," in this usage, is also different from a transvestite in that the social role and dress of the opposite sex are permanently adopted, rather than in the case of occasional cross-dressing. The term would morph into its current meaning in 1992's "Transgender Liberation: A Movement Whose Time Has Come," a pamphlet distributed by activist Leslie Feinberg. According to Stryker, "Transgender, in this sense, was a 'pangender' umbrella term for an imagined community encompassing transsexuals, drag queens, butches, hermaphrodites, cross-dressers, masculine women, effeminate men, sissies, tomboys, and anybody else willing to be interpolated by the term" (4). As such, Feinberg's elaboration of a "transgender" identity subsumes other historically established identities, the two with the longest medical histories being the "transsexual" and the "transvestite" (transvestites having been labeled as such by Dr. Magnus Hirschfeld in *Die Transvestitien* in 1910 and transsexuals by Dr. David Cauldwell in *Psychopathia Transexualis* in 1949).

This "new" bloc of gender variant individuals, "transgender" people or "transpeople", is in many ways not really new at all, but an attempt to establish a non-medicalized, community-

created amalgamation of previously discrete identities into a politically-oriented form under another name. Because of the umbrella-like nature of the term, there has been a temptation on the part of some anthropologists to subsume various non-Western gender variant identities under the label of "transgender" (for examples, see the titles of Besnier 2002, Graham 2003, Kulick 1998, and Sinnott 2004). This slippage between "transgender" identity as a product of very specific late-capitalist identity politics in America and as a general term synonymous with cross-gender has been criticized for its potential for obliterating the processes that create such varied gender identities in favor of an ahistorical conception of non-binary or "third" genders (Towle and Morgan 2002). The duality of the term "transgender," as specifically associated with both a contemporary Western political identity and the more nebulous gender variance, has also been used by "transgender" activists in the project of appropriating non-Western and pre-Modern gender variant identities into the contemporary "transgender" canon through ethnographic data (see Bornstein 1994 and Feinberg 1996) in their attempts to naturalize and reessentialize gender variance, which is discussed in more detail in the fourth chapter.

The merger of formerly detached categories under a common heading of "transgender" directly affects the ways that gender variant people organize themselves, both politically and socially. Previously, male-to-female transsexual individuals who came up in the university-affiliated gender programs of the 1960s and 1970s were often told to integrate as completely as possible into mainstream society; they were frequently advised by their surgeons and psychiatrists to not inform anyone, even their husbands, of their pasts. This was often made possible due to the self-selecting mechanisms of surgical access under the old gender clinic system. Doctors would approve for surgery only those transsexual individuals who could pass very well in their new gender role, under strict guidelines that denied surgery to those whose

bodies or practices would have undermined heteronormativity. The transsexual community quickly learned the appropriate mannerisms and responses to supply their doctors with in order to access medical care and surgery, creating a profile for "true" transsexualism based on a model reminiscent of *The Stepford Wives* in its complete acquiescence to 1950s mainstream standards of dress, behavior, and role for women (Stone 1991). Following publication of a study at Johns Hopkins by Meyer and Reter (1979) claiming that sex reassignment surgeries did not confer objective advantages to individuals and Janice Raymond's (1979) second-wave feminist critique of transsexuality, most of the gender clinics in America closed their doors or became unaffiliated with university centers (Meyerowitz 2004:267).

With the old institutions gone, almost anyone with the financial resources to pursue surgery may now do so (especially in Southeast Asia, a common destination for many transsexual individuals from industrialized countries) except in rare cases of surgeon refusal. The means for modifying the sexed body—specifically, those interventions such as genital and facial surgeries, as well as hormone usage—have in practice largely been detached from the gatekeepers who formerly chose who could receive them. This change in the dynamic between individuals and health care professionals has resulted in a transformation in the conceptualization of gender crossing, from the medical access granted to a select few, to a relatively more empowered community with its own memory and a heavily free-market system that allows members to make their own choices regarding the medical interventions that they feel to be personally appropriate. This means a vastly different population when compared to the transsexual individuals who pursued sex reassignment surgery (SRS) under the old paradigm; many individuals who would have been denied procedures or hormones in the paternalistic past now have access to them, as do female-to-male transsexual individuals (a nearly invisible

category prior to the 1980s), part-time and full-time cross-dressers, androgynes/neutrois (those who prefer to live in-between or outside of the gender binary), drag queens, and others still. While many of these individuals do themselves identify as "transgender," this is not true for all gender variant individuals, especially in the case of some transsexual individuals who regard their gender identities as heteronormative and place their "variance" in their incorrectly sexed bodies that are corrected through medical intervention.

An increasing politicization in transsexual circles, partially attributable to awareness raising found in "transgender" Internet communities, has kept large numbers of gender variant individuals from breaking entirely away from the "gender community" as would have previously done following SRS. Whereas much of the business of the gender-variant community used to be carried out at expensive conferences held throughout the year across America, the Internet has enabled many of those without the means to travel and participate in such gatherings to become involved in the activities of the community at large. Because of the relative anonymity enjoyed by Internet users, many individuals are able to "come out" as gender variant through online message boards and talk about their concerns in a sympathetic environment; this first step is being taken by people who, without the Internet, would either be too afraid or face too many difficulties in accessing similar safe spaces for discussing gender and their feelings.

In discussing matters of gender variance, attention must be paid to the language that is used to describe it. Because of the contested nature of the identities of gender variant individuals, any term used to describe them entails staking out a political position as a result of the assumptions that underlie each term. Indeed, the very use of the term *gender variant* (as well as *cross-gender*) will be objectionable to some, as it indicates that the gender identities of such individuals are variant, while many transsexual individuals make the claim that it is their sexed

body that is problematic rather than their internal sense of gender. I use *gender variant* and *cross-gender* often throughout this thesis simply because I feel that without any better options that they are the least controversial of all the possible expressions; at the same time, I recognize their potential for violence to the identities of some individuals, and for that I must apologize, for it is certainly not my intent. *Cross-sex* has the inverse problem, as those individuals who find nothing intrinsically wrong with their bodies but rather with social acceptance for their gender expression would not be properly serviced. *Transsexual* is a specific diagnosis that is not only no longer recognized by the American Psychological Association (APA), but also only applicable to those gender variant individuals who seek to alter their sexed bodies. *Transsexual* has been replaced by *gender identity disorder* (or GID) within the context of the diagnosis of gender variance, which obviously carries its own associations with pathology and stigma. *Transgender* has become increasingly popular since the 1980s for its ability to refer to all types of gender variant individuals, though the multiplicity of meanings that it holds for different people due to its nature as an umbrella term makes it difficult to use in describing gender variant individuals as a group. Throughout this thesis I attempted to systematically place *transgender* in parentheses when referring to this community-based formulation of gender variance, in an effort to call attention to how highly socially-mediated this term is and to delink it from its more mundane meaning of gender variance. Simply *trans* or its correlate *transpeople* might be acceptable, though it also supposes both the same significance as *transgender* as well as that all gender variant individuals will identify as *trans*, which may not be the case following complete hormonal and surgical transition. The problem of nomenclature will be a continuing theme throughout this thesis, as I attempt to draw attention to the ways that multiple institutions and

communities compete to construct the meanings of gender variance and of gender variant individuals. At present, there is simply no neutral catch-all term.

Theoretical Framework

If the goal of anthropology can be described as coming to a better understanding of humanity, this establishes all predispositions, practices, and ideas both held and enacted by humans as potential areas of study by the discipline. Sexuality and gender have only within the last several decades begun to be recognized by anthropologists as subjects of inquiry in their own right, and the work that has successfully separated race from biological determinism (AAA 1998) is unequaled in terms of the male/female binary. I will briefly examine here the history of anthropological scholarship into matters of sex and gender as well as the contributions of other disciplines that inform current understandings of sex and gender variation, particularly concerning the notion of "transgender" or "third gender" identities.

Looking back to the Boasian era in anthropology, Margaret Mead's *Coming of Age in Samoa* (2001[1928]) marked one of the first critiques of biological determination of gender. Mead's hypothesis, that the tumultuous experience of adolescence in the West (ascribed largely to "natural" pubertal hormonal influences) is not and need not be a universal phenomenon, found evidence in her experience living in the small village of Luma in American Samoa. Though subsequent studies would contest Mead's findings (Freeman 1983), or at the very least critique her failure to question the assumption of sexual biological dimorphism (Herdt 1994:44), her introduction of the category of gender into anthropological inquiry (a subject previously recognized as exclusive to sexology) would set the stage for future anthropological inquiry.

In a rare example of cultural anthropological fieldwork done in the United States during the 1960s, Newton's *Mother Camp* (1979) investigated the world of drag bars and femininity's

place at the "stigmatized bottom rung of the social scale" (Stryker and Wittle 2006:121) of gay male life. Newton paints an intriguing picture of a specific time and place within gay male culture and its symbolic meanings, but because her milieu did not extend to heterosexual male cross-dressers or female-to-male impersonators, her study can only be said to represent a limited window into the various forms of gender variant behavior and identities. One cannot help but wonder if such research intimated the first stirrings of a discipline considering the potential for study within its own culture, or if the Otherness of the participant population made them every bit as exotic and foreign in the eyes of researchers as any faraway tribal community. Bolin's *In Search of Eve: Transsexual Rites of Passage* (1988) would become the first anthropological study of individuals coming to terms with their gender variance and the effects of their transition between the sexes in their everyday lives, specifically for a group of American transsexuals in the Midwest, using the trope of ritual to explore the liminality of the transition process.

Weston's "Gay/Lesbian Studies in the House of Anthropology" (1993) provides a useful overview of anthropology's historical engagement with gender and sexuality. Weston describes an uneven field of inquiry, in which "review articles…lament the lack of ethnographic material on sexuality in general and homosexuality in particular" (340) and, where ethnography has been carried out, an overreliance on descriptive observation that has not fully employed "the theory explosion that has characterized queer studies in the humanities" (360). Examining the state of "Queer Studies in the House of Anthropology" in 2007, Boellstorff finds a discipline transformed by the study of globalization:

> One of the most significant developments since 1993 has been the growth in ethnographies of persons outside the West who see themselves as "lesbian" or "gay" in some transformed sense of these terms….This research has little patience for nostalgic approaches that dismiss lesbian women and gay men outside the West as contaminated by the foreign, to seek instead ritualized forms of transgender or homosexual practices that supposedly reveal regimes of idyllic pre-colonial tolerance. [22]

Boellstorff also comments on the "notable increase in ethnographic work on forms of transgenderism, although very little of it [carried out] by transgender-identified ethnographers" (21). Following in the anthropological tradition of studying non-Western cultures, almost all anthropological studies of sex and gender variance have looked outside of Anglo-American societies, including such gender variant identities as Brazilian *travestís* (Kulick 1998), Tahitian *māhū* (Elliston 1999), Indian *hijras* (Nanda 1994, Reddy 2005), Malaysian *mak nyahs* (Teh 2002), Filipino *bantut* (Johnson 1997), Albanian sworn virgins (Young 2000), Thai *kathoey* and *toms and dees* (Jackson 1997a, 1997b; Sinnott 2004), and indigenous North American two-spirit people[2] (Roscoe 1991, 1998). Such studies have provided tremendous data regarding the potentials for gendered identities around the world, through examples of variability in terms of self-identification, behavior, relationship dynamics, private and public labor divisions, child-care responsibilities, and religious functions.

It is clear that while variations on normative sex and gender identities are present in many societies, the forms that such variance takes are obviously embedded in the meanings of those societies. While the identities of Western transsexuals are informed by the biomedical institutions that have positioned them as "men in women's bodies" (or vice-versa), such a conceptualization is alien to other cultural systems, such as within Polynesian or Native American cultures which regard gender variant individuals as being dually gendered. The elaborations of gender variance are anchored in the broader cultural systems that frame them, and without these structural supports, they make little sense that can be generalized across

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Notes

[2] "Two-spirit" is the term that has achieved the greatest currency following the renunciation of "berdache" as a descriptor. Anthropologists traditionally used "berdache," from an old Arabic word meaning "male prostitute" (Nanda 2000:13) to describe gender variant individuals in Native American societies, illustrating the former conflation of sex role with gender identity.

cultures. Through my engagement with the psychological, medical, and lay discourses most relevant to the conceptualization of gender variance in the West, I will show how important the mechanism of culture is in the experiences and perceptions of gender variant individuals.

My study is greatly indebted to that of David Valentine (2007), whose ethnography of the category of "transgender" (carried out in the milieus of gender variance in New York at the close of the millennium) pays specific attention to both the academic and cultural processes that have divorced gender from sexuality in current understandings of sexual orientation and gender identity. He notes that "for much of the past 150 years, homosexual men have *not* been seen as 'men'" (236) due to theories originating in nineteenth century Austro-German psychology that posited homosexuality as an inversion of normative sexual desire, wherein the physiological male possessed the soul of the female and vice-versa[3] (Halperin 2000). In America, subsequent activism by gender-normative middle-class white gay men who wanted to remove the associations with femininity from male homosexuality (Valentine 2007:43) would disentangle the common origins of homosexuality and what is now called "transgender" identity by emphasizing sexual orientation as a question of object choice[4] having nothing to do with inherent gender variance. Valentine's ethnography reveals that these transformations in gay identity politics have not necessarily filtered down to lower-class individuals, who may still self-identify as gay or as belonging to the gay community, where many mid–20th century transsexual individuals once more commonly claimed membership (43). This reveals serious hurdles for social outreach programs that may seek to improve the lives of "transgender" individuals who may or may not identify as such. Valentine evokes a process of "having to un-know what

[3] *Anima muliebris virili corpore inclusa*—"a woman's soul confined to a man's body," an elaboration by the first "homosexual" activist Karl Heinrich Ulrichs. Writing more than fifty years later in 1920, German sexologist Magnus Hirschfield modified this theory, placing the origin of inversion in the glands (*glandula inclusa*) rather than in the soul (*anima)* (Levay 1996).

[4] By "choice" I do not mean to infer an active decision-making process that would equate gay identity to mere preference, but as a naturally occurring variance to heteronormative desire.

[gender variant individuals] know about themselves and learn a new vocabulary of identity" (135) in order to access the social services with limited funding that is intended for them as "transgender" people but potentially unavailable to those espousing identities now considered culturally illegible by middle-class social workers. The individuals who have been left behind by shifting gender politics are likely to be the most vulnerable, and the requirement that they accede to new ways of self-identifying (no longer as having same-sex desire but as individuals with gender identities different to those assigned at birth) can prove difficult in both their awareness of and access to the discourses that would frame them as "transgender" and potentially damaging in the denial of a former system of self-understanding.

Valentine astutely warns against viewing the participants in his ethnography as "uneducated," "mistaken," or "premodern" in not making the distinction between their "sexual" and "gendered" identities as well as warning against accepting these identities as "more accurate, more true, [or] more valid" (245). Instead, he argues that the gender/sexuality split should be recognized as "simply one way of carving up how we know about ourselves and others" rather than assuming its relevance across cultures and time. As he mentions, this is not the same as reverting to previous ideologies that would hold sex and gender as one and the same or at least causally linked (239). For Valentine, the lack of separation between sexual and gendered identities on the part of his study's participants (or, rather, their recognition of their own gender variance as having both sexual/erotic *and* gendered components) makes their understandings of self difficult to comprehend from the perspective of the now-dominant sex/gender binary.

In many ways, my own study represents a reengagement with the populations and identity politics examined by Valentine ten years prior. Because Valentine's ethnography of the category "transgender" took place within the physical confines of New York City, he had access

to a great number of gender variant individuals, though he was limited in that his participants were selected by virtue of the fact of spending time in specific physical spaces (i.e. "transgender" community centers, drag bars, red light districts, etc.). This may have led to an unintentional self-selection of his study participants, since his conclusion that "transgender" was the more preferred middle-class descriptor of gender variance did not include the opinions of gender variant individuals who were not likely to be present in such spaces. My findings point to a more nuanced acceptance of this term, with "transgender" itself being rejected by some for the same reasons of its perceived association with lower-class gender variant expressions; whether this is due to the difference in our study populations or representative of a shift in discourse since his research I cannot be certain. In either event, our findings reveal how the observation and representation of attitudes towards identity terms is liable to fluctuate depending on the population studied whether over time or by place; the preoccupation of anthropology with the mechanism of culture for making meaning underscores how highly appropriate our discipline is to such a study of self-conceptualization.

The academic field of "transgender studies" has largely been formed in response to those discourses in women's studies that have sought to reinforce the sex binary and sex essentialism. Lesbian-feminist Janice Raymond's *The Transsexual Empire: The Making of the She-male*, first published in the late 1970s, argued that transsexual individuals are tools of patriarchy created by men to gain access to and control women's spaces and politics. Raymond was one of the first academics to treat the subject of transsexuality outside of medicine, and as such was influential in forming the views of many young feminists (as well as the public) on transsexuals. The title of Raymond's book alludes to a medical-industrial complex, a vast conspiracy of male psychiatrists, laboratories, and surgeons attempting to recreate womanhood in their own image in

what she calls "a very ancient myth… of single parenthood by the father" (106) or "male mothering" (107). She does not point out that transsexual surgeries and hormone replacement therapies developed at the fringes of the medical establishment, and are often regarded unfavorably to this day by that establishment (Riddell 2006:151). The nature of Raymond's argument is incendiary, particularly evidenced by her oft-quoted claim that "all transsexuals rape women's bodies by reducing the real female form to an artifact, appropriating this body for themselves" (104). Susan Stryker credits Raymond, noting that "because [The Transsexual Empire] provoked such an outraged, anguished, and deeply motivated counter-response from transgender people, it also did more than any other work to elicit the new lines of critique that coalesced into transgender studies" (Stryker and Wittle 2006:131). Sandy Stone's "The *Empire* Strikes Back: A Posttranssexual Manifesto" (1991) was especially important in addressing both the lesbian-feminist critique that transsexual individuals use hormones and surgical intervention to maintain the sex binary and the lack of agency ascribed to them in such discourses. Other disciplines have also made substantial contributions to better understanding contemporary "transgender" identities and gender variance, in the form of accounts from historical sources (Meyerowitz 2004), biological sex diversity in the natural world (Roughgarden 2004), legal rights and experiences (Currah et al. 2006), and the nature of sexuality (Foucault 1978) and gender and performativity (Butler 1990). My own analysis of gender variance can be thought of as a humanist one, with respect for the individual and her autonomy as the primary concern.

As gender variant identities (unlike homosexuality) are still subject to a pathologizing medical gaze, a substantial body of medical literature has been built up around the subject both for research and patient treatment. One major topic of debate that has yet to be resolved is the question of "transgender" prevalence; the paucity of empirical studies into the topic makes it

difficult to give an accurate picture of a population. Gender-variant identities and behavior are highly stigmatized, and most studies of prevalence are centered on the medical discourses of transvestism, transsexualism, and intersexuality (a problematic diagnosis of genotypical/phenotypical mismatch, or the presence of a combination of male and female traits or tissues). The boundaries between the intersex and "transgender" communities are not well-defined, as there are gender variant individuals who are also intersex and others who believe that gender variance is a neurological form of intersexuality not yet medically understood and diagnosable. According to Lynn Conway (2001), estimates of routine cross-dressing in the United States range from two to five percent of the adult male population. The current version of the Standards of Care for Gender Identity Disorder (WPATH 2001) takes the "most recent prevalence information" for transsexual individuals as 1 in 11,900 for males and 1 in 30,400 for females from a 1993 study in the Netherlands (Bakker et al.) which counted the number of individuals diagnosed as transsexual and who "generally underwent sex reassignment surgery." More recent studies, which have reevaluated the data from earlier reports, place the prevalence for male-to-female transsexualism between 1 in 500 and 1 in 1000 (Conway 2007); that of gender variance is thought to be one order of magnitude greater, at 1 in 100. Ranges for prevalence of intersexuality vary even more widely depending on the criteria one wishes to use. In "Sexing the Body" (2000), Anne Fausto-Sterling asserts that as many as 1.7% of births may be intersex in some form. Dr. Leonard Sax criticizes Fausto-Sterling for including conditions such as Klinefelter's syndrome and Turner syndrome in this figure, which he argues dilutes the meaning of "classical intersex conditions" (2002:175), the prevalence of which he places at 0.018% of the general population. One gets the feeling that activists are interested in seeing the gender variant population classified as such at the highest number statistically feasible, while

physicians are more interested in parsing out "true" transsexual and intersex individuals to keep the numbers low. This makes sense, as the larger the "transgender" community is perceived to be, the better to raise public awareness and the greater the chance of getting politicians to go to the mat for them. On the other hand, small prevalence rates ensure the social and cultural invisibility of gender variant individuals, reducing the significance of protective legislation and preserving the legitimacy of a pathologizing discourse. This is especially relevant in the case of transsexual individuals, who currently require psychological and medical evaluation (validation) to pursue palliative care, i.e. hormone replacement therapy and most sex reassignment surgeries.

My own study pulls from a great variety of sources to render legible the meanings of sexuality and gender in the lives of gender variant individuals. However, as previously stated, gender variance is a universal phenomenon, the forms that it can take on are highly malleable according to the meanings of the society in which gender variant individuals are embedded. Multiple discourses surround the topic of gender variance, ranging from the universal, cross-cultural phenomenon represented in anthropological ethnography, to the concepts of performativity and category building and affinity produced in sociology, women's studies, and gender studies, and finally to the diagnoses of "gender identity disorder" and pathology espoused by psychology and medicine. My study intends to show that these minefields are more than theoretical, as they play out in the lives of gender variant individuals and communities as they come to frame their identities both based on these discourses as well as in opposition to them.

Ethical Considerations

In entering into any study either involving or directly related to human subjects, one must be cognizant of the potential for harm that could result from one's research for the individual participants or for the population(s) to which those individuals are members. Perhaps nowhere is

this reflexivity more essential than for researchers studying the highly stigmatized individuals whose lives diverge from heteronormative expectations of dress, behavior, and identity. Since many cultures (including contemporary American culture) presume a gender identity that is visually recognizable and stable over the course of one's lifetime, the violation of this taboo can provoke visceral—and, all too often, violent—reactions from one's social circle and broader society. Great care must be taken on the part of those who study or treat such populations to make sure that their work (even that of a theoretical nature, since the effect of the ivory tower can extend far beyond its walls) does not have the potential to increase the stigma attached to these individuals and increase the practical difficulties of their everyday lives.

Academic research into the lives of stigmatized individuals or their behaviors places a heavy burden upon the researcher to be aware of her position of authority in relation to her participants and to do as much as possible to diminish their stigma when doing so does not have a negative effect on other individuals.[5] In his seminal work on stigma, Erving Goffman (1963) defined this contaminating characteristic as "an attribute that is deeply discrediting" which reduces the possessor "from a whole and usual person to a tainted, discounted one" (3). Carrying stigma can have a profound effect on an individual's or a community's sense of self-worth, as well as creating emotional problems from constant societal disapproval or the fear of it. Sandy Stone (1991) quotes the following passage that is one of many which illustrate that medical and psychological studies of transsexual individuals have often presumed inherent pathology given the high rates of gender variant individuals co-presenting with depression and/or schizophrenic tendencies seen in mental health care environments without attention to their stigmatized identities:

[5] I make this distinction because stigma reduction may not always be favorable, such as in the cases of abuse or where individuals purposefully seek to harm others.

> In a study of 56 transsexuals the results on the schizophrenia and depression scales were outside the upper limit of the normal range. The authors see these profiles as reflecting the confused and bizarre life styles of the subjects. [Walters and Ross 1986:58,3]

More recently, a group of transsexual activists who were criticized for using unconventional tactics in opposition to the publication of *The Man Who Would Be Queen* (a debate detailed further below) were diagnosed by one sexologist in a peer commentary paper as exhibiting "narcissistic rage" as a result of perceived injury[6] (Lawrence 2008). The ability to label gender variant individuals with disorders is a powerful tool, and unfortunately one still wielded against them.

In addition to the question of pathologization and the medical field, research into the lives of stigmatized individuals have been plagued by an unethical lack of attention to the privacy and autonomy of individuals. Like the patients who were deceived and denied medical treatment in the infamous Tuskegee Syphilis Experiment, sexual minorities have a long history of abuse at the hands of researchers who place the pursuit of knowledge above the potential for repercussions to their daily lives. Laud Humphreys' Ph.D. dissertation (1970) on anonymous male same-sex behavior in public restrooms is a well-known example cited for its lack of consent procedures during participant observation and the information recorded by Humphreys to later interview participants at their homes. Though the research yielded valuable information on the men who participate in anonymous public sex, the fact that individuals were unable to refuse being made into subjects of study raises serious concerns about the rights of research participants and the disparity in power between researchers and their subjects. In terms of studying gender variant populations, both those who do not support them and those who claim to

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[6] Lawrence notes that "transsexuals are probably at an increased risk for the development of narcissistic disorders—significant disorders in the sense of self—as a consequence of the inevitable difficulties they face in having their cross-gender feelings and identities affirmed by others, both before and after gender transition" (2008:457). While she recognizes the risk of gender variance resulting in concomitant problems, it seems odd to elevate anger at the way that the group to which one belongs is represented to disorder.

can be seen to sometimes fall into the same trap of disregarding the agency and autonomy of individuals, as seen in the case of Janice Raymond, who regarded all transsexuals as tools of patriarchy, and in the case of Michael Bailey, who posits that only two types of transsexual exist, and that those who claim to defy this categorization are not being truthful or are deluded.

The 2003 book *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* by psychology professor J. Michael Bailey is the most recent example of research dealing with gender variant populations that caused considerable controversy in its representation of participants. Bailey appropriates the theories of sex researcher Ray Blanchard, who divided male-to-female transsexual individuals into two different categories, that of the "autogynephile" and the "homosexual;" the first described as a "natal male being sexually aroused by the thought of himself as a woman" (Dreger 2008:374) who then seeks to procure a woman's body, while the "homosexual transsexual" would be considered a very effeminate male who would pursue sex reassignment "in part, because being a woman makes more sense than trying to live as a very effeminate man attracted to heterosexual men" (374). While sex and gender have often been regarded as the same subject both historically in early psychological elaborations of gender variance and still today in other cultures, the delinking of gender from sex through feminists' efforts to denaturalize gender roles and gender-normative gay activism is today received wisdom in the West as popular culture has acknowledged that biological sex does not necessarily determine gender roles or sexual orientation. By conflating gender identity and sexual orientation, the potential for disaster is obvious, as gender variant individuals' desire for medical intervention may be reduced to the fulfillment of a paraphilia.

Bailey's book has been faulted for the unsystematic nature of its research despite the academic position of power used by its author to access his participants (Windsor 2008).

Bailey's lack of attention for the self-narratives of his participants and their unease with his categorizations of them (as either "autogynephilic" or "homosexual") is especially relevant, for it demonstrates a lack of respect for the dignity of those who enabled his research in the first place. Dreger (2008:381) notes the presence of the overarching

> theme that virtually all "non-homosexual transsexuals" are autogynephilic, no matter what they claim about themselves and their histories. Bailey says that autogynephilic transsexuals "sometimes misrepresent themselves as members of the other [type of transsexual…T]hey are often silent about their true motivation and instead tell stories about themselves that are misleading and, in important respects, false." [Bailey 2003:146; n. 173]

Similar to anthropologist David Valentine's observations of the disconnect between the middle-class identity terminology used by "transgender" outreach programs and the populations that they are intended to help, with Bailey one sees the mapping of categories onto individuals who may be resistant to such processes. The reasons for such opposition go beyond an exercise in semantics, since such labeling can have real consequences for the parties affected. Dreger remarks upon Bailey's critics' mistaken belief that his "rejection of the feminine essence narrative," (383) the feeling of having a female gender identity commonly reported among male-to-female transsexual individuals, means that he does not support access to SRS. While in Bailey's eyes neither "homosexual transsexualism" nor "autogynephilic transsexualism" should stand in the way of hormonal or surgical sex reassignment, that is not necessarily a view held among other academics and health care professionals. Bailey himself writes that "some psychiatrists refuse to recommend for sex reassignment any man who has had even one incident of erotic cross-dressing" (2003:174), so clearly the potential for diagnosis as an "autogynephilic transsexual" could have a substantial impact on the individual seeking sex reassignment. The labeling of some transsexual individuals as "homosexual" due to their attraction to men also angers many gender variant people assigned male at birth, who feel that the term repositions

them as men rather than women. Though Dreger claims that Bailey does not seem to view sex work negatively, his following passage clearly establishes a profile for "homosexual transsexuals" that less enlightened researchers could use to cause harm:

> Nearly all the homosexual transsexuals I know work as escorts after they have their surgery. I used to think that somehow, they had no other choice….I have come to believe that these transsexuals are less constrained by their secret pasts than by their own desires…including the desire for sex with different attractive men [Bailey 2003:210]

According to Dreger, "Bailey says that he doesn't care primarily about whether the book had a positive or negative effect; he cares that he told the truth" (2008:414). This disconnect reaffirms the role that anthropology can play (given the stance of other disciplines, perhaps the role that it *needs* to play) in the study of representations of gender variance, as any anthropologist worth her salt will have as her primary concern the welfare of the individuals who give their permission to be the subjects of study.

Dreger clears Bailey of accusations that he should have conducted his research within the framework of the institutional review board (IRB) process because his stories "were all anecdotes and not scientific studies" (2008:402). However, this is disingenuous given her claim that if "the knowledge [the researcher] intends to gain is unlikely to be generalizable in the scientific sense, the research does not fall under the purview of the researcher's IRB" (401), since Bailey's appropriation of Blanchard's theory obviously does make generalizable claims about all transsexual women. This is why I view the IRB process as critical in the collection of oral histories, for if my own research were unintended to make any sort of claims to knowledge, then that research would have no reason to be undertaken in the first place. I view my responsibilities to my study participants, particularly in terms of their right to self-define, the greatest debt that I must repay in conducting my research in a fair and transparent manner.

The Internet and its Application in Research

My initial research took place on the Internet fora and discussion boards where gender variant individuals congregate to discuss issues of gender variance and identity. Contrary to earlier emphasis within academic writing on the "virtuality" of the Internet, gender variant individuals use this medium to write gender on their bodies outside of the established institutional milieu, weakening the very real hold of the psychological and medical communities on gender variant identity. My study investigates the ways in which English speakers from across the world understand their own gender variance in terms of available medical and popular paradigms by recruiting participants from these virtual spaces of gender variance.

Though the Internet has been a common fixture in many American households since the late nineties, academia has been slow to engage itself in such a popular new mass media technology. This is especially true in the social sciences, and in anthropology in particular, where Sara Dickey (1997) notes that media has often been positioned as "peripheral to culture" (Wilson 2002:450). Much of the work that has been done has been an attempt to reposition the Internet as a form of culture itself, attached to and of the "real" world. Internet scholarship prior to the millennium was centered on a model referred to as *cyberspace*, a term coined in 1984 by William Gibson in the cyberpunk work *Neuromancer*. Cyberspace was meant to infer a revolutionary shift, a new, disembodied virtual world removed from the physical world that had created it. Writing in 1999, Philip Agre reacted against the Internet as virtuality:

> The Internet is not growing apart from the world, but to the contrary is increasingly embedded in it….And so long as we focus on the limited areas of the Internet where people engage in fantasy play that is intentionally disconnected from their real-world identities, we miss how social and professional identities are continuous across several media, and how people use those several media to develop their identities in ways that carry over to other settings.

Indeed, the ways to interface with the Internet have only increased (mobile phones, cars, etc.), making it more portable and therefore more accessible than ever before, leading Agre to comment that "it no longer makes sense to speak of a boundary between the cyberspace world and the real world" (2002:182). In one of the first ethnographies of on-line activity, Miller and Slater found that the previously held assumption that the Internet was virtuality and therefore "opposed to and disembedded from the real" (2000:4) had no basis. Instead, the Trinidadian subjects of their study used the Internet as an additional tool in maintaining communications among their heavily-diasporic communities. These findings were similar to other studies, which reported substantial Internet usage that carried over the social distinctions and population identities found in the everyday world, and often facilitated contact between more geographically dispersed groups (Lysloff 2003, Bird and Barber 2002) that could be considered every bit as real as the "imagined communities" (Anderson 1983) of nationalism. Not to throw the baby out with the bath water, it has also been recognized that the lack of face-to-face interaction does create the potential for new opportunities in social interaction (Wynn and Katz 1997), where "the performative character of all social realities and identities can be brought to light, deconstructed, and transcended" (Miller and Slater 2000:5).

It is my belief that the Internet has been particularly suited to the needs of the "transgender" community in both identity formation and community organization. "Transgender" identity is part of a nascent gender variant identity movement whose members are both widely dispersed geographically as well as in terms of particular gender identification according to the transgender "umbrella" first elaborated by Feinberg. Unlike the categories of race, ethnicity, nationality, or religion, gender variant identities generally carry no direct connection between generations within families. Since my study is not tied to location (rather

desire to access transgender spaces online) for participant observation, I believe that my study represents a more diverse gender variant population, including those who do not associate with gender variant organizations in everyday life or who are not visibly gender variant and would therefore go unnoticed by the general public (or, in this case, the ethnographer's eye). The "transgender" community could effectively be described as a diaspora without a homeland, making it especially predisposed to organization through the medium of the Internet and therefore most comprehensively studied in that environment.

Like so many of the spaces of late capitalism, Internet discussion boards toe the line between public and private. Posts made by members of "open" boards (that is, accessible to the public without a membership and password) can be seen by anyone—some boards are even cached and searchable through Google—while other, more "closed" boards may have multiple layers of member authentification to keep out "lurkers" or people who are regarded as not eligible for participation. Though fora are privately owned, they tend to be used by members as if they were public space, while ideally maintaining the terms of service laid out by owners. Because the Internet allows a certain degree of anonymity, I believe that participants are perhaps more likely to be truthful than they might be in the context of face-to-face interaction, though that same anonymity also prevents me from being certain that the gender histories and experiences reported through my study are completely accurate. Though many members of discussion boards do not share personal data such as full name and location with their online communities, I tend to agree that the pseudonyms used by members are in themselves a form of personal identification to which personalities are attributed (Bird and Barber 2002) and that it would therefore be a breach of privacy to reveal such identifying characteristics in my published work. For the purposes of my study, I protected participants' privacy through the use of an

anonymous questionnaire and since I was granted a waiver of documentation of consent by the IRB I will have no record of their true identities.

In short, though the risks posed by my research to individuals are real in the stigma that could be attached to them for having participated and in the conclusions that I draw, I believe that a careful approach to respect for their privacy and for their understandings of self mitigates the potential for either indirect or direct harm.

Research Methodology

Many of the larger issues that this study attempts to address are the result of questions that I myself formed in the course of my participant observation on various "transgender" online discussion boards and websites first begun in early 2007 and continuing to the present day. Because so many of these fora are viewable by the public without membership and a password, and because they often serve as virtual support groups for the individuals that participate, I concluded that pulling citations directly from these fora would constitute a breach of the privacy of the individuals concerned; what is said in these contexts is often quite personal and surely not intended for use by academics. Gender variant individuals who seek medical interventions such as hormone therapy and surgery may be regarded as the unwilling collaborators in both medical and nonmedical research which use their search for understanding and treatment to advance institutional knowledge in a process to which many gender variant individuals would not consent were they not dependent on such authorities for help. Though I have read countless well-thought-out and well-argued opinions on matters of "transgender" identity and health care, to include them here even with the consent of the individuals who made them would present a danger to them in an era in which search engines catalogue and trace the activity of Internet subscribers.

To this end, I created a Zoomerang-hosted questionnaire with approximately fifteen questions (included here in the appendix) with the intent that I could include as many opinions on these topics as possible within the framework of this study while protecting the identities of the questionnaire respondents. With the permission of forum owners, I placed a message on two different discussion boards stating my position as a researcher and requesting participation in my study with a link to the Zoomerang questionnaire; a total of twenty-one responses were received, though not all respondents answered all of the questions listed. The questionnaire was written in order to address what I found through my participant observation to be the most salient in regards to "transgender" identity and health care, and oftentimes the most controversial as well. Because individuals who are less likely to identify as "transgender" are not often found on discussion boards that are promoted as "transgender" fora, I have relied on quotes from blogs (web logs) with stated anti-"transgender" opinions to flesh out the arguments against this category, for reasons further elaborated upon in the fourth chapter.

In the realm of human research in particular, claims to objectivity should be viewed as extremely suspect, as all researchers come to their subject with their own biases and their own social positions relative to their subjects and peoples that they study. Just as participants' answers to my questionnaire that are used to structure my arguments within this study were prompted by the questions that I saw fit to be asked, those questions were deemed to be relevant based on my own subjective experience as a participant observer in online forums. As illustrated in Horace Miner's "Body Ritual Among the Nacirema" (1956), the framework through which researchers view their subject is so fundamental and so often taken for granted that a lack of reflexivity on their part can distort their final product to such a degree as to render it unrecognizable to the population or subject in question. I can only hope that my recognition of

my own biases and positions prevent me from misrepresenting the topics at hand any more so than any researcher who must pull multiple strands of thought into a coherent form. With the recognition in anthropology that no researcher is truly objective, many individuals are now free to study their own cultures with the added benefit of their own experiences and insights as a member of that culture. However, Narayan views the category of "native anthropologist" as problematic, as the matter of shared identity is not monolithic (1993:676); thus, while I can make claims to certain insights as a participant in "transgender" culture, my specific experiences of race, sex, gender, socioeconomic status and so on that cut across the "transgender" category make it impossible for me to claim knowledge of all "transgender" people.

Limitations of the Study

There were numerous difficulties in coordinating this study within the strict timeframe of my study program. Before evolving into a study of the politics of gender variant identities with participants recruited online, I had hoped to study how gender variant individuals used the Internet as a source of community. Information of use to gender variant populations used to be confined to the individuals and physical spaces of that world, such as drag bars and gay ghettos; hormone usage falling outside of doctor's prescriptions was relegated to risky, illegal purchases made on the streets of substances of indeterminate origin and quality. This has changed, however, and from the first "transgender" bulletin board system online has grown a substantial community where information is free and available no matter one's location. From general information websites to specialized sources of consumer-oriented empowerment-through-education on issues such as electrolysis, prosthetics, surgical procedures, and hormones, as well as discussion boards related to activism and legislation, hormone usage and surgeons, and self-discovery, the Internet has a substantial impact on the lives of gender variant individuals. Of

particular interest is the use by gender variant individuals of video blogging technology such as Youtube; in my own study, multiple respondents reported their subscriptions to the "channels" there that discuss gender variance as principal information sources.

My personal experiences in transgender spaces online have led me to believe that the freedom of information there has correlated with less tolerance among many gender variant individuals for following the requirements of the SOC; many seem to prefer to not waste time with those mental health professionals who are slow to grant permission letters for hormone replacement therapy or surgery, making them perhaps more likely to "doctor shop" or to forego GID diagnosis altogether by pursuing surgery outside of the United States. The ability to begin researching gender variance anonymously online prior to transition as well as the knowledge that can be gained of cheaper surgical alternatives abroad can save gender variant individuals both time and money that would otherwise be spent going through the traditional SOC requirements, and I suspect that the Internet has substantially altered the terrain of gender transition for many individuals. This hypothesis is worthy of future investigation, and I regret that I was unable to treat this subject more completely within the present study.

Particularly in the area of gender variance and psychology, my study has privileged the issues faced by gender variant individuals assigned male at birth. This is the result of many factors, such as the preoccupation with female-identified gender variant individuals in both ethnographic accounts and within psychology. The greater attention traditionally assigned to male-born gender variant individuals may have to do with the privileged position of men in patriarchal societies and the assumption of the inferiority of women, leading to a presumption of deficiency (be it moral, sexual, mental, etc.) in male-assigned individuals who reject that assignment. According to Bollough and Bollough, "the social status gained by transgendered

[i.e. male-identifying] women appears to be less threatening to society than the social status lost by transgendered men and helps account for the cultural focus on male [i.e. female-identifying] gender noncomformity" (Nanda 2000:7). The lack of attention to the question of female-born, male-identifying individuals in Blanchard's (1985) transsexual taxonomy and in Raymond's (1979) critique of male-to-female transsexuality reflect this bias towards "explaining" gender variance in individuals assigned male at birth. The greater ability of women than men in the West to adopt the clothing and behaviors regarded as belonging to the opposite sex is a likely cause for the traditional undercounting of female-born individuals in studies of the prevalence of gender variance (see Bakker et al. 1993).

Finally, my own preoccupation with male-born female-identifying individuals in this study is largely attributable to the conditions of my research. Several of the online fora where my participant observation took place limit access to different threads based on the sex of the reader established during the registration process; as I registered my accounts as a woman, I was typically unable to view or participate on female-to-male discussion subfora, and was only privy to such discussions when a male-identifying individual chose to post their discussion to the general thread for all to read. I admit that I am not sufficiently versed in the identity politics surrounding male-identified individuals, especially in regards to their intersections with lesbian and "butch" identities. I hope that my lack of attention to these issues have not implied my indifference to these questions, but rather that I simply did not have the time to educate myself on these questions in order to explore them in this thesis and give them the respect they deserve.

A substantial roadblock that I faced in the course of my study was in gaining approval from my university's Institutional Review Board (IRB), the peer review process through which all researchers conducting original research with human "subjects" are ethically obligated to

receive authorization. The first draft of my questionnaire included a final rubric that would have allowed participants, if they so chose, to leave their email addresses so that I could both send them a copy of my thesis and potentially ask follow-up questions should their responses raise additional questions or if I had difficulty in understanding what they had written. I waited for two months to start the questionnaire participant recruitment process as the IRB was not convinced that the data collected over the Internet would be sufficiently secure to collect identifying data from study participants. In order for this study to be carried out at all within the time constraints of my Master's program, I eventually had to relent and remove the question asking participants to provide their email addresses. This had a deleterious effect on my study, since the inability to contact participants for follow-up questions limited my effectiveness as a researcher to delve as deeply into respondents' answers as I should have been able to. Because so many IRBs must depend on the websites that host research studies to demonstrate that data collected through their systems is secure, substantial improvements need to be made on the part of these hosts to reaffirm the robustness of their safety measures; while many faculty researchers have the luxury of waiting through numerous IRB applications and modifications and approvals, student researchers with a graduation deadline do not. As long as the burden of proof is placed on researchers with regards to Internet security, the ability to conduct research online will be impeded, which is a problem that will only become exacerbated as Internet research becomes more and more popular.

Finally, the questions of gender variant identity addressed by this thesis cannot be said to be in any way exhaustive of the many possible conceptualizations that exist. Because of the conditions under which my research was conducted and the inability to follow-up with respondents, this thesis lacks the richness or "thick" description characteristic of most

ethnographic accounts that look at the lives of people. Instead, my study is best read as an ethnography of the categories of gender variance themselves rather than as an examination of gender variant individuals themselves. I have simply aimed to explore the complexities of gender variance in terms of two of the most dominant contemporary discourses, those of the medical lens and popular culture. If my work has any positive effect on the fight for recognition of the autonomy of gender variant individuals, it will have been worth it.

CHAPTER 2 – INSTITUTIONS OF HEALTH

With the synthesis of sex hormones and the advances in plastic surgery made in the 20th century, many gender variant individuals are now able to alter their bodies to more closely conform to their identified sex. The processes for determining the eligibility of patients for these medical interventions have been polemical for their conceptualization of gender variance as "disorder." With the support of the medical and psychological literature regarding gender variance, I will discuss the current mechanisms in place for the receipt of treatment and the associated endorsement of psychology as the proper arbiter of individuals' cross-gender claims. I then go on to examine patients' experiences of and attitudes toward medical and psychological authority in framing the discourses of gender variance. I use the responses pulled from my questionnaire to illustrate that while certain forms of transsexual typology are viewed as stigmatizing, many gender variant individuals affirm the role of psychology in determining treatment eligibility and classification due to the legitimating authority that such a framing provides to their own identities. At the same time, differential access to officially sanctioned care sometimes entails working outside of that system in procuring the means for altering the body (specifically hormones) without necessarily subverting the utility of that framework.

"Gender Identity Disorder"

Transsexuality, if regarded as the feeling of belonging to the sex to which one was not assigned at birth and the concomitant desire to transform one's body as much as possible to embody that sex, was born as a phenomenon on December 1, 1952, as the headline "Ex-GI Becomes Blonde Beauty" splashed across the front page of the *New York Daily News*. Christine Jorgensen, who had traveled to Denmark in pursuit of experimental medical treatment, became an overnight celebrity and introduced to the world the concept of surgical sex change. While

Jorgensen was not the first such sex reassignment case (see Hoyer 1933), publication of her treatment was for many the first consideration that sex might be less straightforward than previously thought. News of this modern medical miracle spread quickly, and doctors soon found themselves presented with patients claiming to be like Christine Jorgensen and in need of the same care. By 1979, the first protocol for the treatment of transsexual individuals was established in the form of the "Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons." The SOC, now in its sixth revision (WPATH 2001), consists of guidelines for the diagnosis and treatment of "gender identity disorder" (GID) in America as well as in countries without their own local protocol. The SOC establishes the relationship between individuals with GID and the medical institutions that treat them both in terms of eligibility for care and the mechanisms of access. In this chapter, I will be examining how individuals with GID interface with health care institutions and the role of psychology in shaping that dynamic.

The SOC currently defines its relevant patient population as those whose "concerns, uncertainties, and questions about gender identity…become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity" (WPATH 2001:2). The minimum requirements established by the SOC are intended to help guide individuals with GID as far as they and their mental health care professionals deem necessary in order to alleviate their feelings of gender dysphoria. The general requirements for the commencement of cross-sex hormone replacement therapy (HRT) include patient understanding of the possible benefits and risks of HRT and a three-month period of either documented cross-sex living or psychotherapy. Genital surgeries generally require that the patient be a legal adult with at least twelve months of HRT use and twelve months of continuous cross-sex living as well as two letters of recommendation from mental health care

professionals, one of whom should be a Ph.D. clinical psychologist. In addition to the eligibility requirements, the mental health care professional recommending treatment must also attest to the "readiness" of the individual to receive hormones or surgeries. Evaluation of individuals requesting medical treatment for cross-sex identity for eligibility and readiness is therefore assigned through the SOC to the domain of psychology rather than to the physicians who dispense hormonal and surgical treatment.

This system has received considerable criticism from those who feel that mental health care professionals are consequently placed in the position of "gatekeepers" between cross-sex individuals and the medical interventions that they seek. According to Hale (2007), the mechanisms of the SOC violate the principle of patient autonomy by requiring gender variant patients to justify the changes they wish to make to their body to a degree unlike any other category of adult patients. Whereas patients presenting with requests for vasectomy or plastic surgery are examined for fitness for such procedures directly by their surgeon, Hale contends that "the SOC presupposes either that the general presumptions of competence and capacity to make autonomous choices do not apply to gender variant prospective patients, or that physicians are uniquely incapable of assessing the readiness of these patients" (496). He goes on to state that while the potential changes in social status that such interventions entail may be viewed as undesirable by non-gender variant individuals, the "principle of beneficence tells in favor of providing gender variant prospective patients with that which is beneficial to them," (497) which does not rise to the level that necessitates a mental health care professional's assessment. Follow-up studies of post-operative transsexual individuals reveal extremely low rates of regret (Pfäfflin and Junge 1998), though they only include patients who have received treatment in the framework of the SOC or its analogs abroad, no studies having yet been done on post-operative

outcomes including individuals who pursued surgery in contexts with less-stringent requirements or even on-demand. Hale closes by arguing that even if self-referred sex reassignment patients experience less beneficial outcomes than those treated under the SOC, "proponents of the SOC's mental health evaluation requirement would still need to argue convincingly that the principles of non-maleficence and beneficence override the principle of respect for autonomy in this area of medical policy-making" (503).

Hale's assessment of the role of psychology in the SOC only scratches the surface in terms of the problematic relationship between individuals with GID and those who determine their care. Because of the enormous expenses, almost universally disavowed at present by insurance companies, for hormone treatment, hair removal, and surgeries, incurred beyond standard living expenses, the additional requirement of being seen by mental health care professionals is not a trivial financial burden. A preliminary report on the findings of the first comprehensive National Transgender Discrimination Survey by the National Center for Transgender Equality and the National Gay and Lesbian Task Force (2009) have found rates of unemployment among transgender individuals at twice that of the American population as a whole as well as twice the rate of individuals living on $10,000 a year or less. While many individuals diagnosed with GID stand to benefit psychologically from therapy in working out their gender-related issues, those who are already certain of their intent to transition often regard the therapy requirements as an obstacle to the medical interventions that they seek.

In many cases, the professionals charged with the treatment of individuals with GID have seemingly been unaware of the extent to which some of their patients view their caretakers as potential impediments to their treatment. Drs. Kubie and Mackie reported in 1968 that transsexual individuals were "tailor[ing] their views of themselves and their personal histories to

prevailing 'scientific' fashions" (Billings and Urban 1982:274); famed psychoanalyst Robert Stoller made similar claims in 1973, stating that "Those of us faced with the task of diagnosing transsexualism have an additional burden these days, for most patients who request sex reassignment are in complete command of the literature and know the answers before the questions are asked" (Billings and Urban 1982:273). A lack of awareness among psychologists of their power relative to the individuals that that they are treating for GID and the incentive for those in their care to mimic the available accounts of already-treated individuals remains alive and well, as will be further explored in the case of J. Michael Bailey's book *The Man Who Would be Queen.*

Presently, gender variant individuals who seek medical intervention are referred to medical doctors by mental health care professionals according to the classification and diagnostic protocols published by the American Psychological Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM). Outside of America, gender variant individuals are often diagnosed according to the International Statistical Classification of Diseases and Related Health Problems (ICD), though depending on the country the DSM is often favored for research purposes and in some cases diagnoses as well (Mezzich 2002). Concurrent with the publication of the SOC in 1979 and its standardized differential diagnosis for gender variant patients, "Transsexualism" entered the DSM for the first time with its third revision in 1980, later to be recodified as "Gender Identity Disorder" with the DSM's fourth revision in 1994. The diagnostic criteria for GID according to the text revision of the DSM-IV are as follows:

> There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). This diagnosis is not made if the individual has a concurrent physical intersex condition

> (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D). [APA 2000:576]

These criteria, intended to be broad enough to capture as many different strains of gender variant identity as possible, make several presumptions regarding the etiology as well as the presentation of gender variance. Because individuals with intersex conditions fall outside of the purview of GID, one can assume that GID is itself not being regarded as an intersex condition, but one related to mental dysfunction (hence its inclusion in the DSM in the first place). As seen in the next chapter, this assumption is coming under increasing scrutiny in light of new medical evidence to the contrary. The demarcation between sex and gender is blurred, as diagnosis requires both cross-sex identification as well as either discomfort with ones assigned sex OR "a sense of inappropriateness in the gender role of that sex." The assumption of heteronormativity here is troublesome, since one could justifiably make claims to cross-sex identity while lacking discomfort with the gender roles of ones assigned sex; for example, a lesbian with a strong male gender role is still considered female, even though her gender identity may defy mainstream gender values. Finally, a person with gender identity disorder must display "evidence of clinically significant distress or impairment." While this may seem obvious, the threshold for impairment can be potentially difficult to ascertain, depending on the coping skills of different individuals. A strict reading of the current requirements render well-adjusted, functional individuals seeking medical treatment for GID ineligible, unless the mental health care professional responsible for the diagnosis broadens their reading of "distress" to be inherent to gender dysphoria itself (Cohen-Kettenis and Pfäfflin 2009).

In light of current plans for a fifth revision of the DSM, anticipated in 2012, multiple parties are engaged in attempting to shape the final outcome of the GID diagnosis. As noted in

Drescher 2009, of primary concern among LGBT activists are the stigmatization inherent in the inclusion of GID in the DSM and the fears over the financial repercussions that its removal might have. Though many comparisons have been made between homosexuality's presence in the DSM prior to its removal in 1973 and the GID diagnosis, the fact remains that homosexuality requires no form of medical intervention, while hormone replacement therapy (HRT) and gender-confirming surgeries do. The recognition of GID as a disorder in both the DSM and the ICD are the current justifications for its treatment and, in countries with universal health care systems and among a few American insurers, for financial reimbursement of its related expenses. According to Drescher, the inclusion of transsexualism in the DSM in 1980 was instrumental in changing medical and public opinion of transsexual individuals, both of which regarded transsexualism as an expression of neurosis or psychosis at a much higher level than today; since the gender theories of John Money, who held that gender identity was acquired rather than innate, were hegemonic among psychologists, the appreciation of transsexual individuals' complaints as legitimate and unresponsive to reparative therapy was extremely influential in lessening its associated stigma:

> In the 1970s, professional advocates of the medical model of transsexualism found themselves arguing against a common psychiatric belief that saw trans people as severely mentally disturbed. Using an alternative medical model of illness, albeit one less pathologizing than the theories of neurosis and psychosis they opposed, they expanded professional awareness and knowledge about gender identity and sex reassignment and were eventually successful in changing psychiatric and medical opinions regarding the authenticity of trans subjectivities. [Drescher 2009]

At this point in time, the question of GID's inclusion in the DSM seems to be whether it is more helpful or harmful. Though Drescher concludes by maintaining its continued utility, he is clearly aware of the positive legal and social changes that followed the DSM's deletion of homosexuality.

Affirmation by the medical community that gender identity variance does not constitute mental disorder would almost certainly have a positive social effect on the perception of gender variant individuals, and motions to this effect are becoming more common. In January 2010, a statement released by the Cuban Multidisciplinary Society for the Study of Sexuality (CNESDS) called for the elimination of GID from the DSM as well as other mental disorder classification systems, and in February of the same year France became the first nation to delist transsexuality as a psychological affliction (Le Monde 2010). According to accounts on French transgender discussion boards online, some doctors are currently claiming reimbursement for costs incurred in treating patients with GID under the more general heading "off-list long-term illness" as the previous categorization for GID on the "long-term illness" list for financial reimbursement is no longer valid. Though this situation may change if French medical insurance chooses a new mechanism for the reimbursement of GID-related costs, this example would make it seem that it is quite possible for treatment of gender dysphoria to be recognized as valid and, if solicited by the individual concerned, worthy of medical care and insurance coverage outside of the paradigm of mental disorder.

"Homosexual" and "Autogynephilic" Transsexuality

Complicating the relationship between gender variant individuals and mental health professionals is a current strain of psychological theory that is polemical due to its implications for standards of treatment among different "types" of individuals with GID due to its attention to sexuality as a primary motivator for seeking treatment and its supposed usefulness as a diagnostic criterion. The most recent flare-up between activists and academics involved the 2003 book *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* by psychology professor J. Michael Bailey. As a result of his acquaintance with several male-to-

female transsexual individuals, Bailey came to believe in the theories of Ray Blanchard, whose typology of male-to-female transsexuality (Blanchard 1985, 1989) divided these into two groups, "homosexual transsexuals" and "non-homosexual" or "autogynephilic transsexuals." While "homosexual transsexuals" are marked by their attraction to men, "autogynephilic transsexuals" report attraction to women, women and men, or neither. The main criticism of this view is its classification of androphilic transsexual women as "homosexual" in defiance of their female gender identities, and in the classification of non-androphilic female transsexuals as "autogynephilic," or sexually aroused with the thought of themselves as women.

According to Alice Dreger, professor of clinical medical humanities and bioethics in the Feinberg School of Medicine at Northwestern University, "In Bailey's take on Blanchard's theory[…]MTF transsexualism is fundamentally about *sexuality*—or more specifically, eroticism" (374). Though some male-to-female transsexual individuals do regard themselves as autogynephilic, Bailey's contention that all female transsexuals fall into one of these two types and his assertion that "autogynephilic" transsexuals "sometimes misrepresent themselves as members of the other [type of transsexual…T]hey are often silent about their true motivation and instead tell stories about themselves that are misleading and, in important respects, false," (Bailey 2003:146; n. 173) have raised considerable ire among transgender activists who regard his conflation of gender and sex as undermining the identities and narratives of male-to-female transsexual individuals. Though Bailey and Blanchard both claim to personally support the treatment of both "homosexual" and "autogynephilic" transsexuals, including sex reassignment surgery (Bailey and Triea 2007), they seem unaware of how their characterization of male-to-female transsexuality as the sex-driven behavior of gender variant men may cause harm to the identity claims and care of transsexual individuals. Bailey writes that "some psychiatrists refuse

to recommend for sex reassignment any man who has had even one incident of erotic cross-dressing" (2003:174), clearly providing the impetus for patient avoidance of being labeled "autogynephilic," as a recent case study of a diagnosed "autogynephiliac" whose therapist "disagreed with her wish to have sex reassignment surgery" (Duišin 2009) demonstrates. Given the risk of undermining transsexual individuals' treatment requests, Blanchard's affirmation that "reassignment surgery… is an empirical matter that must be decided on grounds other than etiology" (2008) reveals a woeful obliviousness to the consequences of his ideology.

The years since publication of *The Man Who Would be Queen* have done little to quell the animosity between the supporters and opponents of Blanchard's transsexual typology, as Blanchard, Bailey, and Lawrence have continued to uphold its primacy in their research. In "Deconstructing the Feminine Essence Narrative" (2008), Blanchard attempts to identify the central themes of popular theories of male-to-female transsexuality and relate their implausibility through his own research. Blanchard describes the "feminine essence theory" of transsexuality as male-to-female transsexual individuals' perception of themselves not as "like women or that they wish to be women… [but] that they *are* women" (434), usually in concert with a belief in transsexuality as a neuroanatomical intersex condition, as well as a belief in the existence of only one "true" type of womanhood that all women share. Blanchard holds that since his research has found these two separate types of male-to-female transsexuality, the feminine essence theory cannot be true because these two types most likely have different etiologies and would therefore render the belief in a single type of "essential" neurological woman impossible. In regards to the question of "homosexual" and "autogynephilic" transsexuality as distinct and unique phenomena, Blanchard notes that he has

> published at least two studies that suggest at least some transsexuals who deny autogynephilic arousal are consciously or unconsciously distorting their histories….There

> could still be some nonhomosexual transsexuals whose denial of any autogynephilic arousal is accurate….How does one decide when the discrepant self-reports of a minority of patients indicate psychological denial and when they indicate a bona fide separate syndrome? [437]

A 2007 article by Bailey and Kiira Triea similarly holds that "the standard, feminine essence narrative, and the associated brain-sex theory, are incorrect, in the sense that they do not represent reality, even if they do correspond with many transsexual individuals' beliefs and identities" (522). Bailey defends the nomenclature of "homosexual" transsexuals, reporting that "we retain the terminology because it emphasizes the fact that homosexual MtFs are a subset of, and developmentally related to, other homosexual males. Furthermore, it emphasizes the most efficient and practical way of distinguishing homosexual and autogynephilic transsexuals" (524). There are no citations provided for any of these claims, and I cannot find any studies that describe androphilic male-to-female transsexual individuals as a subset of homosexuals excepting the anthropological literature of cultures where the contemporary Western divide between sex and gender have not taken root and "traditional" gender variant identities are associated with same-sex attraction, such as the *kathoey* and *toms* of Thailand (Jackson 1997a, 1997b; Sinnott 2004).

As a result of its popularization, Blanchard's typology has received increased attention and scrutiny from not only transgender activists but in psychological quarters as well. Nuttbrock et al.'s (2009) study of 571 male-to-female transsexuals from the New York City metropolitan area found a strong association between three measurements of sexual orientation and different measurements of transvestic fetishism, with the prevalence of transvestic fetishism reported at nearly thrice the rate among gynephiles than among androphiles. However, they also concluded that Blanchard's sample had not been sufficiently diverse for age and ethnicity, as the "white" and oldest age cohorts in Nuttbrock et al.'s study (whom the authors describe as the most similar

to Blanchard's cohort) were both twice as likely to report transvestic fetishism; they also found transvestic fetishism in 23% of the "homosexual" cohort and its absence in 27% of the "nonhomosexual" transsexuals, noting that the associations with transvestic fetishism "were strong but clearly not deterministic" as in Blanchard's binary typology.

A clear theme in the academic debate over Blanchard's typology and more generally the inclusion of GID in the DSM is the difficulty in determining what constitutes pathology and what is merely normal human variation. According to Drescher, what facilitated the removal of homosexuality from the DSM in 1973 was the redefinition of mental disorder; the analysis of Robert Spitzer, who would later become chair of the task force for the third revision of the DSM in 1980, found that "with the exception of homosexuality and perhaps some of the other 'sexual deviations,' [mental disorders] all regularly caused subjective distress or were associated with generalized impairment in social effectiveness of functioning" (Drescher 2009). Drescher regards this description of psychiatric disorders as "characterized by dysfunction and distress" as "a unique formulation," as it shifted the focus in psychology from simply diagnosing the phenomena they observed in practice to "contemporary scientific research models and to the empirically based practices of other medical specialties." With the recognition that homosexuals were not as a category impaired except in the social stigma associated with their sexual orientation, its removal from the DSM became a necessary step in eliminating its associated iatrogenic stigma.

The view of mental disorder as requiring intrinsic and therefore not socially derived dysfunction and distress is not accepted in all psychiatric quarters. Anne Lawrence, an advocate for Blanchard's theories and self-proclaimed "autogynephiliac," recently published a call for the inclusion in the upcoming DSM revision of his "erotic target location errors" (ETLEs), the idea

that "some persons with paraphilias erroneously direct their erotic interest toward peripheral or inessential parts of their preferred erotic targets" (2009:194). Lawrence proposes that "autogynephilic" transsexuality is one of these ETLEs, upholding Blanchard's view of "autogynephilia [as] a misdirected form of heterosexual impulse" (Lawrence 199) in which "men erroneously locate their preferred erotic target, women, in their own bodies," and that "autogynephilia" should replace "transvestic fetishism" in the DSM-V and should be emphasized "in accounting for the key symptoms of GID in nonhomosexual men" (210). Moser (2009a) has responded by criticizing Lawrence's failure to demonstrate what constitutes "peripheral or inessential" aspects of sexual interest, as well as the disregard for the APA's assertion that "A paraphilia must be distinguished from the nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement" (Moser 2009a:383). Indeed, the assumption that any "nonhomosexual" male-to-female transsexual individuals' arousal to thoughts of themselves as women constitutes pathology had gone unexamined until Moser 2009b found high rates of erotic arousal to lingerie and personal grooming in a sample of 29 nontranssexual women. Lawrence (2010) claims that Moser's survey instrument did not accurately reflect Blanchard's diagnostic criteria for "autogynephilia" and that nontranssexual women's arousal to the thought of themselves as women does not constitute genuine "autogynephilia" as the element of fetishism at *being* a woman is not present.

Moser 2009c points out that "what is defined as 'normal' sexual behavior, what is a mental disorder, what is a crime, and what constitutes a sex crime do change over time" (324), therefore any unusual sexual interest "must cause the dysfunction to be a mental disorder," rather than the pathologization of socially-devalued variance. Blanchard et al. 2008's support for the inclusion of hebephilia (erotic arousal to pubescent children aged eleven to fourteen) in the

DSM-V has found disapproval among multiple scholars for the lack of evidence that "a sexual interest in pubescent minors implies that the individual suffers from a mental disorder, specifically a Paraphilia" (Moser 2009c), why ephebophilia (attraction to 15- and 16-year-olds) and gerontophilia (attraction to the elderly) escape this classification (DeClue 2009), and Blanchard et al.'s failure to define or measure mental disorder (Tromovich 2009).

Many of the same problems that plague Blanchard et al.'s categorization of hebephilia as mental disorder are similar to the problems with GID and the "homosexual" and "autogynephilic" transsexual typologies in that the assumptions of mental disorder that sanction their inclusion in the DSM have not been empirically validated. In fact, multiple studies of transsexual individuals have found rates of non-clinical psychological functioning (Cohen-Kettenis and Pfäfflin 2009). Since the primary criteria for mental disorder has been impairment and/or distress since the DSM-III (Meyer-Bahlburg 2009), the continued presence of GID in the DSM can be attributed to a clearly different standard by which gender variant individuals are judged. Bailey and Triea 2007's formulation that "Autogynephilia appears to be a paraphilia. Paraphilias are unusual, intense, and persistent erotic interests" (524), a definition that fails to meet the APA's own characterization that paraphilias "cause 'clinically significant distress or impairment in… functioning' or '…marked distress or interpersonal difficulty'" (Moser 2009c:324), demonstrates the shaky foundations upon which gender variant diagnoses appear to be based. As has been shown, the categorization of gender variant identities as associated with sexual pathology may further stigmatize those whom diagnoses such as "autogynephilia" purport to help. Because of the risks to transsexual individuals inherent in such diagnoses, the burden of proof must lie with psychologists to establish, through rigorous examination, that it is not social norms that are informing diagnoses of pathology if claims to scientific validity of psychology are

to be made. Given Blanchard's position as chair of the paraphilias subcommittee for the DSM revision, and the GID subcommittee's apparent lack of attention to recently published neuroanatomical data (APA 2010), any impending reevaluation of the appropriateness of the presence of gender variant identities in the DSM seems unlikely.

The Practice of Treatment and Patients' Responses to Medical Authority

The conceptualization of gender variance under the psychological paradigm of GID is controversial within the transgender community largely due to the connotations that such a designation carries. I will delineate here several examples of transgender individuals' attitudes towards the diagnosis that include its acceptance, its rejection, and multiple shades of opinion between these two poles. The citations used have been obtained in the course of my research carried out in the form of an online questionnaire under the approval of my university's institutional review board (refer to the 'Methods' subsection of the introductory chapter for more information). Though these opinions cannot be said to be exhaustive of the many different stances towards GID, I believe that they do provide as accurate a representation as possible under the constraints of this project of the broad variety of discourses surrounding so complex an issue.

As previously established, the recognition of GID in both the DSM and the ICD are the current justifications for its treatment and, in countries with universal health care systems and among a few American insurers, for financial reimbursement of its related expenses. As such, its potential for stigmatization is in some ways offset by the many successful transitions that are managed through its diagnosis and its subsequent SOC-prescribed care. Agreement with the principles behind GID and the SOC that affirms its usefulness appear to be correlated with a strict reading of biology and the qualifications for its diagnosis. In the words of one respondent:

> I recognize that since I have XY karyotype genes, my brain's gender—had things developed properly—I would have had a male gender identity, thus since I was born with

> a female gender identity, this would make my condition a disorder, effecting my gender identity. I personally feel no negative stigma from having a disorder. It just is. It's a medical term for me, and terms are needed to define things in order for them to be researched.

This respondent alludes to the brain-sex theory of gender variance, using the mismatch between the gendered body and the gendered brain to conclude that GID is an appropriate term as it describes the end result of a biological error in the womb. Since sexual differentiation of the genitalia occurs between the sixth and twelfth weeks of pregnancy while the sexual differentiation of the brain is proposed to take place later (Garcia-Falgueras and Swaab 2010), the fault is placed with the brain, which does not agree with the chromosomal and genital sex. By valorizing the chromosomal and genital sex as the "true" sex, this take on GID is in accord with the popular notion of sex and recalls the theories of Harry Benjamin, who is credited for his early treatment of transsexual patients and his suspicions of biologically-determined cross-gender identity (see the third and fourth chapters for more information).

Inversely, several respondents stated their objections to this reading of GID by asserting that the term GID is too closely related to its psychological meaning of mental disorder and cannot be shifted to legitimization through the lens of the biologically cross-gendered brain. One respondent asserted that "my gender dysphoria is no more of a disorder than club foot, 47XXY or any other birth defect;" a second argued that "the entire name has the connotation that our gender is a mistake that should be corrected, not our bodies."

Another respondent makes the claim that "while the term [GID] is accurate, I don't consider myself to have any sort of disorder." This seemingly contradictory opinion (regarded by the respondent as possibly a form of "cognitive dissonance") is understandable, since one may recognize a brain-body mismatch without wanting to be subject to the stigma of having a "disorder," or more simply, without feeling oneself to be disordered. This dilemma is most

likely the grounds for several respondents' reports of their dissatisfaction with the term GID, though their takes on what should stand in its stead are far from uniform. Returning to the theme of physical rather than mental defect, one respondent asserts their preference for identification with an intersex condition, though "until it gets changed GID will have to do;" another proposes that simply "condition" might be an improvement over "disorder."

The ambivalence towards this term cannot be overstated: while many may be uncomfortable with the implications of "disorder," its deployment by medical authorities is still considered something of a necessary evil, as highlighted in the following citation:

> I do not identify with the term gender identity disorder, because I don't see it as a disorder. I feel it's a physical defect, not a psychological one. However, I do understand the need for the term as it is used by the medical world. They need labels, and if that one makes it easier for them to justify providing medical care, they're welcome to it. It's just not a term I use myself.

Statements such as the above reveal that respondents appear to be quite aware of the power that medicine holds in the shaping of perceptions, with one of them referencing the removal of homosexuality from the DSM and its effects. One respondent explicitly affirms this through their acceptance of the GID moniker, by noting that "it doesn't really matter what it's called, it only matters what the general public are led to believe it means." According to this point of view, the designation by which medical authorities refer to gender identity variance within their own realm is less important than the social meaning that the term carries, be those connotations derived from the world of medicine or elsewhere.

Many respondents' feelings are tempered with the idea that for all of its problems, GID is a superior characterization than the diagnosis that it supplanted, transsexuality. This respondent's sentiments best exemplify this attitude:

> I prefer gender identity disorder out of personal opinion. I believe when the average person with no experience in dealing with these sort of things hears the word transsexual,

> they pick up on the sexual part of the word and believe it to be a fetish or a perversion. By removing the word sex from the term I believe it will help the public to begin to understand the issue instead of treating it like some sexual perversion.

The shift from *transsexual* referring to a medical diagnosis to its contemporary associations with pornography and prostitution is regarded by many respondents as undesirable; in the face of the alternative, GID is preferred for its "getting the word 'sex' out of the picture," as one respondent puts it. Another says "it's a good step if they see it as a disorder instead of a sexual thing," echoing Drescher 2009's recollection of the intentions behind the creation of the SOC in 1979.

Indeed, the power that medical authority carries is implicit in such claims, and is viewed positively by some individuals with GID because of its potential to drown out competing social discourses regarding the etiology of gender variant identity. Though the medical recognition of any state that deviates from social norms can be perceived as stigmatizing, the scientific validity that such a designation conveys may well be regarded as preferable to folk models of illness. As evidenced by the search for the biological causes of homosexuality in the form of the "gay gene," many individuals with stigmatized identities would welcome "proof" that those identities have their basis in biology, with the belief that such evidence might reduce the social disapproval that comes with sexual and gender identities that are often popularly framed as a matter of "choice."

Aleshia Brevard, in her autobiography detailing her transition from male to female in the early 1960s, relates the following story explaining her diagnosis as transsexual:

> According to Dr. Benjamin…the hormonal bath that determines the sexual assignment of the child occurs later in the gestation period. In some cases, mine as an example, the external sexual assignment and the mental sexual assignment do not jibe. It was what I'd said all along—my pieces didn't fit. Dr. Benjamin's was a wonderfully scientific explanation as far as I was concerned. My misery was not something I'd caused. I wasn't crazy. Here was a medical standard that I could live with. I'd merely had a small mishap during my hormonal bath—big deal. I was the product of a biological accident, and that could be corrected. Dr. Harry Benjamin was my liberator. [2001:29]

For Brevard, Dr. Benjamin's scientific explanation for her gender variance was a substantial improvement compared to her own fears that she was simply "crazy." The guilt and shame through which she had been raised to interpret her female identity were substantially reduced thanks to the power of the medical gaze to explain and label her feelings.

The God-like status ascribed to the physician is a very common theme in early transsexual narrative, since the diagnosis and treatment prescribed by medical authorities vindicates the assertions of the transsexual patient through the power of science. This faith in medical science has been referred to as the "biotechnical embrace" (Good 2007) in its ability to wrap up both healthcare provider and patient, which manifests in a can-do attitude about turning what was once considered future science (the "medical imaginary") into a reality. The power to transform an attribute as supposedly fundamental as sex is an incredible thing, and the support of medical authority to validate the identities of individuals with GID is for many a necessity in the transition process. The current SOC reaffirms the usefulness of the GID diagnosis by stating that "formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments" (6), while also arguing that "the designation of GIDs as mental disorders is not a license for stigmatization, or the deprivation of gender patients' civil rights."

A final group of respondents purport to reject the GID label entirely due to their perceptions of its implications of their own identities as negative. Most respondents who reported feeling this way state that they do not believe that there is anything wrong with their gender identity, and many associate the term "disorder" with both stigma and illness. In contrast to the SOC's claims of practical intent, for these individuals the use of the term "disorder" and GID's presence in the DSM both constitute pathologization of their identities. One individual

makes the claim that "that diagnosis is meant and often used to provide justification for attempting reparative therapy for transgender individuals," while another states that "in my mind [GID] means someone who is unsure or has problematic relations with his/her own gender." Due to the inability to ask my respondents follow-up questions, I cannot be certain, but I would venture that these respondents did not intend to say that GID has no useful purpose, as the above respondent explicitly alluded to the existence of people who do not have stable gender identities, but rather that its application does or should not extend to all transgender individuals, or at least not those with relatively uncomplicated cross-sex identities.

Confirmation and Challenges to Medical Authority

On the broader questions of health care access and treatment, transgender individuals face many difficulties, particularly in regards to finding health care professionals who are sympathetic towards transgender individuals, knowledgeable about their issues and treatment, and whose services can be afforded. Sanchez et al. 2009 notes that "the medical literature does not provide sufficient data on transgender individuals' access to medical care, availability of culturally competent providers, and access to supervised hormonal regimens to assist the 'transition' to their self-identified gender" (713), though the handful of studies that have been carried out both elucidate and confirm my respondents' experiences as well as my own experiences and perceptions. Sanchez et al.'s survey of 101 male-to-female transgender individuals in New York City found that 32% of participants had difficulty finding health care providers with knowledge of transgender issues, while 30% reported difficulty finding transgender-friendly providers and 29% reported problems of affordability. 79% of Sanchez et al.'s cohort using HRT reported obtaining them from a physician, though 23% got them from other sources such as through friends, on the street, or on the Internet. According to Sanchez et

al., "the perception that health care providers lack necessary expertise to supervise hormone therapy, along with the wish to maximize and accelerate feminization, may at least partially account for the utilization of hormones from multiple and nontraditional sources" (717).

In the course of my participant observation, I took part in discussions on several online fora devoted to "do-it-yourself" hormone usage. Individuals on these boards exchange the latest in medical trials and studies regarding the effect of exogenous hormones, and often fault the medical communities' cautiousness in hormone prescription dosages. The common premise on which these boards are based is that because so many doctors are not familiar with treating transgender patients, a community in which individuals are well aware of the risks and processes involved in cross-sex hormone administration may well be more beneficial than trusting doctors to provide appropriate care (a suspicion that is partially attributable to continued prescription by some doctors of equine estrogens despite their increased risk of stroke [Anderson et al. 2004] and the contemporary availability of bio-identical humans hormones). These groups serve as media through which individuals can become aware of and discuss the availability of through-the-mail hormones from Asia, and similarly to the breakdown in the gender clinics in America in the late 1970s, they enable many individuals who would not normally be able to receive hormones under prescription to obtain them. This can have multiple effects, from the positive for individuals who really do not require or cannot afford therapy in order to access HRT or for those who are only mildly gender dysphoric and use hormones without the intention of transitioning, to the disastrous for those who begin a hormone regimen and permanently alter their bodies only to later decide that it was a mistake. Cross-sex HRT has previously been restricted to transsexual individuals actively transitioning from one binary gender to the other; the Internet has enabled people to access these drugs on a networked scale far larger than the old hormone street trade.

Though for the purposes of this thesis I was regretfully unable to give these hormone groups the attention that I wanted to and did not recruit any of my survey respondents from these sites, I believe that the processes that have caused the membership of such groups to swell are highly relevant to the present study as they relate to a lack of knowledgeable, sympathetic, and affordable health care professionals.

The wide availability of the Internet is substantially changing the relationship between laypersons and individuals with authority based on specialized knowledge. While many transgender individuals may now have access to a large range of the medical knowledge previously only available in the context of a medical or research library, very few doctors specialize in cross-sex hormone administration and sex reassignment surgeries. Those transgender individuals seeking medical intervention outside of urban areas may find themselves in the position of having to educate their own doctors in the protocols and necessities of their treatment. Dewey 2008 relates the following strategy pursued by some individuals seeking HRT:

> To find a doctor who will prescribe hormones, some trans-individuals will self-medicate for several months through the purchase of hormones on the Internet. Assuming that doctors desire to care for and keep patients healthy, they then approach the doctor and tell him or her that they need assistance in regulating hormones as the hormone usage could have grave side effects….Patients then share with the doctor all the harmful side effects of taking such drugs without professional guidance. They will tell their doctor what prescriptions they need and what particular tests are needed so that long-term negative physical effects do not develop. [1352]

Given the reduced autonomy with which transgender individuals must work, it is unfortunate, though unsurprising, that receiving doctor-prescribed HRT may necessitate self-medication in cases where the GID diagnosis is either not applicable or seeing a mental health care professional is either unaffordable or unwanted. Among the nine respondents to my questionnaire that are currently on HRT, two report having self-medicated in the past. Since most American insurance

companies not only do not cover transgender-related treatments but also often regard GID as a pre-existing condition, its application to an individual can cause substantial difficulties in obtaining health care insurance after diagnosis. According to Dewey, forms of resistance like doctor-shopping and self-medication "convey that [trans-patients] are not satisfied with current methods of treating trans-people" (1353) as they "'work' to make previously exclusive medical knowledge more accessible."

Those respondents to my questionnaire who receive medical care related to transgender issues report varying degrees of satisfaction with the availability and quality of care. While many report positive experiences, the cost of treatment and providers' awareness of transgender treatment needs appear to be major sticking points. None report any poor treatment with the exception of mental health care professionals. Many appear to receive their transgender-related treatment from a general practitioner, and regard themselves as having to play a proactive role in their relationship with their doctor. One respondent claims that "in many ways, I have had to train my gender team," while another states "the biggest problem is that most doctors don't know what transsexuality is any more than the general population. I've had to seek out those knowledgeable enough and willing to treat me… and others I've had to educate myself." Of those respondents on HRT asked whether they feel as well informed as their health care providers about cross-sex hormone treatment, all but one reports either feeling as well informed or even more informed. Though one respondent states that they leave it to their GP to determine treatment, almost all other respondents report having done research into HRT online in medical journals, on self-medicating forums and in books. Multiple respondents report being the first or only "transgender" patient that their doctor has treated.

Since most respondents either on or planning to begin HRT report substantial self-education about the subject, one might expect that many would support the removal of the mental health evaluation and GID diagnosis to access medical interventions. However, of the nineteen respondents expressing an opinion on this subject, the vast majority upholds the necessity of some form of mental health evaluation as opposed to a more on-demand system. Some describe their support for the current SOC requirements in terms of the benefit of having a second opinion that could more objectively assess their eligibility and readiness; as one respondent says, "we need to have someone outside the situation to take a step back and look at our options for us and what they think, with an educated opinion, our response to such a life change will be." Others frame the GID diagnosis as a stamp of approval from medical authorities that legitimizes the identities of transsexual individuals and their need for treatment:

> Although I dislike them I think it is important to have gatekeepers to administer the process of weeding out those who really don't belong on the transition path. If anyone could just walk into a doctor's office and request authorization for SRS, as transsexuals we would lose what credibility we have in one heck of a hurry.
>
> Hormones make major changes in your body, and the surgeries are for real. Both come with very real risks, and the effects are difficult, if not impossible, to reverse. It's insane to make this on-demand, particularly when there is already stigma against trans people. People need to be very sure that this is what they need, and making them wait some is probably a good thing in the big picture.

For these respondents, the gatekeeping that the SOC indicates is useful not only in identifying those individuals who should receive treatment, but also in indentifying those who do not. The desire that ineligible individuals should not receive HRT and surgeries is directly implicated in the maintenance of the GID diagnosis. The reporting of negative outcomes due to the acquisition of HRT and surgeries by individuals with other psychological disorders is viewed as endangering the limited institutional legitimacy that treatment of GID possesses in the medical community and potentially jeopardizing the ability of future individuals with GID to receive the treatment

that they merit. Others still frame their argument in terms of the potential for harm that unnecessary treatment could do to the individuals who should not be treated, as illustrated in the three responses below:

> The current SOC helps screen those that should not have hormones and surgeries, the suicide rate will go up if it was available on demand due to people regretting their choice after.
>
> I believe surgery should be approved by a health care professional so as to make sure autogynephilics, fetishists, and the mentally skewed don't do irreversible damage to themselves which they may end up regretting.
>
> I think there needs to be some professional approval so people don't abuse the system and later sue the doctors, to avoid people who are depressed or genderqueer from going through with transition and then saying the doctor "ruined their lives."

The principal concern among those who support the current system appears to be that individuals who receive transgender-related treatment are vetted to assure the smallest number of negative outcomes. Despite their support, many respondents also recognize that the principle of "one-size-fits-all" does not apply to transgender individuals and their treatment, with some calling for less strict guidelines or the dropping of waiting periods prior to approval for HRT and surgeries. Only one respondent comes out firmly against the SOC requirements:

> I think it's kind of ridiculous that we can't get our medical treatment like anyone else can and have to go through gatekeepers… It can be argued that [some] people need to be looked out for. But that's currently the state of pretty much every other voluntary surgery today: up to the patient. So I think we should be held legally competent to make our own decisions about our bodies.

Indeed, while many of the respondents who are concerned over the prospect of unfit individuals receiving treatment believe that the current SOC prevents this, there is little (if any) evidence to support such a claim. Pfäfflin and Junge 1998 and Lawrence 2003 found extremely low incidences of regret among post-op transsexual individuals, though no studies have yet been

conducted to examine the rate of post-op regret among transsexual individuals who transitioned outside of the general requirements.

Since the requirements for sex reassignment surgery are not globally uniform, many Western transsexual individuals have opted to travel to Thailand for surgery, both for its generally lower cost (for those whose insurance does not cover transgender-related care or whom opt to "go private") and the ability to receive surgery either without mental health evaluation or through a one-time consultation with a Thai therapist. One respondent remarks upon this state of events, calling into question the received wisdom that the SOC screens out anyone:

> I feel there should be a tighter control over these treatments. They should of course be available to all who need them, but it honestly seems to me to already be an on demand system. If a person has the money, they get what they want, instead of those who need it getting it. Sadly, I feel that most GID treatment is more capitalistic than humanitarian. If you have the money, you can pay the right people to get exactly what you want, but if you're broke, you get nothing in many places, as insurance refuses to cover it.

It has been established that transgender individuals will often use whatever means necessary in convincing doctors of their need for treatment if they personally believe that they need it. The reports of transgender individuals "lying" to their doctors (Billings and Urban 1982, Bailey 2003) are extremely common in the literature and reflect patients' anxiousness to meet the expectations of their health care providers in order to qualify for treatment. If patients who are determined to receive treatment cannot be stopped from providing medical professionals with the "classic" transsexual narratives that are expected of them, just who is being spared from the self-harm of unnecessary treatment?

What underlies respondents' approval of the current framework seems to be the institutional endorsement of their identities and acknowledgment of the medical necessity of hormonal and surgical intervention more so than the alleged existence of many undeserving individuals presenting for treatment and needing to be "weeded out." Medical authority is

welcomed for its control over the interventions that transsexual individuals seek, and in many cases GID is specifically regarded as superior to alternative conceptualizations of gender variance, as its current focus is on treatment of the body rather than of the mind. Most respondents endorsed the role of psychiatry in determining treatment as this process grants legitimacy to their identities with the power that the authority of medicine provides. Many individuals do seek out treatments either outside of or in addition to the SOC, yet accept that framework as the ideal basis upon which treatment is founded.

While individuals who are genuinely confused about their gender would no doubt require the aid of a mental health professional rather than proceeding straight to transsexual transition, I question whether the SOC serves to safeguard these individuals as much as to sanction the transitions of transsexuals with the force of medical authority and approval. As Dewey argues, "when trans-patients effectively use medical knowledge they can be viewed as credible and worthy of sought-after treatments" (1348). For transgender individuals seeking HRT or surgery, the recitation of accepted (and expected) norms in their interaction with health care professionals creates their eligibility for treatment and renders their choices regarding their bodies as valid within an established medical framework for understanding gender variance. Without the medical authorization for transition, or as anthropologist Anne Bolin framed it, a transsexual "rite of passage," transgender individuals may feel a lack of validation in their transitions as medically necessary and their gendered identities as "real." Given the standards of heteronormative society and its marginalization of gender variance, this desire for approval is entirely natural and undeserving of condemnation. However, is it difficult to imagine a different sort of stance towards transgender individuals that recognizes their autonomy to make decisions

regarding their own bodies, and that respects their claims to gendered identity without psychological validation?

CHAPTER 3 – CONTRIBUTIONS OF MEDICAL RESEARCH

Twentieth century advances in medicine have allowed thousands of gender variant individuals to more closely align their sexed bodies with their internal sense of gender. As demonstrated in the previous chapter, the mechanisms of access to these medical interventions are controversial, and they have varied substantially according to geographic location as well as over time. The extent to which modern medicine can transform the secondary sex characteristics of gender variant individuals is relevant to my study as it informs the desire of individuals to seek treatment and to an extent enables the shifts in identity upon which contemporary "transgender" identities are predicated. Whether or not gender variant individuals who desire medical interventions agree with the mental health evaluations required for accessing treatment, they are dependent upon the consent of medical authorities in order to receive said treatment; as such, the ways in which medicine describes the needs, the care, and the identities of gender variant individuals have a substantial role in shaping how such individuals make sense of their own gender.

Though doctors have published their findings on the effects of cross-sex steroid administration for decades, there have been few surveys of the literature to broadly examine the many changes that the sexed body undergoes during the course of such treatment. In this chapter I will be examining the available medical literature to determine the changes to the body that take place during cross-sex hormone treatment, as well as recent research into the possible neurological and genetic origins of gender variance. In order to specify which population of gender variant individuals is most concerned with these interventions, for brevity's sake I will be using the term "transsexual" as that is how gender variant individuals seeking bodily modifications are almost universally referred to within this literature.

Because cross-sex hormone replacement therapy usually occurs only within the specific context of transsexual health care management, the opportunities for its study are relatively limited. The breakdown of the gender clinic system in the United States and the off-label nature of cross-sex hormone treatment (i.e. the use of HRT being not specifically intended by pharmaceutical companies for transsexual individuals) have resulted in a general lack of scientific inquiry into its effects in America due to the unavailability of patient populations being managed centrally by a handful of gender specialists. As such, most research currently being carried out on the medical interventions sought by transsexual individuals comes from those countries with both universal health care and programs to which gender variant individuals are referred by their general practitioners for treatment.

I intend to review the available literature on cross-sex HRT to ascertain which effects have been measured, as well as what remains to be studied. Such a review is relevant to this study as claims often made by transsexual individuals to a biologically predetermined cross-sex identity have only recently begun to be examined, and psychological research cannot stand alone if a full picture of gender variance is to be formed. Because theorization of gender variance as mental "disorder" remains an assumption rather than empirically established fact, research into the biology of transsexual individuals—both prior to treatment as well as during and after—is necessary to clarify the nature of transsexuality. My principal concerns are to determine to what degree transsexual individuals may become indistinguishable from nontranssexual individuals, which adaptations are not induced by exogenous hormone introduction, and the social role that HRT plays in the transition process. Also to be addressed are the literature related to transsexuality and neuroanatomic functions to determine whether popular theories of the gendered brain are supported by research, and the implications that such studies may have on the

identity formation processes of gender variant individuals. While the methodological problems of earlier research into the "brain-sex theory of transsexualism" have largely been rectified in more recent studies, it appears that their findings are not being taken into account by those responsible for the DSM revision process (APA 2010).

I present this information here in an effort to bring these discourses into increased conversation with each other, as all are highly relevant to the conceptualization of gender variance and the treatment of transsexual individuals. If the traditional transsexual narrative of essential cross-sex identity is indeed reflected in their neuroanatomy, such a recognition by medical authorities might undermine the prevailing psychological opinion that positions transsexual individuals as biologically normative in regards to their sex assigned at birth. Such acknowledgment could overturn the assumption that transsexuality represents mental disorder, substantially changing the treatment model following the diagnosis of GID. I believe that a review of the scientific literature is necessary in order to demonstrate how medical authority works to frame identities and how it connects to the politics of treatment.

Transsexuality's Biological Etiology?

Following the first diagnoses of "sexual inversion" in the psychiatric literature of the late 1800s to the first published accounts of changes in sex (Hoyer 1933, Star 1955), transsexual individuals relied upon the narratives of their forebears in both shaping their own understandings of gender and convincing medical professionals of their need for treatment. As Meyerowitz relates, "In traditional medical histories, doctors often stand as pioneers in science. In the history of transsexuality, doctors, with a few exceptions, lagged behind, reluctant pioneers at best, pushed and pulled by patients who came to them determined to change their bodies and their lives" (2006:363). Indeed, while a few sympathetic doctors, such as endocrinologist Harry

Benjamin, would take the stories of their transsexual patients to heart, their early interventions leading to the establishment of the Standards of Care (WPATH 2001) still being used to treat transsexual patients today, many viewed the legitimization of transsexual narratives as, according to one doctor, "collaboration with psychosis" (Billings and Urban 1982:269). As a result of treating these first transsexual patients in America, Benjamin came to suspect a biological etiology for transsexuality, condemning the disinterest in its study:

> In this country, psychology and psychoanalysis still dominate the field of sexual deviations. Many psychologists, particularly analysts, have little biological background and training. Some seem actually contemptuous of biological facts and persistently overstate psychological data, so much so that a distorted, one-sided picture of the problem under consideration results. Psychiatrists with biological orientation strongly disagree and even decry the exclusive psychoanalytic interpretations. But their voice is heard too rarely. [Benjamin 1999[1966]:43]

Benjamin's suspicions have long received little attention from those in the mental health fields so often tasked with diagnosing transsexual patients and ordering their care. The theories of gender neutrality at birth, first formulated by psycho-endocrinologist John Money in the 1950s (see Colapinto 2000), have only recently begun to encounter resistance in the social sciences, where principles of the social construction of gender have received greater emphasis. While the lack of an easily accessible transsexual patient population in America due to the disbanding of the gender clinic system has made systematic research difficult, the continued presence of these in Europe has promoted research into the etiology and medical treatment of transsexuality. The following will be a brief survey of the research conducted within the past fifteen years into the possible neurological and genetic predispositions for transsexuality, gathered using the search queries "transsexualism brain" and "transsexual brain" on PubMed as well as from consulting the bibliographies of germane entries.

The first apparent study of the brain in view of determining differences between transsexuals and nontranssexuals appeared in "A Sex Difference in the Human Brain and its Relation to Transsexuality" (Zhou et al. 1995). Researchers examined the bed nucleus of the stria terminalis (BSTc), a sexually dimorphic part of the amygdala implicated in sexual behavior and the regulation of the release of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), in a post-mortem analysis of the brains of six male-to-female transsexual individuals. The BSTc of these transsexual women was found to be similar in size to that of natal female controls, while that of homosexual men was found to be similar in size to that of heterosexual male controls. As all male-to-female transsexual individuals had received cross-sex hormone therapy (both estrogen and cyproterone acetate), attempts were made by the authors to control for the effects of adult hormone levels by including in the study a natal woman who had suffered from an adrenal tumor causing high levels of circulating androgens as well as two post-menopausal women, all of whom were found to have a normal female-sized BSTc, and a natal man whose adrenal tumor resulted in high blood levels of estrogen, whose BSTc was male-typical in size.

A follow-up study by Krujiver et al. (2000) using many of the same brain samples as Zhou et al. 1995 counted the number of neurons within the BSTc, finding nearly twice as many neurons in the BSTc of both heterosexual and homosexual men (as well as in the one female-to-male transsexual individual in the study), with similar neuron numbers between natal female controls and male-to-female transsexual individuals. Since the lack of circulating androgens in the male-to-female transsexual group might have skewed results, the results from two men orchiectomized due to prostate cancer were included in the male sample, both of whom had male-typical neuron numbers; the inverse was true of two post-menopausal female controls and a

25-year-old woman with Turner syndrome, all of whom had female-range neuron numbers. A final sample from an 84-year-old man with strong cross-sex affiliation that had neither received any form of HRT nor sex reassignment was also found to be in the female range for neuron count.

Results from the two studies above were somewhat tempered by the discovery that the sexual differentiation in BSTc volume is not apparent before adulthood (Chung et al. 2002). One critique of the brain-sex theory of transsexualism (Lawrence 2007) viewed this revelation as problematic, since transsexual individuals often report cross-sex feelings beginning in childhood, before the sexual differentiation of the BSTc becomes measurable. Since atypical fetal hormonal exposure has been implicated in cases of intersex disorders and potentially transsexuality as well (Swaab 2004), Chung et al. 2002 posited that the processes set in motion in the womb may only become apparent in the BSTc later. Lawrence 2007 also criticizes Zhou et al. 1995 and Krujiver et al. 2000 for stating that adult sex hormone levels had not seem to impact their studies, since their supposed controls (nontranssexual men and women who had either significantly high androgen or estrogen levels) had not experienced atypical sex steroid levels for any length of time comparable to the duration of cross-sex hormone therapy in the transsexual individuals studied. A study of eight male-to-female transsexual individuals and six female-to-male transsexual individuals both prior to and during cross-sex hormone therapy using magnetic resonance imaging (MRI) has confirmed the effect of cross-sex hormone therapy on brain size, with a decrease in hypothalamus and total brain volume concurrent with estrogen and anti-androgen treatment in male-to-female transsexual individuals and an increase in hypothalamus and total brain volume in female-to-male transsexual individuals treated with androgens (Hulshoff Pol et al. 2006).

More recent analyses have attempted to resolve the flaws in previous study designs through both the inclusion of participants who have not yet received cross-sex hormone therapy and in differentiating their participant populations based on sexual orientation, most likely at the recommendation of gender psychologists who have posited divergent influences for androphilic and gynephilic transsexual women (see Bailey and Triea 2007, Blanchard 2008). Berglund et al. 2008 used MRI to record patterns of cerebral activation in twelve male-to-female transsexual individuals asked to smell the odorous steroids (more commonly known as pheromones, or chemicals secreted by the body that are believed to influence behavior) 4,16-androstadien-3-one (AND) and estra-1,3,5(10),16-tetraen-3-ol (EST). Similar to female controls, transsexual women showed activation in the hypothalamus on passively smelling AND, while passively smelling EST activated the amygdala and the piriform cortex; the overall pattern of activation among transsexual women differed significantly only from the male controls, with results being closest to those of female controls. The exclusive recruitment of gynephilic male-to-female transsexual individuals controlled for the possible effect of sexual orientation on activation patterns, and because participants had no history of cross-sex hormone use, Berglund et al. 2008 gives credence to transsexuality as having a biological basis.

Garcia-Falgueras and Swaab 2008 used post-mortem brain material to determine whether the hypothalamic uncinate nucleus, composed of the interstitial nucleus of the anterior hypothalamus (INAH) 3 and 4, might reveal any sex atypical morphology among transsexual individuals. The most marked differences were found in INAH 3, which was found to be 1.9 times larger in control males than in control females and to contain 2.3 times as many cells, with male-to-female transsexual individuals having similar volume and number of neurons as control females and the sole female-to-male transsexual individual in the study matching control male

volume and neuron number. This study, using much of the same brain material as Zhou et al. 1995 and Krujiver et al. 2000, as well as incorporating new material, was unable to entirely control for cross-sex hormone therapy; however, because the INAH volume and neuron number for castrated men was found to be in the intermediate range between male and female controls, the lack of testosterone in male-to-female transsexual individuals due to hormonal and sex reassignment does not fully account for their female-range INAH 3 volume and neuron number. The same 84-year-old man with strong cross-sex affiliation that had neither received any form of HRT nor sex reassignment examined previously in Krujiver et al. 2000 showed a male-range INAH 3 volume, but a female-range neuron count. As the brain material studied was from a sample "mostly composed of non-homosexual early onset male-to-female transsexual people" (3145), no comparisons were made on the basis of sexual orientation.

Three studies into transsexuality and neuroanatomy carried out within the last year have all pointed to differences in male-to-female transsexual individuals compared to male controls. One study recruited 24 male-to-female transsexual individuals not yet treated with cross-sex hormones for MRI comparison of gray matter volume with control males and females (Luders et al. 2009). Researchers found gray matter volumes in male-to-female transsexual individuals comparable to that of male controls, except for a significantly larger volume of gray matter in the right putamen compared to control men, leading them to conclude that there may be specific neuroanatomical features associated with transsexual identity. The larger number of gynephilic transsexual women included in the sample prevented the authors from making comparisons on the basis of sexual orientation. Gizewski et al. 2009 also used MRI to compare cerebral activation among male-to-female transsexual individuals while viewing erotic material. While male controls showed significant activation in areas involved in emotional and erotic

processes—the thalamus, the amygdala, and the orbitofrontal and insular cortex—male-to-female transsexual individuals showed no significantly higher activation patterns relative to female controls. All transsexual participants were "non-autogynephilic" (441), therefore presumably androphilic. Finally, Schöning et al. in press compared the ability of male-to-female transsexual individuals to perform visual-spatial tasks both prior to and during cross-sex HRT in relation to male controls. Male controls had significantly greater activation in the left parietal cortex, a region associated with mental rotation processes, while both transsexual groups showed stronger activation in the temporo-occipital regions independent of cross-sex hormone therapy. The transsexual groups were composed of participants of various sexual orientations.

In the course of my research, I also came across a small number of studies concerning possible genetic predispositions for transsexuality. Though the first found no correlation between steroid 5-alpha reductase (SRD5A2) polymorphism and either female or male transsexuality (Bentz et al. 2007), two more recent studies purport to have found other genetic associations. According to Bentz et al. 2008, being a carrier of the mutant CYP17 -34T>C C allele (which encodes 17α-hydroxylase) is significantly associated with female-to-male transsexualism, though not male-to-female transsexualism. Hare et al. 2009 have reported a significant association with male-to-female transsexualism and the AR allele, with transsexual individuals having longer AR mean repeat lengths than male controls, leading the authors to speculate that such reduced androgen and androgen signaling might contribute to the female identities of male-to-female transsexual individuals.

The Impact of Hormone Replacement Therapy

My search for articles was carried out on PubMed, using the search queries "transsexual hormones" and "transsexual sex steroids." These queries returned approximately 100 results,

from which I collected several dozen having direct bearing on the issues of physiological change due to HRT. As previously stated, most of the research returned was from those countries with active gender clinic programs, the Netherlands in particular, with gender teams from other European countries providing nearly all of the remainder of relevant articles. By dividing the teams' findings according to the body processes affected, I will address the changes (or lack thereof) incurred during cross-sex HRT.

The most common hormonal treatments reported in the literature are oral 17ß-estradiol valerate, 2–4 mg/d or transdermal 17ß-estradiol, 100 µg twice a week (preferred for those over forty years old due to increased risk of changes in hemostatic variables with oral estrogen) for male-to-female transsexual individuals, or in the case of female-to-male transsexual individuals, intramuscular injections of testosterone esters of 200-250 mg every two weeks, or (where available) testosterone undecanoate at 1000 mg every ten to twelve weeks (Gooren et al. 2008) Many, such as Gooren, view the addition of progesterone to the male-to-female HRT regimen as unnecessary; however, comparisons of the breast tissue of male-to-female transsexual individuals to that of men who developed gynecomastia (mammary enlargement) due to prostate cancer treatment point to the need for progesterone (or any progestative agent) for full development of the female breast (Kanhai et al. 2000), leading many endocrinologists treating male-to-female transsexual individuals to prescribe either progesterone or an anti-androgen (i.e. anti-testosterone) with progestative properties such as cyproterone acetate. The addition of a gonadotropin-releasing hormone agonist (GnRHa) to the standard male-to-female estrogen treatment has been found to sufficiently induce impairment of testosterone production without the use of cyproterone acetate (Dittrich et al. 2005).

Some of the most apparent physical transformations experienced by transsexual individuals are those relating to adipose tissue and lean muscle mass. Anthropometric measurements of male-to-female transsexual individuals reveal increased subcutaneous fat deposits, with a proportional increase in visceral fat and a decrease in thigh muscle (Elbers et al. 1999). Compared to controls, they exhibit lower total and regional muscle mass and lower muscle strength in addition to higher total and regional fat mass (Lapauw et al. 2008). Breast tissue formation begins shortly after commencement of HRT, with maximal development usually reached after two years; because of the relatively larger dimensions of the male chest, reportedly up to half of HRT-treated male-to-female transsexual individuals will be disappointed with final breast volume and pursue breast augmentation surgery (Gooren 2005). For female-to-male transsexual individuals, the thigh muscle area increases, while subcutaneous fat deposition, especially at the hips and thighs decreases, but slight increases in visceral fat are also measured (Elbers et al. 1999). The clitoris becomes larger, and in some cases, becomes sufficient for penetrative intercourse (Gooren 2005). The breasts show marked reduction of glandular tissue and prominence of fibrous connective tissue (Slagter et al. 2006), though reconstructive surgery of the chest is almost always necessary in order to approximate the male chest. The addition of a dihydrotestosterone (DHT, the strongest metabolite of testosterone responsible for many male secondary sex characteristics) blocker to the HRT regimen results in a failure to gain lean mass, suggesting that DHT may play a role in muscle growth (Meriggiola et al. 2008).

Bone density also undergoes significant changes during the beginning of cross-sex HRT. One study of male-to-female transsexual individuals found lower bone mineral content and areal density of the lumbar spine, total hip and distal radius, and smaller cortical bone size compared to controls (Lapauw et al. 2008). Conversely, Sosa et al. 2003 found lower values for free

testosterone (i.e. testosterone not bound to receptors) and higher values for bone mineral density both in the lumbar spine and in femoral neck, leading the researchers to conclude that long-term estrogen administration to natal males may produce an increase in serum estradiol, contributing to better bone health. This finding is corroborated in Reutrakul et al. 1998, which also found long-term estrogen exposure to be correlated with an increase in bone mineral density. Findings related to the effect of testosterone on bone health of female-to-male transsexual individuals remain less clear, given the ability of testosterone to aromatize into estradiol; according to Gooren and Giltay 2008, adequate doses of testosterone can preserve bone mass in genetic females, and "the best predictor of bone loss was the elevation of serum LH levels." For female-to-male transsexual individuals, HRT with letrozole, an aromatase inhibitor that blocks the synthesis of estrogen, in addition to testosterone undecanoate administration, resulted in a decrease of bone mineral density by an average of 0.9 g/cm^2 (Meriggiola et al. 2008).

Skin and hair growth also see changes due to cross-sex HRT. Following the suppression of androgens in male-to-female transsexual individuals, hair growth continues but at a slower rate, and all parameters of hair growth and sebum production decline with the exception of facial hair (Giltay and Gooren 2000). The decrease in sebaceous gland activity may result in dry skin and brittle nails (Gooren 2005). For female-to-male transsexual individuals, the process of body hair accumulation seems to mimic that of natal men at puberty, in that it occurs over a matter of years rather than in the shorter time frame that other changes, such as fat distribution, take place (Giltay and Gooren 2000). Acne is estimated to occur in forty percent of patients, as well as an irreversible deepening of the voice at six to ten weeks following first testosterone administration (Gooren 2005).

The introduction of exogenous hormones into the bodies of transsexual individuals causes in a plethora of modifications in the serum levels of endogenous hormones as a result of the feedback loops that govern the hormonal axis in the body. Levels of leptin, a hormone that helps to regulate energy intake and its expenditure, have been shown to be lower in male controls than among female controls and male-to-female transsexual individuals, while adiponectin, a protein hormone that modulates metabolism including glucose regulation, was found in higher levels in male-to-female transsexual individuals than in their female-to-male counterparts (Resmini et al. 2008). A similar study found decreased adiponectin levels, as well as decreased leptin and high-density lipoprotein cholesterol in female-to-male transsexual individuals in spite of the increase in body mass index, waist circumference, and lean body mass following six months of testosterone administration, increasing cardiovascular risk for female-to-male transsexual individuals (Berra et al. 2006). Estrogen HRT for male-to-female transsexual individuals has also been shown to be related to significantly raised levels of nitrous oxide, a neuronal mediator naturally occurring endogenously, and reduced levels of both Interleukin-6, a signaling molecule that stimulates energy mobilization which leads to increased body temperature, and superoxide dismutase, an enzyme that acts as an antioxidant defense in somatic cells (Wilson et al. 2006). In male-to-female transsexual individuals, the concentration of lipid/lipoprotein cholesterol and sex hormone-binding globulin (SHBG), the glycoprotein to which sex hormones are attached in transport throughout the body, have been reported within female norms (Damewood et al. 1989). High levels of estrogen have also been correlated to an increase in prolactin secretion, which may result in prolactinoma, a tumor of the pituitary gland, beyond the normal prolactin levels of less than 500mIU/L (Goh and Ratnam 1990). Plasma total homocysteine, an important amino acid, is also linked to sex hormone levels, having been shown to decrease in male-to-female

transsexual individuals and to increase in female-to-male transsexual individuals along with changes levels of creatinine, a by-product of muscle metabolism excreted by the kidneys, and albumin, the principal protein in blood plasma which helps maintain the body's fluid balance (Giltay et al. 1998). In male-to-female transsexual individuals, estrogens and anti-androgens reduce circulating levels of phenylalanine, tyrosine, and tryptophan (essential aromatic amino acids and that are precursors of catecholamines, the "fight-or-flight" hormones released by the adrenal glands in response to stress, as well as serotonin, a neurotransmitter), while testosterone administration increases plasma tryptophan levels in female-to-male transsexual individuals (Giltay et al. 2008). In an example of genetic expression perhaps taking precedence over sex hormone levels, cross-sex hormone administration fails to alter the plasma levels of homovanillic acid (HVA), a metabolite of the neurotransmitter dopamine, in transsexual patients (Giltay et al. 2005).

Cognitive changes have also been reported due to cross-sex HRT. Miles et al. 1998 suggested that estrogen improved the verbal memory of male-to-female transsexual individuals, though a more robust study design later failed to duplicate that result (Miles et al. 2006). Reported with androgen administration to female-to-male transsexual individuals is an increase in spatial ability performance, sexual arousability, and aggression proneness (Gooren and Giltay 2008). Hypoactive sexual desire disorder (HSDD) is reported in one-third of post-operative male-to-female transsexual individuals, though it is claimed that this is not substantially different from natal female controls, despite the lower free testosterone levels of hypogonadal male-to-female transsexual women compared to natal women (Elaut et al. 2008). The perception of pain has also been studied in transsexual populations, with the implication that estrogen

administration may worsen feelings of pain in male-to-female transsexual individuals while testosterone may lessen pain in female-to-male transsexual individuals (Aloisi et al. 2007).

The risks inherent in cross-sex HRT are numerous, but rates of mortality have not been reported any higher than in comparison groups (van Kesteren et al. 1997). The administration of oral ethinyl estradiol to male-to-female transsexual individuals has been largely discontinued by gender clinics (though unfortunately still prescribed by many uninformed physicians) due to its association with resistance to the anti-coagulating effects of Proteins C and S, with the molecular structure of ethinyl estradiol contributing to the risk of venous thrombosis (Toorians et al. 2003) in 2-6% of male-to-female transsexual individuals treated with it (van Kesteren et al. 1997). Though rare, the literature has reported cases of meningothelial meningioma (Gazzeri et al. 2007) and mammary fibroadenoma (Kanhai et al. 1999), as well as cases of breast cancer in both male-to-female and female-to-male transsexual individuals, prolactinoma, ovarian cancer, benign prostatic hyperplasia, and prostate cancer, and cardiovascular disease (Gooren 2005).

Finally, Cohen-Kettenis and Goozen 1998 discusses the role that a luteinizing hormone-releasing hormone (LHRH) agonist can play in the treatment of young persons presenting for treatment as potentially transsexual. Treating adolescents with cross-sex HRT can be potentially dangerous given common childhood experiences of cross-sex identification, but not treating them can be equally traumatizing to those individuals who are indeed transsexual and do not want to undergo the pubertal processes of their birth sex. LHRH agonists bind to the pituitary to prevent the secretion of luteinizing hormone and follicle-stimulating hormone and therefore the downstream production of sex hormones in the gonads, suppressing puberty in the individual until he or she reaches an age (usually around sixteen years old) that the decision can be made to begin cross-sex HRT. The suppression of puberty can be of immense benefit to children who

strongly identify as gender variant, preventing those physiological developments that cannot later be altered through cross-sex HRT, such as the increase in skeletal robusticity, lowering of the voice, and development of facial hair among males and the widening of the hips and breast growth in females.

Implications of the Literature

On the whole, transsexual individuals appear to adapt well to the physiological changes brought about by cross-sex hormone replacement therapy. The increase in prescription of bioidentical 17ß-estradiol for male-to-female HRT in lieu of the previous standard of ethinyl estradiol has resulted in lower incidences of deep-vein thrombosis, leading to lower rates of complications. It is clear that cross-sex HRT has the ability to affect a wide array of changes to the bodies of transsexual individuals to help align their physiologies with their internal sense of gender identity. There seems to be a positive correlation with treatment at a young age and psychological functioning and well-being (Cohen-Kettenis and Goozen 1997). This is unsurprising, since one measure of the success of cross-sex HRT is partly a factor of the age at which HRT is undertaken and the accumulation of time under such treatment. The greater the concordance of the transsexual individual's body to that of the target sex, the greater the chances of being socially legible (or "read") as a member of that sex and gaining the gendered experience and acceptance that is the goal of sex transition. The ability to conform to mainstream expectations of the male or female body can reduce the dysphoria that transsexual individuals experience, potentially giving them greater confidence and ability to interact socially.

Recent findings in neural imaging studies with transsexual individuals have given greater credibility to theories of the gendered brain, which had been in question given the methodological shortcomings of the first instances of brain research using post-mortem material

from transsexual individuals. Lawrence 2007's call to "abandon the brain-sex theory of transsexualism" appears to have come too soon, as cross-sex anatomy has now been confirmed in both HRT-treated and non-treated individuals. Though Berglund et al. 2008, Luders et al. 2009, Gizewski et al. 2009, and Schöning et al. in press have refuted critics' assertions that cross-sex neuroanatomy is largely due to cross-sex HRT, the sample sizes of these studies as well as their novelty prevent any definitive statements as to the congenital nature of transsexuality and will therefore require continued research. In addition, while some of these studies specifically chose populations of either androphilic or gynephilic transsexual women for their research, none of them were able to compare results between these two groups, leaving Blanchard's contention that "the brains of both homosexual and heterosexual male-to-female transsexuals probably differ from the brains of typical heterosexual men, but in different ways," (2008:437) unchallenged. According to Garcia-Falgueras and Swaab 2010, "sexual differentiation of the genitals takes place in the first two months of pregnancy and sexual differentiation of the brain starts in the second half of pregnancy, [therefore] these two processes can be influenced independently, which may result in extreme cases in transsexuality" (22). If this statement is accurate, the presence of both neuroanatomical as well as genetic evidence of cross-sex identity may point to either an atypical fetal hormonal environment produced as a result of genetic prearrangement or a multiplicity of processes resulting in cross-sex identity of different intensity among different individuals. In short, biological evidence supporting Blanchard's claim of different etiologies for male-to-female transsexualism has neither been offered nor disproven at present.

Support for transsexuality as an intersex condition may have substantial medicosocial implications. If transsexual individuals' claims to gendered identity are reflected in their

anatomy, treatment to align their bodies with their internal sense of gender might be reframed as correction for congenital abnormality, no longer requiring justification for treatment through the pathologizing "gender identity disorder" diagnosis common today. Indeed, if there were a biological basis for cross-sex identity, assertions made by transsexual individuals to feeling differently gendered from childhood would essentially be validated through the power that medical authority represents. If that were the case, would referring to such individuals as male-to-female transsexuals still make sense if their original state is not accurately reflected in the term "male" (or vice-versa for female-to-male transsexuals)?

Since the establishment of the SOC in 1979, the medical professionals who are the direct providers of cross-sex HRT and surgery have officially relegated the task of determining patient eligibility for these interventions to the world of psychology and mental health care professionals. As such, the research that links transsexuality to neuroanatomy may conceivably undermine the appropriateness of the GID diagnosis. For those who disagree with the categorization of gender variance as mental disorder, the ability to point to a biological basis for their identities may be seen as liberating, since such studies would provide evidence that their cross-sexed identities are not a product of an impaired mind. It could also be a double-edged sword, as not all individuals who desire medical intervention may possess cross-sexed neuroanatomy, and might therefore be construed as ineligible for treatment.

In addition, institutional belief in biology-based difference has also been associated in the past with attempts to alter such differences in the form of eugenic projects. If a "transsexual brain" could be identified, it might be perceived as the object in need of correction as opposed to the primary and secondary sex characteristics. Much like the search for the "gay gene," studies into brains of transsexual individuals carry substantial risks, as the application of such findings

cannot be guaranteed in advance. In Iran, the diagnosis of gender identity disorder requires that the individual receive sex reassignment surgery, whether they want it or not; a means of determining cross-sex neuroanatomy might be used by ideologically conservative regimes to either forcibly convert or even exterminate gender variant individuals. Even if cross-sexed identity is reflected in neuroanatomy, it is unclear whether this fact would improve the treatment options of transsexual individuals. Though in America it could result in insurance coverage under the rubric of correction of a congenital disorder, a resolution released in 2008 by the American Medical Association has already plead the case for the medical validity of doctor-ordered transsexual medical treatment and the necessity of its coverage by insurance (AMA 2008).

For all of the good that a diagnosis of a neuroanatomical intersex condition could do in social terms, since a biological foundation might reduce the stigma of violations of heteronormativity so often framed as a matter of "choice" or "sin," the practical effects of treatment seem almost irrelevant, as there is no reason to believe that transsexuality confirmed through anatomical observation would be any more "real" than self-reported transsexuality. Indeed, what makes a transsexual individual is their desire to align their bodies with their internal sense of gender (all else being equal) except in cases of schizophrenia or other unrelated mental disturbances. Whether such a condition can be confirmed neuroanatomically or not may amount to Blanchard's parsing of "homosexual" and "autogynephilic" transsexuals—a worthy academic pursuit, perhaps, but potentially just as harmful in its implications for how health care professionals might treat "different types" of transsexual individuals. If such brain research proves fruitful, the common arguments among certain transsexual individuals about who is a "true" transsexual or who transitioned for the "right" reasons could simply be replaced by

arguments about who can claim the mantle of having of "naturally" female brain versus the "unnatural" decision to transition anyway in spite of having a male brain. Examples of the potential for this slippage will be presented in the next chapter in the form of the Harry Benjamin Syndrome movement.

Improving the lives of transsexual individuals will likely have more to do with the study of the outcomes of treatment rather than focusing the processes underlying coming *into* the diagnosis of GID. All of the respondents to my questionnaire who report HRT use claim satisfaction with the changes that HRT has brought to their bodies and the associated mental effects of their reduced bodily dysphoria. Though my own questionnaire can make no claims to scientific validity or proper representation of gender variant individuals, this finding that GID-diagnosed individuals respond well to cross-sex HRT is well supported within the literature, which also shows that HRT can make many of the substantive changes that transsexual individuals desire. As there have been to date no studies on the incidence of post-operative regret among self-referring transsexual individuals and the literature affirms the positive effects of treating self-identifying transsexual individuals, future medical studies should focus on measuring outcomes across multiple mechanisms for treatment (traditional American SOC, modified local SOCs, and self-determined treatment plans) to determine how different protocols may or may not result in differential outcomes.

CHAPTER 4 – "TRANSGENDER" AS POLITICAL IDENTITY

"Transgender" has become an extremely common way of referring to gender variant individuals, and its use by LGBT activists is paralleled with its popularity in media. It remains highly controversial both outside of and within gender variant communities, since it corrals many different individuals with different identities and different needs into a single sociopolitical grouping. Many of the themes discussed in this chapter are a result of my own participant observation in online "transgender" discussion boards, and original citations are pulled from the responses to my questionnaire returned by twenty-one individuals (see introduction chapter for more information). I demonstrate how the "transgender" community is home to multiple schisms in terms of self-identification and what constitutes gender variance. Some transsexual individuals prefer this term because they feel that their sexed body is what is undergoing alteration due to medical intervention, while other individuals who would have traditionally been considered transsexual accept the label of "transgender" as less stigmatizing. The inclusion of both individuals who wish to alter their bodies and those who do not under the "transgender" umbrella is a source of tension, as the acceptance of medical authority by transsexual individuals is seen as undesirable or stigmatizing to other gender variant individuals, while some transsexuals fear that their cross-sex essentialist narratives may be undermined through their association with other gender variant individuals.

Despite the reorganization in the West of nonheteronormative identity and behavior along the lines of "sexual orientation" (i.e. homosexuality) and "gender identity" (i.e. transgenderism), "transgender" as a classification system cannot be considered entirely hegemonic. In his ethnography of the category of "transgender," David Valentine (2007) finds that members of underprivileged racial and class backgrounds are less likely than white, middle- and upper-class

individuals to self-identify as "transgender," instead favoring terms such as "gay," "queen," "fem," or "butch" to describe their sexual or gendered identities. Valentine argues that

> in mainstream gay and lesbian politics, difference from heteronormativity is that which is to be elided. That is, contemporary mainstream gay and lesbian politics works to minimize the difference between homosexuality and heterosexuality, precisely by removing the visibility of (class-inflected and racialized) gender difference from the category "gay." [133]

Because contemporary gay identity has been shaped by activists to entail gender normativity, individuals with reduced access to such discourses of political identity are at risk of being "left behind" by the communities and social services that purport to represent them, not to mention the potential for the erasure of their identities due to the cultural illegibility of the terms that they use to describe themselves.

Though Valentine does an excellent job describing the fractures in "transgender" self-identification according to class, race, and age, one comes away from his ethnography with the impression that the category of "transgender" is deployed in a relatively uncomplicated way among those with greater access to mainstream representations of cross-gender identity. This may have to do with the milieux of gender variance in which his research was conducted and their associated participant population, or perhaps that a shift in debate that has occurred in the time between our studies. In my own experiences and research, I have found the label of "transgender" to often be contentious, but in a different manner than Valentine describes. Rather than relating to the tensions between the conceptualization of sex and gender as disparate categories, the problems with "transgender" have to do with the multiplicity of meanings assigned to it by the different groups subsumed under its umbrella. Much of the debate to which I have been a witness has been centered on the disagreement whether "transgender" identity constitutes either a liminal or permanent state. The implications of this question are seen by

some as impacting negatively the identity claims of transsexual individuals, while others are not bothered by the notion of a "transgender" identity. To elucidate these differing points of view, I will rely on the answers received to my questionnaire, whose respondents were recruited from popular online discussion boards where gender variance is discussed.

Elaboration of "Transgender" Identity

"Transgender" as an umbrella term for gender variant identities is accepted by many who view it as useful in terms of sociopolitical organization and self-identification. Following the questions, "Do you identify as transgender?" and "Why?", fourteen out of the total of twenty-one respondents clearly reply in the affirmative, most using the simple "transgender" in their responses, though in some cases this was conjugated in forms such as "transgender female" (for a female-identifying person) or "trans man" (for a male-identifying person). A few respondents give more nuanced answers, such as "Firstly, I identify as female. Transgender is more of a term I can use to help my friends/family understand easier." This respondent, though privileging her female identity, regards "transgender" as an established shorthand that sums up her gender history in acceptable way for others' comprehension. Another replies that "I identify as a male person whole happens to be trans. Trans is a part of my identity, but it does not encompass my identity." Yet another respondent replies in the affirmative, followed by "I am transsexual, which as a condition is considered part of the transgendered spectrum." Other examples of respondents' acceptance of "transgender" as an aggregation of identities include the answers "Transgender(ed) is a generic term that encapsulates many identities," "the label transgender is commonly used to refer to all gender/sex different people," and "transgender refers to anyone who does not agree or fit in typical gender roles—and no, I don't mean homosexuals. It's talking about transsexuals, cross-dressers, anyone who's intersex, anyone who identifies as

genderqueer." A fifteenth respondent's answer could not be coded as affirmative or negative, as their reply of "I identify as transsexual" could be taken, as I will show, to mean either that they do self-identify as "transgender" or that they do not.

For some respondents, there appears to be substantial slippage between the terms transsexual and "transgender." The following are several examples of responses to the query, "Do you identify as transgender?"

> Yes, because since my diagnosis and the commencement of treatment in 2009 I have been happier, felt more complete and more fulfilled than I ever did in my previous 50 years.
>
> Yes. I've always known that I should have been born into a female body.
>
> Yes, I identify as transgendered. I have known for as long as I realized that there was a difference in genders that I was never meant to be the gender that I am. My closest friends knew it, and finally I have accepted it publicly.
>
> Yes, I identify as transgender. Though my body is male, I feel that I am female. I also plan to change my body, as much as I can, to fit the gender I identify with. "Transgender" is the term that I prefer; I'd rather use it than "transsexual," for instance.

While all of the above respondents report "transgender" self-identification, their statements of having been meant to be female rather than male all along closely resemble those of traditional transsexual narratives. For the first three respondents it is unclear whether their "transgender" identities are synonymous with transsexuality, or something different; for the final respondent, "transgender" is positioned as preferable to the term transsexual. This sentiment is echoed in another's statement that "I prefer the term trans or transgendered over transsexual, merely because of the strong stigma associated with the term, mainly because of the lack of knowledge and understanding by general society," as well as with the dissatisfaction with "transsexual" reported in response to the questionnaire item about GID. For these respondents, "transsexual" harbors too many negative associations (most likely due to its link to the pornography and sex

industries), while “transgender” is a more neutral term that can carry the same strong gender variant meanings of “transsexual” but without its accumulated historical baggage.

Because of this study took place online, I am not able to make any assertions as to the socioeconomic status or race of the respondents who view “transgender” negatively. However, as I discuss later in this chapter, the economic preconditions that allow an individual to afford medical intervention do suggest that claims to lifelong cross-sex affiliation are more easily promulgated where that identity can be fully actualized through complete hormonal and surgical transition. Much like in Valentine’s study, where the gender variant identities of the lower class and racial minorities were marginalized by the new “transgender” taxonomy, it makes sense that those individuals who can more effectively assimilate into the broader society as ordinary men and women are more likely to prefer that to the maintenance of a gender variant identity. Such an inclination may also have to do with one’s own politically informed perception of the validity of a confirmed gender variant identity, with those who tend towards social conservatism more likely to reject their own membership to such a stigmatized minority group.

Viewing the term “transsexual” as irreparably tainted is not, however, an opinion shared by all gender variant individuals. Six respondents choose “transsexual” as the term with which they identify, five of these doing so while rejecting the term “transgender” as applicable to their identities. For three of these six respondents, “transgender” is regarded as problematic because to them it negates their understandings of their gendered selves as continuous and permanent. According to one respondent, “The term transgender would suggest a transition of gender. My gender has always been female. I use the term transsexual/transsexed as a definer for my body’s physical condition, i.e. sex.” Another rejects “transgender” on the same grounds, stating “I do not identify as transgendered; I identify as a transsexual. I do so because transgendered implies

that I am changing my gender, whereas transsexual implies that I'm changing my physical sex." The third and final respondent to espouse this view says "I consider myself to be transsexual because I identify as a woman and have every intention of having corrective surgery as soon as it's possible." For these respondents, "transgender" identity represents a threat to the cogency of their claims to a lifelong female gender identity. A fourth respondent makes the same implication in his support for a transsexual identity and his statement that "transgender refers to anyone who does not agree or fit in typical gender roles," a definition that he presumably doesn't feel to be applicable in terms of his own gender identity. A final respondent to elaborate on their transsexual identity notes that "transgender encompasses transvestites, cross-dressers, the intersex, drag queens, drag kings, etc., which I prefer not to be associated with." Thus, among respondents who report a preference for "transsexual" over "transgender," their difference from nontranssexual individuals is described as an incongruence of the body, framing that difference in terms of sex rather than gender, which is described as stable and as no different from nontranssexuals. As can be seen in the case of the final respondent, this emphasis placed on gender normality may correspond to a dislike for (or, at least, a desire not to be seen as similar to) those "transgender" individuals who do violate heteronormativity, as I will discuss later in this chapter.

An additional framing of "transgender" identity, only supported explicitly by two respondents, is the concept of "transgender" individuals as inherently different from those who are neither transsexual nor "transgender" (referred to by the following respondent as "cissexuals"). According to this respondent, "Some transsexuals think of themselves as not different from cissexual men and women, but I really don't; I think there are significant differences between us and cissexual people that should be embraced, not ignored." This

interpretation of "transgender" identity is also associated with the inclusion of gender variant individuals under the "transgender" umbrella who do not identify as belonging to the sex not assigned at birth, such as transvestites, cross-dressers, drag queens, as well as individuals who reject either maleness or femaleness, such as one respondent who says "I identify as transgender because I do not fit either extreme of the gender continuum (male–female)." In many ways, this form of "transgender" identity runs counter to the claims of transsexual individuals, who claim that their bodies are not in accord with their gender identity. Instead, it is related more closely to the original intent of Virginia Prince, who told Leslie Feinberg that "There had to be some name for people like myself who trans the gender barrier—meaning somebody who lives full time in the gender opposite to their anatomy. I have not transed the sex barrier" (Feinberg 1996:x). Rather than concentrating on the body as the source of their gender dysphoria, "transgender" individuals according to this model do not necessarily believe that there is anything to be corrected in their sexed bodies but rather identify with a gender identity that defies social norms.

Much like the attempts of gay activists to label premodern figures such as Alexander the Great or Shakespeare as homosexual, in opposition to the claims that position homosexuality as a distinctly modern identity cultivated by the individual liberties afforded by capitalism (D'Emilio 1997), "transgender" activism has also seen appeals to the notion of a "transgender" identity that crosses cultures and epochs. Feinberg's *Transgender Warriors* (1996), Bornstein's *Gender Outlaw* (1994), and Brown and Rounsley's *True Selves* (1996) exemplify the primordial "transgender" argument, often positioning gender variants as the shamans and ritual-keepers of their societies. Towle and Morgan (2002) criticize the appropriation of anthropological texts in these narratives both for their romaniticization of gender variant identities outside of the modern West and their ahistoric insistence on a universal sameness of "transgender" individuals. Despite

their lack of academic rigorousness, these accounts remain popular among "transgender" groups for their positive portrayals of gender variance and their reaffirmation of the role of culture in shaping opinions towards gender variance.

One important feature that distinguishes these different concepts of "transgender" appears to be its permanence (or lack thereof) as an identity. For the above respondent, "transgender" individuals are inherently different from normatively sexed and gendered people, and that difference is meant to be celebrated for it gives the gender variant individual insight into sex, gender, and potentially, spirituality, that others do not possess. On the other hand, some individuals regard their difference as having nothing to do with gender, but with the body; once surgically corrected, many of these individuals view the labels of "transgender" and transsexual as no longer applicable to their state of being. This split is remarked upon in the literature, though in such a way that it does not accurately reflect the terrain of gender variance today. In her introduction to the anthropological literature on crosscultural sex and gender variation, Serena Nanda (2000) identifies mind/body dualism as the basis for the invention of transsexuality in the West. According to Nanda,

> The transsexual is only a transitional status: a person is a transsexual when s/he is in a temporary, in-between sex status, moving from one sex to the other….The concept of gender identity permits the conflict expressed by transsexuals to be understood as a discordance between anatomy and subjectively experienced gender: the male or female organs are viewed as "merely" a mistake that must be corrected. [94]

Nanda defines transsexuality as a liminal, or temporary, shift between the two recognized sexes. While she acknowledges the transsexual narrative of stable gender identity, she argues that this is not always true, as studies such as Bolin's (1988) have demonstrated a process of reconceptualization of self that occurs through the experience of living as their sex of affiliation.

Nanda seems to believe that transsexuality is outmoded, often using the past tense to describe transsexual identity prior to it being largely replaced by a system she refers to as "transgenderism," embodied by "transpeople (transgenderists) [who] do not consider themselves limited to a choice of one of two genders" (98). She states that

> Unlike transsexuals of the 1970s and 1980s, transgenderists today challenge and stretch the boundaries of the American bipolar system of sex/gender oppositions and renounce the American definition of gender as dependent on a consistency of genitals, body type, identity, role behaviors, and sexual orientation. [99]

With the increase in "transgender" accounts published in the late 1990s that stressed gender variance as the dominant theme, Nanda was most likely writing about what appeared to be a shift in the identity formation of sex/gender variant individuals. In retrospect, it is perhaps clearer that transsexual (i.e. appropriately gendered, inappropriately sexed) narratives have not been sublimated by the "transgender" paradigm, as evidenced by the continued existence of self-identified transsexual individuals as well as "transgender" identifying individuals who use this term to signify the same meaning as "transsexual."

Though Nanda may have jumped the gun by favoring "transgenderism" as a more contemporary model of Western sex/gender variance, it is clear that the discourses surrounding transsexuality have changed. A copy of the SOC from its third revision in 1981 details the requirements for HRT and surgeries based upon the diagnostic criteria for transsexuality in the DSM-III, which at the time included the "persistant wish to be rid of one's own genitals and to live as a member of the other sex" (APA 1980:261-262). The current DSM no longer makes reference to the dislike of one's genitals for diagnosis, and the SOC now states that HRT is not contraindicated in individuals who desire neither cross-sex living nor surgery. While this change in diagnosis is likely partly attributable to the recognition by health care professionals that early transsexual accounts of genital hatred had the effect of incorrectly applying that expectation to

all transsexual individuals, it is also likely that the rise in "transgender" consciousness may have altered the opinions of those who formerly would have been considered transsexual towards a "one-size-does-not-fit-all" approach to transition. At the same time, the line between transsexuals and nontranssexuals has blurred, as the defining feature of transsexuality, the desire to permanently alter one's sexed body, is now also a common feature of individuals who ascribe to the many forms of "transgender" identity. Among the eighteen respondents to my questionnaire who are either on HRT or planning to use HRT, only twelve report having had some form of gender-confirming surgery or the desire to do so; three individuals report viewing surgery as an option to be decided later, two individuals did not specify their surgical status, and one stated their indifference, noting "I am perfectly contented to remain 'transgender' for the rest of my life" (a nineteenth individual with no plans for HRT reports a desire for mastectomy). Interestingly, most individuals who report having had surgery or a desire to do so stress in their responses the highly subjective nature of transition through their support of others who do not feel that surgery is a necessity, as illustrated by multiple variations on the response "I feel that for me, yes, [surgery] is necessary, but I know for many it isn't." Also, whatever their perceptions of their own sexed and gendered identities, the query as to whether the categories of "man" and "woman" are broad enough for all individuals to fit into either one of these categories received a negative response from all twenty-one respondents, with most referring to a "spectrum" of possible gender identities, indicating a fairly liberal attitude towards the self-identification of other "transgender" individuals.

Differential Approaches to Gender

The "transgender" umbrella combines multiple identities into a singular sociopolitical unit that has become shorthand for understanding gender variance in mainstream culture. As I

have shown, this coalition is not without its internal stresses, especially in terms of individuals' stances on their own gender identities in relation to gender heteronormativity. The association of both individuals with an internal sense of cross-sexed gender and individuals who either feel no allegiance to either gender or who pointedly question the social construction of gender identities is the result of a "transgender" project that is founded more upon the principle of individuals' transgression of gender normativity rather than the diverse motivations and identities behind these. A disconnect remains between the way that gender is understood by "expatriates" of the gender system and the way that transsexual individuals conceptualize their own identities. Attempts by gender theorists to elucidate the issues of gender "transgression" have contributed to a widened gulf between those who theorize gender and differently-gendered identities and those who have lived experience as transsexual people. This division has been characterized by an emphasis on "performativity," or the gender binary as culturally constructed, on the part of social theorists, as opposed to the essentialist narratives of self-identified gender often reported by transsexual people. This is evidenced by the differential usage of the interventions (hormonal and surgical) sought out by gender variant individuals to transform the body from an uncomfortable gender presentation to another that is more aligned with the inner sense of gender.

Christian Klesse has noted "the fact that in particular transgendered people assume centrality within Queer Theory as a sign for category crisis or deconstructive performativity, does not mean that their concerns are put central and addressed in a satisfying way within queer theory or politics" (2007:287). Because their gender identities are classified as liminal to the heteronormative gender binary—and therefore containing the seed of doubt that can disrupt the entire system—transsexual peoples' (as well as "transgender"-identified individuals as well) lived experiences are ripe for the examination of gender boundaries and expectations. According

to Klesse, "transgender" narratives purport to "reveal the fact that gender is instable, never self-identical and nothing more than the effect of the normative rules of citationality" (287).

These analyses stem from the work of Judith Butler, whose seminal *Gender Trouble* highlighted the shift in gender studies from a "natural" basis for biological sex to a model of sex as never preceding culture, thereby blurring the lines between the feminist concepts of sex and gender as separate entities. Butler refers to the naturalization of sex as "the repeated stylization of the body… within a highly rigid regulatory frame that congeal[s] over time to produce the appearance of substance, of a natural sort of being" (1990:33). In this line of argument, the bodies that are classified within science as either male or female do not intrinsically carry any further meaning than the ability to produce offspring; all other meanings attributed to having a penis or a vagina (indeed, the requirement for all individuals to have either one or the other, whether fertile or not), and even what sufficiently constitutes a penis or a vagina in "ambiguous" cases, are culturally mediated and cannot be said to reflect pure biological fact. Butler's theory, then, expounds upon Simone de Beauvoir's well-known maxim, "On ne naît pas femme: on le devient," by recognizing the continual enculturation necessary to produce "men" and "women," making the implication that perhaps everything that is labeled male or female could be due to the work of culture and not biological determinism.

From the perspective of gender variant individuals, this viewpoint could potentially be regarded as liberating, since the designations of "man" or "woman" are established as cultural processes rather than the result of mere one-to-one correspondences (i.e. man = penis or woman = vagina). For those "transgender" individuals who prefer to live in-between the culturally recognized boundaries of male and female, who feel that the trappings of either gender is for them only so much drag, a theory of gender which concerns itself predominantly with issues of

performativity may well be the most appropriate one. Consider the following quote from *Gender Outlaw* by Kate Bornstein, a performance artist who surgically transitioned from male-to-female in the mid 1980s:

> I know that I'm not a man—about that much I'm very clear, and I've come to the conclusion that I'm probably not a woman either, at least not according to a lot of people's rules on this sort of thing. The trouble is, we're living in a world that insists that we be one or the other—a world that doesn't bother to tell us exactly what one or the other *is*. [1994:8]

Also:

> I'm told I must be a man or a woman. One or the other. Oh, it's OK to be a transsexual say some—just don't talk about it. Don't question your gender any more, just be a woman now—you went to so much trouble—just be satisfied. I am *so* not satisfied. [145]

For individuals such as Bornstein, transitioning from one binary gender to the other under a traditional transsexual paradigm may prove to be unsuitable, especially when one's starting point is a gender identity firmly rooted neither in the culturally recognized camps of "man" and "woman." Bornstein says that she does not regret her sex reassignment surgery, since she prefers having a vagina to having a penis; though not transsexual in the traditional sense (i.e. having a strong sense of belonging to the opposite gender, but rather the "other" gender by default), surgery provided her with a chance to remake her own body in a manner that altered the male-gendered organ into something with which she could be more comfortable.

However, for many transsexual individuals, who, like normatively-gendered people, do feel an inner affinity for the designations of man or woman, a theory of gender which posits gender variant individuals as primary evidence for the performative nature of gender holds the danger of representing their gender identities as less "real" than the relatively unproblematic (or, at least, unquestioned) gender identities of non-gender variant people. As illustrated later in this chapter in my examination of "Harry Benjamin Syndrome," attempts by some transsexual

individuals to position themselves as inherently different from—and perhaps more deserving of medical treatment than—other gender variant individuals may be due to this perceived threat to their identities by those who "queer" gender. Jay Prosser (1998) identifies the difficulty in viewing gender variant individuals' struggles and identities as inherently subversive in terms of heteronormative gender:

> If, for queer theory, transition [from one sex to the other] is to be explored in terms of its deconstructive effects on the body and identity (transition as a symptom of the constructedness of the sex/gender system and a figure for the impossibility of this system's achievement of identity), I read transsexual narratives to consider how transition may be the very route to identity and bodily integrity. In transsexual accounts, transition does not shift the subject away from the embodiment of sexual difference but more fully into it. [6]

Transsexual individuals use hormonal and surgical interventions in order to make their bodies match an internal sense of gender identity and to erase as much as possible the markers of the sex to which they were assigned at birth. For Prosser, this makes them fundamentally different from "transgender" individuals (in spite of the contemporary umbrella usage for "transgender" under which transsexuality and all other forms of gender variance are subsumed), who deploy the symbols of gender in unexpected or contradictory ways as an expression of their own non-binary gender identity.

Contrast the viewpoint of Bornstein with that of Aleshia Brevard, whose narrative of sex reassignment surgery in the early 1960s reflects the more gender essentialist themes of transsexual autobiography:

> For Benjamin's Girls [patients treated by Dr. Harry Benjamin], womanhood and anonymity were dual goals. One could quietly have surgery, with the promise of a "normal" existence to follow. None of us knew what the long-term physical consequences of our actions would be. Few of us cared. We were interested in living peacefully in the present. [2001:29]

Brevard and her cohort pursued surgery not with the goal of becoming transsexual or remaining gender variant; "transsexual surgery," as Brevard terms it in her book, was the means to an end, the path that one would take to come out on the other side of the gender equation as female. This is very different from the outcome more common in post-modern "transgender" identities, in which the gray area between genders, the transition process, may turn out to be the final destination rather than the rite of passage it was for Brevard.

David Valentine comments on the harm that can be done to transsexual individuals as the result of this elision under the heading of "transgender" of the different objectives of different gender variant individuals. Valentine eschews Nancy Scheper-Hughes' assertion of "precultural" ethical stances (Scheper-Hughes 1995) by noting that what is perceived as violent to one party may be neutral or even liberatory to another. Despite the long and often painful interventions that many transsexual individuals undergo in their undertaking of living and being perceived by others as the sex with which they identify, those identities are regularly undermined in a society that often does not accept the validity of transsexual claims to cross-sex identity. In his ethnography of "transgender," Valentine remarks upon the claim of harm by one of his study participants due to the actions of one of Valentine's colleagues. Attempts to "queer" the boundaries of gender (especially by those who have pursued cross-sex HRT and surgery) can be perceived as a real threat to the identity claims of transsexual people. According to Valentine, "Cindy was angered by our analysis because she perceived it as an attack on her desire to live as a woman—and that such a transition would be re-read, re-represented, as nothing more than a falsity" (222). Not only does this reveal the differential power of figures of authority (such as academics) to frame discourse, but the inherent risks carried by the association within the "transgender" paradigm of individuals with dissimilar gender identities and attitudes toward

gender. In the following section, I will examine this viewpoint in a broad sketch of the opposition to "transgender" as an umbrella term for gender variance.

Anti-"transgender" discourse

In this discussion of the themes connected to anti-"transgender" ideology, I use a content analysis of several online web logs, or "blogs." As useful as such a content analysis of these blogs may be, this methodology is employed mainly as a result of the very condensed time in which this thesis was prepared. Though I would have preferred to carry out interviews or at least ask those with anti-"transgender" views to complete an in-depth questionnaire, time constraints as well as a limited set of parameters in which I could carry out my study (refer to the methods subheading in the introduction for more information) prevented me from giving this subject the full attention that it deserved. As such, the citations pulled from the blogs relevant to this topic provide an imperfect but still useful examination of the viewpoints discussed. While I am allowed to cull and present from these blogs examples of an anti-"transgender" discourse, those who prepared the texts concerned are unable to respond to the meanings and implications that I assign them. I find this unfair to the authors and their viewpoints, but given that anti-"transgender" attitudes seem to be completely absent in the literature concerning gender variance, I feel obligated to at least present an outline of the themes present in such opinions, however superficial that analysis may unfortunately be. A potential downfall in such an examination is that while these discourses are produced in a type of political forum, they do not provide any direct insight into the experiences of those that author them. If the lack of two-way communication between the authors of these blogs and myself should cause me to misconstrue the intent of their message, then at least I will have opened a dialogue in which future researchers may correct any erroneous interpretations and bring additional attention to the subject. On the

subject of Harry Benjamin Syndrome in particular, one opponent remarks that "HBS is way past due for a peer review" (Amato 2010), and I agree; in my view, the limitations of this examination do not nullify the good that can be done by bringing the present subject to light.

As discussed in the methods chapter, the Internet provides a forum for both open communication as well as closed. While one may argue that all data that is available for viewing without a password is fair game for use in research due to a lack of expectation of privacy, I believe that there is a qualitative difference between data that is shared in the context of a support group-like discussion board and data that is offered in exposition of a given topic or perspective. Researchers, who would not be allowed to attend and tape record the proceedings of a real-world support group without the permission of the facilitators and participants, should neither be allowed to do so simply because that interaction is occurring online. Though online community forums that do not require passwords for viewing take place in semi-public space, there is no expectation on the part of participants that their words may be lifted from their original context to be used by researchers. When it comes to blogs, however, I believe that such texts are offered up in order to advance the viewpoint of their authors and that readership by any and all is assumed in their attempt to disseminate a specific sociopolitical viewpoint. Just as there is no need to contact the owners of well-read political or pop-culture blogs in order to cite them, the potentially smaller readership of the blogs cited here should not in itself change the "publicness" of the data therein. Indeed, blogs that advance social and political ideas are an updated form of the pamphlet or the small-circulation newspaper, and I have no doubt that the pamphlet that was the first to widely disseminate the ideology of the "transgender" umbrella (Feinberg 1992) would have likely been distributed in blog form had such a medium been common at the time, or inversely, that if the blog were not a contemporary medium for such

ideas, that the opinions expressed here would likely have been published in small-scale newsprint instead. The only danger that I can see in citing blogs is in the potential for the thoughts lain out inside to be connected to the real-world identities of the writers. In my view, if the authors of the blogs cited here do not wish to be associated with the content of their blogs, then they will have taken the precautions necessary to keep their true identities separate from the pseudonyms used online.

Harry Benjamin Syndrome

The most easily identifiable ideology opposed to the "transgender" umbrella is referred to as "Harry Benjamin Syndrome" (or HBS) by its supporters. The origins of HBS are difficult to determine, but the term seems to originate from a Spanish euphemism for transsexuality, *Síndrome de Harry Benjamin* (Women Born Transsexual 2009). The webpage that describes HBS with the greatest detail that one finds on Googling the term "Harry Benjamin Syndrome" is owned by Charlotte Goiar, who is apparently a layperson (Amato 2010) with no medical qualifications who self-identifies as an individual with HBS and has played a critical role in the online diffusion of HBS as a medical condition. According to Goiar (2010), HBS "is an intersexual condition occurring in the early stages of pregnancy that affects the process of sexual differentiation in the brain between male and female." As such, it is regarded as a "physiological, not a psychological, condition," in contrast to the APA-endorsed "gender identity disorder." Goiar goes on to argue for a differentiation between transsexuality and HBS:

> In the past, there were many different names for HBS, the most common of which was *Transsexuality*. However, HBS is NOT transsexuality…. Recent studies tell us that neurological gender identity, not anatomical gender structures, determines the actual sexual identity of an individual. Therefore, someone born with HBS is already a member of the "opposite" sex. This overturns the term transsexualism because there is no "change of sex." Rather, one only does corrective surgery on physical structures.

Goiar's definition of gender variant identity reframes the gender and sex dichotomy by locating not only gender in the brain, but sex as well. Genitals become an ancillary marker of sex, while the brain is the seat of sex identity; since sex identity (male or female) and gender identity (man or woman) are in agreement with most people, this distinction is only relevant to the case of HBS sufferers, whose internal sex identity is not accurately reflected in the primary signs of sexual differentiation. Rather than positing the mind as not conforming to the body, as in the diagnosis of "gender identity disorder," HBS favors the brain as the true location of sex identity and (in the case of HBS sufferers) the genitals as nonconforming.

While recent studies of the gendered brain suggest a biological etiology for transsexualism, there has been substantial criticism of the HBS model in transgender circles due to the ideological baggage that some view as staining an (otherwise intuitive) explanation of the origins of gender variance. In particular, the vilification on the part of HBS supporters of non-heteronormative individuals and behavior have caused significant turmoil in online "transgender" communities resulting in a common association of the HBS movement with anti-gay attitudes. The following blog post of a woman who identifies as having had HBS relates her dissatisfaction with being included under the "transgender" umbrella:

> [Transgender people] pollute how the public sees true-TSs. Look up "transsexual" in any search engine, and you will find photos of naked gay men with breast implants having sex with similarly mutilated gay men. The promoters of these sites lie and pretend that transgendered gay males in dresses are women, when they act and behave nothing like women and don't want any of the reproductive equipment of women…. TGs often live as women to loophole any gay sex they have to try to make it more acceptable to society and to try to lower their guilt for the man on man sex. [Purple Speaks 2009]

This passage speaks to the discomfort felt by some transsexual women over their association with those who violate heteronormativity outside of the acceptable bounds of HBS. While transsexual women are positioned as truly women, gender variant individuals whose bodies or

behaviors do not conform to heteronormative standards for their self-identified sex are regarded as inauthentic. For those who both believe in a strict biological etiology for transsexuality and do not accept the arguments for the innateness of homosexuality, being linked to "transgender" identity is perceived as a trivialization of their identity.

Because HBS advocates seek to draw distinctions between themselves and other gender-variant individuals, they have been criticized for their exclusionary discourse and the sometimes arbitrary lines drawn between those who they believe to qualify as having HBS and those who do not. Amato, an early supporter of Goiar's HBS theory who has since become disillusioned due to its devaluation of nonheteronormative gender identities, describes her experiences with the HBS community online:

> What I learned had little to do with HBS. [The discussion board] instead turned out to be an anti-GLBT group. People who asked simple questions and needed support were diagnosed by militant members as being transgendered, perverts, and fetishists. Gays and lesbians were also denigrated with frequent slurs. In fact those who did support GLBT rights were banned simply for supporting them.

In my own experience, the discourse found on these fora does indeed tend to run towards social conservatism, which inherently structures the efforts by members to parse out those who "truly" have HBS from those with other forms of gender variance. Ideally, the qualities of an HBS sufferer the standards of the "true transsexual" (early manifestation of discomfort with sex assigned at birth, androphilic, hatred of their sex organs) as described by Harry Benjamin (1999[1966]) whose early treatment of transsexual individuals in America combined with his belief in a biological etiology for transsexualism no doubt contributed to the naming of HBS after him. Extreme partisans deny the "realness" of certain transsexual individuals who fail to meet that standard. According to Amato, "[Goiar] believes that if you are born with the condition

that it disappears if you have been married or are a non-op for medical reasons. NO professional would say this. You either are born with it or you are not" (2010).

At its most conservative, HBS encourages the maintenance of gender roles and relations, again questioning the validity of transsexual individuals who question patriarchy. According to a quotation on Goiar's HBS website attributed Gurney and Mills, "Transsexualism (HBS) is about being a particular sex, not doing it. It is also about recognizing gender norms, not challenging them." Innateness of gender ("being") is valued, while the trappings of gender ("doing," presumably referring to the imitations of femininity in which cross-dressers and drag queens engage) are devalued; ironically, the call to avoid challenging gender norms seems to require that "true" transsexual individuals use those tools of femininity (make-up, dress, etc.) that are considered artifice for non-transsexual gender variant people. The following citation, from a blog whose author uses both the terms TS and HBS, is demonstrative:

> True TSs need a society in which the traditional gender dichotomy remains intact. TGs wish to destroy this…. If you have a penis and want to keep it, you are a man, no matter what. Even children know that men have penises and women don't. It is dishonest to present as a woman while having the inborn emotional core of a man…. MtF TSs really are born with female brains. MtF TGs were born with male brains and choose to defy not only society, but their own nature. Any "femininity" they express is either gay male effeminacy or fake. [Purple Speaks 2009]

The perceived difference between femininity as expressed by men and as expressed by women is founded in the HBS support for the naturalness or innateness of transsexual identity due to cross-sex neuroanatomy, with a strong underlying belief that gender roles are an affect neither in non-gender variant people nor in HBS individuals. While HBS sufferers are expressing their internal sense of gender as a function of their naturally female brains, the gender expressions of other gender variant individuals does not have a natural basis and is therefore invalid.

In addition to the features that encourage exclusion among HBS and other anti-"transgender" advocates, another common criticism of these viewpoints is of the classist (and sometimes, consequently, racist) underpinnings that such arguments presuppose. The economic assumptions of the availability of the capital to afford long-term health care treatment as well as surgery that one must often travel to access (again, non-operative transsexual individuals are regarded as not "true") are implicit in HBS discourse:

> The physical and mental abuse me and others like me have endured hardly puts us among any kind of "elite." I had to personally find every penny of the money it cost for my surgery. I lost my family my friends my career my home my business, in fact I pretty much had to give up everything and begin life again. This had to happen before I could transition and did not happen after. The facts are that I began my female life with carried over debt. Hardly a position of "elite." Yet the accusations pour in over the things I say that I am privileged and elitist; you think you're better than anyone else don't you? These are the words repeated over and over again. The answer I give is "Well no but I am certainly different." [CassandraSpeaks 2010c]

> First off, the primary thing that determines who does, and who does not, get surgery is how badly the person wants it…. Now, there are a lot of transgender people who live in poverty. Many of them have other issues, such as drug abuse, alcohol abuse, lack of education, and mental and behavioral issues that keep them in poverty. Simply put, their lives are not improved by transition but are often made worse. These people do not make any attempt to assimilate into society as women. They prefer being openly identified as transgender. Excuses can be made all anyone wishes, but the truth of the matter is, that most who don't have surgery actually don't want surgery, and would probably not have it if it was offered to them at little cost. [Just Jennifer 2009b]

In the first citation, there is no recognition of the pre-existing conditions that have allowed the author to be able to borrow the considerable capital that allowed her to access surgical care. I should note that I do not mean to condemn the author for her economic status; however, as there exists substantial data that correlates one's lifetime earnings to that of one's parents (see Gouskova et al. n.d.), the "up by the bootstraps" view assumed by HBS supporters shows far too little sympathy for those without the means to access medical interventions, or perhaps simply a lack of consciousness of their class privilege. The second citation furthers this discourse of

privilege, even positing HBS as a condition unique to the middle and upper classes by framing those who are both gender variant and poor as unwilling to conform to the gender norms required to take them seriously as the sex that they claim to be. Instead, the gender expressions of the poor are regarded as unconvincing, and their poverty—exacerbated by their gender presentation—demonstrates a lack of desire to improve their economic conditions. This parallels David Valentine's earlier work, though rather than giving preference to "transgender" identity as in his study, here HBS is regarded as the superior framework for understanding the sex/gender mismatch and a more palatable expression of transsexuality according to upper- and middle-class gender norms.

The strict policing of heteronormativity in the HBS movement recalls the theories of sociologist Pierre Bourdieu (1984) who observed that what is considered normative and proper is a reflection of the socioeconomic status of the observer; the failure of individuals to conform to the norms of behavior usually established by the elite and mimicked by the middle class marks them as not having "what it takes" to succeed and often prevents them from achieving respectability within mainstream culture. Much like the activism by gender-normative middle-class white gay men that displaced gender variant identities from under the heading of "gay" as described by David Valentine (2007), a similar development may be occurring as gender-normative middle-class white transsexual individuals attempt to reframe transsexuality as an intersex condition while relegating other, less "tasteful" forms of gender variance to the status quo of psychopathology. Just as gay activists worked to remove the associations of gender variance from mainstream outlooks on homosexuality, a select group of transsexual individuals similarly hope to shape the public's perception of them towards a heteronormative standard, though not in the form of "transgender" identity as Valentine predicted, but rather through HBS

and similar anti-"transgender" formulations. Such elitism is not lost on the following blogger, who has rejected HBS in favor of the term "woman born transsexual:"

> Part of the reason middle class and older transsexuals first embraced the term transgender had almost nothing to do with any sort of umbrella. Back in the 1970s and 1980s many queens in the sex industry used transsexual in their ads and promoting "trannie porn." Heaven forbid we be associated with lumpen trannie sex workers. Sometimes the classism is so in your face and about as subtle as a note tied to a brick through your front window that you don't need a Marxist education to see it. I'll toss in a streak of racism too since it contributes to people being so far down the economic ladder that SRS will never be obtainable…. [Women Born Transsexual 2009]

Another blogger, who is similarly dissatisfied with the HBS movement, seems to be rather in agreement with its positions on the innateness of transsexuality, but derides the insular nature of the movement and how those with less conservative viewpoints regarding gender are silenced:

> The concept of a *Harry Benjamin Syndrome* was a good idea I think. I doubt there are few classic transsexuals who would not like to see a differentiation, a different terminology used to delineate us from the others who are captured by the transgender umbrella. But it has taken a terrible turn for the worse due to the fanatics who promote it. [Enough Nonsense 2008b]

It should be noted here that opposition to the association of transsexuality with homosexuality is in no way solely the province of the HBS movement (just as not all individuals who identify as having HBS are anti-gay). The following quote, from the same blogger as immediately above, demonstrates that HBS supporters are not unique in wanting the questions of sexuality and gender identity to be delinked, both socially and politically:

> The queer trans activists are hell bent on continuing to link the *gender* issue of the post operative with the *sexuality* issues of homosexuals…. So, as the decades of time have passed since gender reassignment surgery has been readily available, rather than society more and more recognizing post ops as simple male or female, the result of a medical anomaly, instead we are viewed as homosexual men and women who have gone to the ultimate extreme of surgically altering our body. Our status has not been strengthened and solidified as the years have gone by—as should have been the case—but delegitimized. [Enough Nonsense 2008a]

The blogger quoted above blames the inclusion of transsexual individuals within "transgender" political ideology for a lack of respect for what she considers to be a medical condition. Like Purple Speaks 2009, the source of tension for anti-"transgender" transsexual individuals is the fear that their desire to "change sex" will be perceived as motivated by reasons of sexuality rather than comfort with one's body. The theme of wanting transsexuality to be delinked from gay and "transgender" is common in anti-"transgender" transsexual narratives, due to the courtesy stigma (Goffman 1963) that such an association brings. This illustrates the power that different academic discourses (i.e. psychology versus biology) can have in shaping popular opinions towards gender variance, and how gender variant individuals react based upon those discourses in their own processes of identity formation.

The Fixity of Gender Reaffirmed

As in traditional transsexual narrative, a common tenet in many anti-"transgender" narratives is that of the fixity of gender and, in many cases, its binarism. The HBS hypothesis of neurological intersex is in accord with many transsexual individuals' early-manifesting and lifelong consciousness of being the opposite sex of the one they are perceived to be. Anti-"transgender" opponents are often aware of the arguments that have informed the current treatment model for transsexualism within the academy:

> The whole transgender concept is a political construct that depends upon a now debunked Gender Identity Theory by John Money which has long since been discredited… I hold no animosity to [male transvestites]. It's their life and so long as they stay within the boundaries of civilized conduct, I don't have an issue; they are free to live as they please with my blessing. Just don't claim to be like me, don't claim that transsexuals are an extreme version of transvestite, we are not. [CassandraSpeaks 2010b]

CassandraSpeaks refers here to the famous psycho-endocrinologist John Money, whose theories of sex-neutrality at birth (i.e., the feeling of belonging to a given sex being the result of upbringing rather than innateness), long held sway among gender theorists prior to the discovery

in the 1990s of the failures of his infant sex reassignment cases (Colapinto 2000). Again, the desire to disassociate transsexuality from other gender-variant identities and behaviors is present, through the framing of transsexuality as congenital while other gender-variant behaviors are presumed not to be. The lumping of transsexuality with sexualized cross-dressing is deemed damaging to the interests of transsexual individuals by an HBS blogger:

> Transgender is increasingly associated with ideas like gender deconstruction and that gender can be changed at will…. If gender is meaningless, and can be changed at will, then it can be argued that transsexuals should either just express their gender without seeking surgery (thus countering the argument that the surgery should be covered by insurance) or that we should simply just choose to go back to being the gender associated with our birth sex. [Just Jennifer 2009a]

The essential disagreement is whether those who engage in gender play or question heteronormativity threaten the narratives of transsexual individuals. Indeed, one can see that "transgender" as a political conglomeration includes two diametrically opposed camps of thought: one that upholds the innateness of gender, another that views gender as entirely socially constructed and ripe for dissembling and/or reconfiguring, as well as many shades of opinion between these two extremes. Those who believe in the innateness of gender identify a substantial risk of having their senses of self undermined through popular perception of their commonality with other gender identities under the "transgender" umbrella, whether those in the "innateness" camp personally believe in the validity of nonheteronormative identities.

Because the belief in the social construction of gender has been the more common position in the social sciences beginning with the rise of feminism in the 1970s, the language that is used to describe transsexualism is structured in such a way as to render claims to the contrary illegible within the academic realm. While most individuals outside of academia have given little thought to the social construction of gender and view their own gender identities as natural or biologically determined, the view of gender as having a cultural component or as different

than sex has become practically hegemonic in the social sciences, which makes the framing of the claims made to identity by advocates of HBS theory difficult to accurately describe within those discourses. Anthropological research typically makes use of the theoretical framework that feminism has provided by stressing the social construction of identities, specifically in regards to sex and gender. This makes the task of describing the subjective experiences of essential cross-sexed gender identity difficult, as like homosexuality, such identities run contrary to the efforts of heteronormatizing enculturation processes in mainstream society; while most contemporary researchers of sexuality and gender attribute homosexual orientation to some biological predisposition, such benefit of the doubt is not typically granted to transsexual individuals. Whether the relatively simple terms *transsexual* or *cross-gender* or the more academic *non-heteronormative* are used, they all presume that transsexual individuals are indeed not the sex that they claim to be, or at least not in their original body-state (*transgender* has the same problem, since it can either be synonymous with *cross-gender* or intended to refer to the contemporary "transgender" political identity).

If the HBS thesis of brain sex can be proven, and transsexual individuals are revealed to neurologically be the sex that they claim and suffering from a birth disorder rather than a psychological one, what terminology can be used to accurately describe the innateness of their gender and dispel the assumption that they are cross-gendered at all? Even if the brain sex theories go unproven, is it not necessary to reframe the sex/gender debate in order to respect the identities of those that we refer to as *transsexuals* or diagnose as people with *gender identity disorder*? Whether or not the claims to neuroanatomical cross-sex identity have any basis in biology, why must we continue to refer to individuals who identify as a different sex than assigned at birth using terminology that reaffirms that they are, in fact, not? Why must

psychologists continue to refer to androphilic male-to-female transsexual individuals as "homosexual transsexuals," or as still often found within medical literature, "male transsexuals?" Cannot more respectful terms be utilized, beginning with referring to transsexual individuals using the sex designations with which they identify? For advocates of the brain-sex theory of transsexuality, it will require a good deal of work to rally around any new term, since as has been established in the case of HBS any reframing of the gender debate can easily be utilized by those who append socially conservative (or liberal) agendas to that ideology in an effort to deny the dignity of other gender variant individuals.

Intersections with Psychology

Unsurprisingly, anti-"transgender" advocates tend to either disagree with the inclusion of "gender identity disorder" in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders, or as in the case of HBS view "gender identity disorder" as appropriate for the diagnosis of paraphilia but irrelevant to their own gender identities. However, as according to the Standards of Care for Gender Identity Disorders (WPATH 2001) mental health care professionals are regarded as the appropriate authorities for determining the treatment of transsexual patients, their theories of gender have a substantial impact on the formulation of diagnostic criteria and treatment options. The theoretical division of transsexuality into "homosexual" (HSTS) and "non-homosexual/autogynephilic" types, most closely associated with sexologist Ray Blanchard (1985), has been of particular concern due to their contradiction of the gender identities of transsexual individuals. The following citation presents one blogger's distress with this characterization of transsexual individuals attracted to men:

> One of the key features of the genuine transsexual women I have met and counseled is the all powerful need of these women to correct nature's mistake and to then move on

> and form regular relationships, lives, and found families…. Yet, [in] accepting the term HSTS the mantle of "homosexual" falls squarely on the shoulders of those who choose us as partners even if they have no knowledge of the condition we once survived. I find that totally unacceptable. It also means that we can never be the women we claim to be and worse gives the religious right the debating power they need to persuade government to deny us the right to correct birth certificates and to annul our marriages. [CassandraSpeaks 2010a]

By labeling androphilic transsexual individuals as "homosexual," one is explicitly categorizing male-to-female transsexual individuals as men. Transsexual individuals who identify as women, then, are quite understandably upset with the reframing of their sexual identity as male (a category to which many transsexual individuals feel that they never belonged to in the first place). Though the blogger above shares this opinion and feels that her own identity is being inaccurately conceptualized, she goes on to conclude that autogynephilia is an acceptable framework for understanding gender variance. Such an interpretation seems to mean that understanding non-androphilic transsexual women as having autogynephilia, "a man's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman" (Blanchard 1989). How androphilic transsexuality can denote valid womanhood while non-androphilic cannot I fail to comprehend, especially given a paradigm that accepts only androphilic and autogynephilic transsexuality as the two possible transsexual typologies.

Despite its mislabeling of androphilic transsexual women as homosexual, there seems to similar processes at work within HBS ideology as within Blanchard's transsexual typology. Both systems seek to differentiate between types of transsexuality (or "transgenderism"), and each maintains a strict binary between the two with little—if any—room for commonality. Blanchard's typology divides strictly between androphilic and non-androphilic transsexuality (and recognizing both as identities belonging to sexual fetishists who are truly men), while HBS advocates place the line between neurologically-intersex transsexual women and gender-bending

fetishists (that HBS advocates uphold the veracity of their female identities while denying the same to others marks the divergence between the two classifications).

Given the different focuses of transsexual research in North America and Europe (the first valorizing theorizing of its etiology and the latter more concerned with medical intervention) as related in a previous chapter, I argue that is the continued emphasis on transsexuality as pathology in the United States and Canada that has contributed to the persistent strain of competitiveness for "realness" within transsexual and "transgender" communities. While European gender teams produce original research that furthers knowledge in the treatment of transsexual individuals, North American academics have stagnated, producing typologies and the like that are of little—if any—practical benefit. Can we imagine a theory of transsexualism that scraps hierarchical designations and that focuses on treatment rather than pathology and its origins? Can we imagine there being no "true" or "classical" or "pure" transsexualism to defend, where the practical concerns of patients and their gender identity needs are more relevant than determining the Freudian origins and significance of their sexuality?

I believe that anthropology is in a unique position to contribute to the evolution of these discourses due to its dedication to people and how they are impacted and shaped by different cultural systems. Anthropology has examined multiple forms of gender variance around the world, but with the exceptions of Bolin (1988) and Valentine (2007), far too little attention has been paid to the gender variant individuals within our own societies and the issues that they face. The anxiety revealed in this chapter surrounding transsexual "authenticity," exacerbated by the current diagnostic standard, provide examples of cultural specificity in shaping the meanings of gender variance and set the stage for further discussion about how such strain might be alleviated.

Because participant observation and ethnography are capable of producing detailed and complex accounts of cultural dynamics, anthropology can provide a window into the lives of gender variant individuals that I contend would reveal many of psychology's current theories into gender variance such as Blanchard's binary typology to be bunk; indeed, the study of gender variant individuals outside of the clinic would provide much more useful information than can be gleaned about so socially negotiated and malleable a topic. As I have shown, participant observation with gender variant communities reveals a far more multifaceted and nuanced picture of gender variant individuals and identities, and future research into this domain would do well to utilize ethnographic techniques in creating a fuller picture of gender variance. The examination of gender variant identities in the West deserve much more consideration if the stigma associated with such identities are to be reduced and to better facilitate the access of such individuals to the care that they seek.

CHAPTER 5 – CONCLUSIONS

Gender variant individuals and behaviors come in many shapes and forms, and the differences in opinions and experiences that shape gender variance in humans demonstrate the mediating role of culture in this domain. In this study, I have examined the multiple discourses that inform the conceptualization of gender variance in the modern West with a focus on the divergent needs and identities that constitute that experience. Just as the *hijra* of India are enmeshed in a culture that positions gender variance within a religious framework, and the *kathoey* of Thailand are widely recognized for their role in entertainment and media, gender variant individuals in the West are located within a culturally-specific context that emphasizes both the medicalization of difference and the politics of identity. While many gender variant individuals are content to live either full- or part-time as a sex to which they were not assigned at birth, this thesis has concerned itself mainly with those individuals who seek to embody their sex of identification with the support of modern medical technology.

Gender variant identities, glossed simply as "transgender" within mainstream discourse, are the subject of multiple and at times competing forces that seek to claim hegemonic authority over the etiology and treatment of gender variant individuals. In the twentieth century, gender variant identities first found a measure of social legitimacy within the realm of medicine, as gender variant individuals sought out health care professionals who might be willing to listen to their complaints and apply hormonal and surgical treatments in an attempt to ease their patients' experiences of gender dysphoria. News of Christine Jorgensen's surgical conversion from man to woman in the early 1950s caught the attention of a public enamored of the promise of progress and contentment through science, and many individuals who came forward with requests for similar treatment would lead to the establishment of medical standards for the care of

"transsexual" individuals. With the critique of heteronormative standards that came along in the forms of feminism and the gay rights movement in intervening decades, increases in mainstream acceptance for different expressions of sexuality and gender resulted in a "transgender" movement, which would claim as its members all of those who were dissatisfied with the binarism of gender expression in relation to sex assigned at birth. These two models for gender variance—one relying on the authority of medicine to classify and treat, the other preoccupied with the social dimensions of gender—have since maintained an uneasy symbiosis, in part due to the acquiescence of transsexual individuals to medicine as the authoritative means for traversing the sex binary.

Critiques by those who questioned the medical validity of transsexuality (Raymond 1994[1979]) and the benefits of its medical treatment (Meyer and Reter 1979) led to the confirmation of psychology as official arbiter of treatment for gender variant individuals (WPATH 2001), a decision that is regarded as both beneficial and problematic. While many gender variant individuals find validation in the recognition of their gender identities as a condition meriting treatment, others view the inclusion of "gender identity disorder" in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders as the pathologization of their identities and a source of additional stigma. The concern within psychology for parsing out different forms of transsexuality, exemplified by Blanchard's taxonomy of "homosexual" and "autogynephilic" transsexuality (Blanchard 1985), has been a substantial source of dispute, as the implications for differential valorization and treatment of different types of transsexual identity show.

The consolidation of a "transgender" identity and politics has inherited the contentious relationship between gender variant individuals and the authorities on gender variance, with

acknowledgment of their utility in treatment driving their continued patronage. This has been counterbalanced with attempts on the part of some gender variant individuals to reframe the discourse of gender variance as, like homosexuality before it, an expression of human variation not inherently disordered but problematic mainly in its tradition of social disapproval. The categorizations of disease or disorder are linked to the cultural determination of what constitutes illness, and the burden of proof lies with mental health care professionals to demonstrate whether the threshold of pathology has been reached; the availability of data attesting to the existence of many well-adjusted transsexual individuals (Cohen-Kettenis and Pfäfflin 2009) appears to have had no effect on the determination that "gender identity disorder" inherently meets such criteria. Whether individuals diagnosed and treated through hormonal and surgical means for "gender identity disorder" remain forever disordered has also not been established, nor the low incidence of negative outcomes (Pfäfflin and Junge 1998) for the corporeal treatment of a mental disorder explained. Nevertheless, the authority of psychology to determine when "gender identity disorder" necessitates treatment remains unquestioned by many gender variant individuals, who fear that the treatment of ineligible people and their potentially negative outcomes might negatively impact the limited extent to which transsexual treatment has received acceptance within medicine, thereby jeopardizing the continued availability of such care.

The umbrella usage of the term "transgender" to describe gender variant identities and behaviors has been shown to be problematic in its assumption of commonality among those who are perceived as violating heteronormative gender roles. While many individuals who once would have been labeled as "transsexual" due to their desire to utilize hormone replacement therapy and surgery to modify their bodies have embraced "transgender" identification as a more positive, less pathological designation, others have rejected this new taxonomy due to their

insistence that their gender identities are not variant but rather their embodiment of an incorrect sex. For these individuals, that transsexual identification constitutes gender variance from social norms is not in accord with their own internal sense of gender and the assignment of their dysphoria to their sexed bodies. Public perception of the sameness of these two opposed camps within a "transgender" framework can present difficulties for both parties: for those who identify as gender-variant but not sex-variant, attempts to view their identities through a pathological or medical lens are often unwelcome, and for those who identify as sex- but not gender-variant, those who "queer" gender may present a danger in undermining claims to authentic cross-sex identity.

This latter understanding of sex/gender variance has taken the form of the brain-sex theory of transsexuality, in which the neuroanatomy of certain gender variant individuals is thought to exhibit cross-sex features. Though long suspected, this theory has received little study until as of late; though a possible biological etiology for gender variance is supported by the limited data available, it is too early to draw any substantial conclusions on the subject. What unfortunately permeates the discourse of the brain-sex theory among some gender variant individuals is at times an self-legitimizing interest in parsing the "authentic" transsexual individuals from those who presumably should not receive treatment. In many ways, the insistence on determining the neuroanatomical causes of gender variance are as potentially harmful in their implications as Blanchard's taxonomy, as the ability to differentially diagnose transsexuality on the basis of brain sex or sexual orientation could lead to a reliance on such details in determining treatment, rather than the traditional reliance upon self-identification and the desires of the patient in such decisions. Is it appropriate to deny an individual with even one reported instance of fetishization of cross-dressing hormonal or surgical treatment? If a typical

neuroanatomical pattern could be determined in transsexual individuals, would it be alright to withhold treatment from someone whose brainscan did not detect that pattern? In this author's opinion, in the absence of mental disorders (such as schizophrenia or multiple personalities) that might affect the individual's ability to properly assent to treatment, hormonal and surgical interventions should not be withheld from anyone who has the mental capacity to make such a decision for themselves—as is the case for every other medical treatment—especially in the absence of data to demonstrate an increase in negative outcomes without the authorization of a third party.

Though I respect the opinions of those who would disallow treatment for those individuals not meeting certain prerequisites (i.e. heterosexual orientation vis-à-vis self-identified sex, no history of fetishism, desire for genital surgery, etc.), I find it inappropriate to prescribe what any other autonomous individual may choose to do with their own body or what identity they may assume, however damaging that may be to popular opinion of gender variant individuals as a group. Rather than socially conservative transsexual individuals distancing themselves socially and politically from others under the "transgender" umbrella, what may prove more beneficial in the reduction of stigma they fear from that association might instead be activism in support of the depathologization of "gender identity disorder." While the Standards of Care were important at the time of their establishment in framing transsexuality as a legitimate medical condition unrelated to psychosis and meriting hormonal and surgical intervention, I believe that the time has come to remove these requirements, as the circumstances that questioned the validity of cross-sex treatment have substantially changed.

As I have demonstrated, the needs and identities of different gender variant individuals merit an approach that does not assume that all gender variant individuals require the same

treatment (or any treatment at all). The matter of medical intervention is finally a highly personal choice that no one can properly make except for the individual in question. Authoritative acknowledgment of this fact, along with the depathologization of gender variance, would go a long way in both reducing the stigma that gender variant individuals face for carrying a “disordered” identity and potentially soothing the animosity between gender variant individuals who feel that they must vie for legitimacy in the eyes of medicine.

REFERENCES CITED

Agre, Philip E.
1999 Life After Cyberspace. The European Association for the Study of Science and Technology (EASST) Review 18(3). Electronic document, http://www.easst.net/review/sept1999/agre, accessed November 15, 2008.
2002 Cyberspace as American Culture. Science as Culture 11(2):171-189.

Aloisi, Anna Maria, Valeria Bachiocco, Antonietta Constantino, Rita Stefani, Ilaria Ceccarelli, Allesandro Bertaccini, and Maria Cristina Meriggiola
2007 Cross-sex Hormone Administration Changes Pain in Transsexual Women and Men. Pain 132:S60-S67.

Amato, Laura
2010 Laura's Harry Benjamin Syndrome HBS: A Peer Review. Electronic document, http://harrybenjaminsyndrome-not-transsexual.com, accessed February 20, 2010.

American Anthropological Association
1998 American Anthropological Association Statement on Race. Electronic document, http://www.aaanet.org/stmts/racepp.htm, accessed November 26, 2008.

American Medical Association
2008 Removing Financial Barriers to Care for Transgender Patients. AMA House of Delegates Resolution 122 (A-08). April 18. Electronic document, http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc, accessed March 20, 2010.

American Psychiatric Association
1980 The Diagnostic and Statistical Manual of Mental Disorders. 3rd edition. Washington, DC: American Psychiatric Association.
2000 The Diagnostic and Statistical Manual of Mental Disorders. 4th edition, Text Revision. Washington, DC: American Psychiatric Association.
2010 Proposed Revision to Gender Identity Disorder in Adolescents or Adults (302.85). Electronic document, http://www.dsm5.org/ProposedRevisions/Pages /proposedrevision.aspx?rid=482, accessed April 1, 2010.

Anderson, Benedict
1983 Imagined Communities: Reflections on the Origin and Spread of Nationalism. London/New York: Verso.

Anderson, Garnet L., Marian C. Limacher, Annlouise R. Assaf, Tamsen Bassford, Shirley A. A. Beresford, Henry R. Black, Denise E. Bonds, Robert L. Brunner, Robert G. Brzyski, Bette Caan, Rowan T. Chlebowski, David Curb, Margery Gass, Jennifer Hays, Gerardo Heiss, Susan L. Hendrix, Barbara V. Howard, Judith Hsia, F. Allan Hubbell, Rebecca D. Jackson, Karen C. Johnson, Howard Judd, Jane Morley Kotchen, Lewis H. Kuller, Andrea Z. LaCroix, Dorothy S. Lane, Robert D. Langer, Norman L. Lasser, Cora E. Lewis, JoAnn E. Manson, Karen L. Margolis, Judith K. Ockene, Mary Jo O'Sullivan, Lawrence Phillips, Ross L. Prentice, Cheryl Ritenbaugh, John Robbins, Jacques E. Rossouw, Gloria E. Sarto, Marcia L. Stefanick, Linda Van Horn, Jean Wactawski-Wende, Robert B. Wallace, and Sylvia Wassertheil-Smoller.
2004 Effects of Conjugated Equine Estrogen in Postmenopausal Women with Hysterectomy: the Women's Health Initiative Randomized Controlled Rrial. The Journal of the American Medical Association 291:1701-1712.

Bailey, J. Michael
2003 The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism. Washington, D.C.: Joseph Henry Press.

Bailey, J. Michael and Kiira Triea
2007 What Many Transgender Activists Don't Want You to Know (and Why You Should Know it Anyway). Perspectives in Biology and Medicine 50(4):521-534.

Bakker, A., with P.J.M. van Kesteren, L.J.G. Gooren, and P.D. Bezemer
1993 The Prevalence of Transsexualism in the Netherlands. Acta Psychiatrica Scandinavica 87(4):237-238.

Benjamin, Harry
1999[1966] The Transsexual Phenomenon. Düsseldorf: Symposium Publishing.

Bentz, Eva-Katrin, Christian Schneeberger, Lucas A. Hefler, Michael van Trotsenburg, Ulrike Kaufmann, Johannes C. Huber, and Clemens B. Tempfer
2007 A Common Polymorphism of the SRD5A2 Gene and Transsexualism. Reproductive Sciences 14(7):705-709.

Bentz, Eva-Katrin, Lucas A. Hefler, Ulrike Kaufmann, Johannes C. Huber, Andrea Kolbus, and Clemens B. Tempfer
2008 A Polymorphism of the CYP17 Gene Related to Sex Steroid Metabolism is Associated with Female-to-Male but not Male-to-Female Transsexualism. Fertility and Sterility 90(1):56-59.

Berglund, H., P. Linström, C. Dhejne-Helmy and I. Savic
2008 Male-to-Female Transsexuals Show Sex-Atypical Hypothalamus Activation When Smelling Odorous Steroids. Cerebral Cortex 18(8):1900-1908.

Berra, Marta, Francesca Armillotta, Laura D'Emidio, Antonietta Constantino, Giuseppe Martorana, Giuseppe Pelusi, and Maria Cristina Meriggiola
2006 Testosterone Decreases Adiponectin Levels in Female to Male Transsexuals. Asian Journal of Andrology 8(6):725-729.

Besnier, Niko
2002 Transgenderism, Locality, and the Miss Galaxy Beauty Pageant in Tonga. American Ethnologist 29(3):534-566.

Billings, Dwight D., and Thomas Urban
1982 The Socio-Medical Construction of Transsexualism: An Interpretation and Critique. Social Problems 29(3):266-282.

Bird, S. Elizabeth, and Jessica Barber
2002 Constructing a Virtual Ethnography. *In* Doing Cultural Anthropology: Projects for Ethnographic Data Collection. Michael V. Angrosino, ed. Pp. 129-137. Prospect Heights: Waveland Press, Inc.

Blanchard, Ray
1985 Typology of Male-to-Female Transsexualism. Archives of Sexual Behavior 14:247-261.
1989 The Concept of Autogynephilia and the Typology of Male Gender Dysphoria. The Journal of Nervous and Mental Disease 177:616-623.
2008 Deconstructing the Feminine Essence Narrative. Archives of Sexual Behavior 37:434-438.

Blanchard, Ray, Amy D. Lykins, Diane Wherrett, Michael E. Kuban, James M. Cantor, Thomas Blak, Robert Dickey, and Philip E. Klassen
2008 Pedophilia, Hebephilia, and the DSM-V. Archives of Sexual Behavior 38(3):335-350.

Boellstorff, Tom
2007 Queer Studies in the House of Anthropology. Annual Review of Anthropology 36:17-35.

Bolin, Anne
1988 In Search of Eve: Transsexual Rites of Passage. South Hadley, MA: Bergin and Garvey.

Bornstein, Kate
1994 Gender Outlaw: On Men, Women, and the Rest of Us. New York: Routledge.

Bourdieu, Pierre
1984 Distinction: A Social Critique of the Judgment of Taste. Richard Nice, trans. Cambridge: Harvard University Press.

Brevard, Aleshia
2001 The Woman I Was Not Born to Be: A Transsexual Journey. Philadelphia: Temple University Press.

Brown, Mildred L. and Chloe Ann Rounsley
1996 True Selves: Understanding Transsexualism… for Families, Friends, Coworkers, and Helping Professionals. San Francisco: Jossey-Bass.

Butler, Judith
1990 Gender Trouble: Feminism and the Subversion of Identity. New York: Routledge.
2007 *Selection from* Bodies that Matter. *In* Beyond the Body Proper: Reading the Anthropology of Material Life. Margaret M. Lock and Judith Farquhar, eds. Pp. 164-175. Durham, NC: Duke University Press.

Californication
2009 Slow Happy Boys. David Von Ancken, dir. 28 min. Showtime Networks. New York.

CassandraSpeaks
2010a Autogynephilia and Homosexual Transsexual. January 3. http://cassandraspeaks.wordpress.com/2010/01/03/autogynophelia-and-homosexual-transexual, accessed February 20, 2010.
2010b The War of Independence Rages. January 10. http://cassandraspeaks.wordpress.com/2010/01/10/the-war-of-independence-rages, accessed February 20, 2010.
2010c Elitism. January 27. http://cassandraspeaks.wordpress.com/2010/01/27/elitism, accessed February 20, 2010.

Cauldwell, David O.
1949 Psychopathia Transexualis. Sexology 16:274-280.

Centro Nacional de Educación Sexual por la Diversidad Sexual
2010 Declaración sobre Despatologización de la Transexualidad en el V Congreso de Sexualidad [Statement on the Depathologization of Transsexuality at the 5th Cuban Congress of Sexual Education, Orientation, and Therapy]. Electronic document, http://www.cenesex.sld.cu/webs/diversidad/declaracion_trans.html, accessed March 7, 2010.

Chung, Wilson C. J., Geert J. De Vries, and Dick F. Swaab
2002 Sexual Differentiation of the Bed Nucleus of the Stria Terminalis in Humans May Extend into Adulthood. The Journal of Neuroscience 22(3):1027-1033.

Cohen-Kettenis, P. T. and S. H. M. van Goozen
1997 Sex Reassignment of Adolescent Transsexuals: A Follow-up Study. Journal of the American Academy of Child and Adolescent Psychiatry 36:263-271.
1998 Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent. European Child & Adolescent Psychiatry 7:246-248.

Cohen-Kettenis, Peggy T. and Friedemann Pfäfflin
2009 The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults. Archives of Sexual Behavior. Electronic document, doi:10.1007/s10508-009-9562-y.

Colapinto, John
2000 As Nature Made Him: The Boy who was Raised as a Girl. New York: HarperCollins.

Conway, Lynn
2001 How Frequently Does Transsexualism Occur? January 31. Electronic document, http://ai.eecs.umich.edu/people/conway/TS/TSprevalence.html, accessed February 22, 2008.
2007 On the Calculation of the Prevalence of Transsexualism. Paper presented at the WPATH 20th International Symposium, Chicago, September 5-8. Electronic document, http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence of Transsexualism.pdf, accessed February 16, 2008.

Currah, Paisley Richard M. Juang, and Shannon Minter, eds.
2006 Transgender Rights. Minneapolis: University of Minnesota Press.

D'Emilio, John
1997 Capitalism and Gay Identity. *In* The Gender/Sexuality Reader. Roger N. Lancaster and Micaela di Leonardo, eds. Pp. 169-178. New York: Routledge.

Damewood, MD, JJ Bellatoni, PS Bachorik, AW Kimball Jr, and JA Rock
1989 Exogenous Estrogen Effect on Lipid/Lipoprotein Cholesterol in Transsexual Males. Journal of Endocrinological Investigation 12(7):449-454.

DeClue, Gregory,
2009 Should Hebephilia be a Mental Disorder? A Reply to Blanchard et al. 2008. Archives of Sexual Behavior 38:317-328.

Dewey, Jodie M.
2008 Knowledge Legitimacy: How Trans-Patient Behavior Supports and Challenges Current Medical Knowledge. Qualitative Health Research 18(10):1345-1355.

Dickey, Sara
1997 Anthropology and its Contributions to Studies of Mass Media. International Social Science Journal 49:413-432.

Dittrich, R., H. Binder, S. Cupisti, I. Hoffmann, M. W. Beckmann, and A. Mueller
2005 Endocrine Treatment of Male-to-Female Transsexuals Using Gonadotropin-Releasing Hormone Agonist. Experimental and Clinical Endocrinology & Diabetes 113:586-592.

Douglas, Mary
1966 Purity and Danger. London: Penguin.

Dreger, Alice Domurat
2007 Jarring Bodies: Thoughts on the Display of Unusual Anatomies. *In* Beyond the Body Proper: Reading the Anthropology of Material Life. Margaret M. Lock and Judith Farquhar, eds. Pp. 375-488. Durham, NC: Duke University Press.
2008 The Controversy Surrounding *The Man Who Would Be Queen*: A Case History of the Politics of Science, Identity, and Sex in the Internet Age. Archives of Sexual Behavior 37(3):366-421.

Drescher, Jack
2009 Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the *Diagnostic and Statistical Manual*. Electronic document, doi:10.1007/s10508-009-9531-5.

Duišin, Dragana, Jasmina Barisić, and Gordana Nikolić-Balkoski
2009 Case Report of Autogynephilia—Family, Ethical, and Surgical Implications. Psychiatria Danubina 21(2):242-245.

Elaut, Els, Griet De Cuypere, Petra De Sutter, Luk Gijs, Michael Van Trotsenburg, Gunter Heylens, Jean-Marc Kaufman, Robert Rubens, and Guy T'Sjoen
2008 Hypoactive Sexual Desire in Transsexual Women: Prevalence and Association with Testosterone Levels. European Journal of Endocrinology 158:393-399.

Elbers, J. M. H., H. Asscheman, J. C. Seidell, and L. J. G. Gooren
1999 Effects of Sex Steroid Hormones on Regional Fat Depots as Assessed by Magnetic Resonance Imaging in Transsexuals. AJP – Endocrinology and Metabolism 276(2):317-325.

Elliston, Deborah A.
1999 Negotiating Transitional Sexual Economies: Female Māhū and Same-Sex Sexuality in "Tahiti and Her Islands." *In* Female Desires: Same-Sex Relations and Transgender Practices Across Cultures. Evelyn Blackwood and Saskia E. Wieringa, eds. Pp. 230-252. New York: Columbia University Press.

Enough Nonsense
2008a A True, Classic Transsexual. June 20. http://tgnonsense.wordpress.com/2008/06/20/5, accessed February 20, 2010.
2008b HBS and the Fanatics. August 18. http://tgnonsense.wordpress.com/2008/08/18/hbs-and-the-fanatics, accessed February 20, 2010.

Fausto-Sterling, Anne
2000 Sexing the Body: Gender Politics and the Construction of Sexuality. New York: Basic Books.

Feinberg, Leslie
1992 Transgender Liberation: A Movement Whose Time Has Come. New York: World View Forum.
1996 Transgender Warriors: Making History from Joan of Arc to RuPaul. Boston: Beacon Press.

Foucault, Michel
1978 The History of Sexuality. Volume I: An Introduction. Robert Hurley, trans. New York: Pantheon Books.

Freeman, Derek
1983 Margaret Mead and Samoa: The Making and Unmaking of an Anthropological Myth. Cambridge: Harvard University Press.

Garcia-Falgueras, Alicia, and Dick F. Swaab
2008 A Sex Difference in the Hypothalamic Uncinate Nucleus: Relationship to Gender Identity. Brain 131:3132-3146.
2010 Sexual Hormones and the Brain: An Essential Alliance for Sexual Identity and Sexual Orientation. Endocrine Development 17:22-35.

Gazzeri, R, M Galarza, and G Gazzeri
2007 Growth of a Meningioma in a Transsexual Patient After Estrogen-Progestin Therapy. The New England Journal of Medicine 357(23):2411-2412.

Gibson, William
1984 Neuromancer. New York: Ace Books.

Giltay, Erik J. and Louis J. G. Gooren
2000 Effects of Sex Steroid Deprivation/Administration on Hair Growth and Skin Sebum Production in Transsexual Males and Females. The Journal of Clinical Endocrinology & Metabolism 85(8):2913-2921.

Giltay, E. J., E. K. Hoogeveen, J. M. H. Elbers, L. J. G. Gooren, H. Asscheman, and C. D. A. Stehouwer
1998 Effects of Sex Steroids on Plasma Total Homocysteine Levels: A Study in Transsexual Males and Females. Journal of Clinical Endocrinology & Metabolism 83(2):550-553.

Giltay, Erik J., King H. Kho, Ben A. Blansjaar, Marcel M. Verbeek, P. Ben H. Geurtz, Johanna M. Geleijnse, and Louis J. G. Gooren
2005 The Sex Difference of Plasma Homovanillic Acid is Unaffected by Cross-sex Hormone Administration in Transsexual Subjects. Journal of Endocrinology 187:109-116.

Giltay, Erik J., Mathijs C. Bunck, Louis J. Gooren, Frans G. Zitman, Michaela Diamant, and Tom Teerlink
2008 Effects of Sex Steroids on the Neurotransmitter-Specific Aromatic Amino Acids Phenylalanine, Tyrosine, and Tryptophan in Transsexual Subjects. Neuroendocrinology 88(2):103-110.

Gizewski, Elke R., Eva Krause, Marc Schlamann, Friederike Happich, Mark E. Ladd, Michael Forsting, and Wolfgang Senf
2009 Specific Cerebral Activation due to Visual Erotic Stimuli in Male-to-Female Transsexuals Compared with Male and Female Controls: An fMRI Study. The Journal of Sexual Medicine 6:440-448.

Goffman, Erving
1963 Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice-Hall.

Goh, H. H. and S. S. Ratnam
1990 Effect of Estrogens on Prolactin Secretion in Transsexual Subjects. Archives of Sexual Behavior 19(5):507-516.

Goiar, Charlotte
2010 Harry Benjamin Syndrome. Electronic document, http://shb-info.org/hbs1page.html, accessed February 20, 2010.

Good, Mary-Jo DelVecchio
2007 The Medical Imaginary and the Biotechnical Embrace: Subjective Experiences of Clinical Scientists and Patients. *In* Subjectivity: Ethnographic Investigations. João Guilherme Biehl, Joao Biehl, Byron Good, Arthur Kleinman, eds. Pp. 362-380. Berkeley: University of California Press.

Gooren, Louis
2005 Hormone Treatment of the Adult Transsexual Patient. Hormone Research 64(Suppl. 2):31-36.

Gooren, Louis J. G., and Erik J. Giltay
2008 Review of Studies of Androgen Treatment of Female-to-Male Transsexuals: Effects and Risks of Administration of Androgens to Females. The Journal of Sexual Medicine 5:765-776.

Gooren, Louis J., Erik J. Giltay, and Mathijs C. Bunck
2008 Long-Term Treatment of Transsexuals with Cross-Sex Hormones: Extensive Personal Experience. The Journal of Clinical Endocrinology & Metabolism 93:19-25.

Gould, Stephen Jay
1996[1981] The Mismeasure of Man. Rev. edition. New York: Norton.

Gouskova, Elena, Ngina Chiteji, and Frank Stafford
In press Estimating the Intergenerational Persistence of Lifetime Earnings with Life Course Matching: Evidence from the PSID. Labour Economics

Graham, Sharyn
2003 While Diving, Drink Water: Bisexual and Transgender Intersections in South Sulawesi, Indonesia. Journal of Bisexuality 3(3/4):233-247.

Gravlee, Clarence C., H. Russell Bernard, and William R. Leonard
2003 Heredity, Environment, and Cranial Form: A Reanalysis of Boas's Immigrant Data. American Anthropologist 105(1):125-138.

Hale, C. Jacob
2007 Ethical Problems with the Mental Health Evaluation Standards of Care for Gender Variant Patients. Perspectives in Biology and Medicine 50(4 [autumn]):491-505.

Halperin, David M.
2000 How to do the History of Male Homosexuality. GLQ: A Journal of Lesbian & Gay Studies 6(1):87-123.

Hare, Lauren, Pascal Bernard, Francisco J. Sánchez, Paul N. Baird, Eric Vilain, Trudy Kennedy, and Vincent R. Harley
2009 Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism. Biological Psychiatry 65:93-96.

Herdt, Gilbert, ed.
1994 Third Sex, Third Gender: Beyond Sexual Dimorphism in Culture and History. New York: Zone Books.

Hirschfeld, Magnus
1910 Die Transvestitien (The transvestites). Berlin: Pulvermacher.

Hoyer, Niels, ed.
1933 Man into Woman: An Authentic Record of a Change of Sex. London: Jarrolds.

Hulshoff Pol, Hilleke E., Peggy T. Cohen-Kettenis, Neeltje E. M. van Haren, Jiska S. Peper, Rachel G. H. Brans, Wiepke Cahn, Hugo G. Schnack, Louis J. G. Gooren and René S. Kahn
2006 Changing Your Sex Changes Your Brain: Influences of Testosterone and Estrogen on Adult Human Brain Structure. European Journal of Endocrinology 155:S107-S114.

Humphreys, Laud
1970 Tearoom Trade: Impersonal Sex in Public Places. London: Duckworth.

Jackson, Peter
1997a Kathoey><Gay><Man: The Historical Emergence of Gay Male Identity in Thailand. *In* Sites of Desire, Economies of Pleasure: Sexualities in Asia and the Pacific. Lenore Manderson and Margaret Jolly, eds. Pp. 166-190. Chicago: University of Chicago Press.
1997b Thai Research on Male Homosexuality and Transgenderism and the Cultural Limits of Foucaultian Analysis. Journal of the History of Sexuality 8(1):52-85.

Johnson, Mark
1997 Beauty and Power: Transgendering and Cultural Transformations in the Southern Philippines. Oxford: Berg.

Just Jennifer
2009a Transgender Myths…#1 Association with the LGBT has not Hurt Transsexuals. October 22. http://justjenniferblog.blogspot.com/2009/10/transgender-myths1-association-with.html, accessed February 20, 2010.
2009b It is NOT About Class or Privilege. September 26. http://justjenniferblog.blogspot.com/2009/09/it-is-not-about-class-or-privilege.html, accessed February 20, 2010.

Kanhai, R. C. , J. J. Hage, E. Bloemena, P. J. van Diest, and R. B. Karim
1999 Mammary Fibroadenoma in a Male-to-Female Transsexual. Correspondence in Histopathology 35:181-191.

Kanhai, R. C., J. J. Hage, P. J. van Diest, E. Bloemena, J. W. Mulder
2000 Short-term and Long-term Histologic Effects of Castration and Estrogen Treatment on Breast Tissue of 14 Male-to-Female Transsexuals in Comparison with Two Chemically Castrated Men. American Journal of Surgical Pathology. 24(1):74-80.

Keller, Evelyn Fox
2007 Whole Bodies, Whole Persons?: Cultural Studies, Psychoanalysis, and Biology. *In* Subjectivity: Ethnographic Investigations. João Guilherme Biehl, Joao Biehl, Byron Good, Arthur Kleinman, eds. Pp. 352-361. Berkeley: University of California Press.

Klesse, Christian
2007 Racialising the Politics of Transgression: Body Modification in Queer Culture. Social Semiotics 17(3):275-292.

Krafft-Ebing, Richard von
1965[1886] Psychopathia Sexualis: A Medico-forensic Study. New York: Putnam.

Krujiver, Frank P. M., Jiang-Nin Zhou, Chris W. Pool, Michel A. Hofman, Louis J. G. Gooren, and Dick F. Swaab
2000 Male-to-Female Transsexuals Have Female Neuron Numbers in a Limbic Nucleus. The Journal of Clinical Endocrinology & Metabolism 85(5):2034-2041.

Kulick, Don
1998 Travestí: Sex, Gender and Culture among Brazilian Transgendered Prostitutes. Chicago: University of Chicago Press.

Lapauw, Bruno, Youri Taes, Steven Simoens, Eva Van Caenegem, Steven Weyers, Stefan Goemaere, Kaatje Toye, Jean-Marc Kaufman, and Guy T'Sjoen
2008 Body Composition, Volumetric and Areal Bone Parameters in Male-to-Female Transsexual Persons. Bone 43:1016-1021.

Lawrence, Anne A.
2003 Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery. Archives of Sexual Behavior 32(4):299-315.
2007 A Critique of the Brain-Sex Theory of Transsexualism. Electronic document, http://www.annelawrence.com/twr/brain-sex_critique.html, accessed February 20, 2010.
2008 Shame and Narcissistic Rage in Autogynephilic Transsexualism. Archives of Sexual Behavior 37(3):457-461.
2009 Erotic Target Location Errors: An Underappreciated Paraphilic Dimension. Journal of Sex Research 46(2):194-215.
2010 Something Resembling Autogynephilia in Women: Comment on Moser (2009). Journal of Homosexuality 57(1):1-4.

Le Monde
2010 Le transsexualisme n'est plus une maladie mentale en France [Transsexualism is no Longer a Mental Illness in France]. February 12. Electronic document, http://www.lemonde.fr/societe/article/2010/02/12/le-transsexualisme-n-est-plus-une-maladie-mentale-en-france_1305090_3224.html, accessed March 7, 2010.

LeVay, Simon
1996 Queer Science: The Use and Abuse of Research into Homosexuality. Massachusetts: Massachusetts Institute of Technology. Electronic document, http://www.washingtonpost.com/wp-srv/style/longterm/books/chap1/queerscience.htm, accessed April 19, 2008.

Luders, Eileen, Francisco J. Sánchez, Christian Gaser, Arthur W. Toga, Katherine L. Narr, Liberty S. Hamilton, and Eric Vilain
2009 Regional Gray Matter Variation in Male-to-Female Transsexualism. NeuroImage 46:904-907.

Lysloff, René T.A.
2003 Musical Community on the Internet: An On-line Ethnography. Cultural Anthropology 18(2):233-263.

Mauss, Marcel
2007 Techniques of the Body. *In* Beyond the Body Proper: Reading the Anthropology of Material Life. Margaret M. Lock and Judith Farquhar, eds. Pp. 50-68. Durham, NC: Duke University Press.

Mead, Margaret
2001[1928] Coming of Age in Samoa: A Psychological Study of Primitive Youth for Western Civilisation. New York: Harper Perennial Modern Classics.

Meriggiola, Maria Christina, Francesca Armillotta, Antonietta Constantino, Paola Altieri, Farid Saad, Thomas Kalhorn, Anna Myriam Perrone, Tullio Ghi, Carlotta Pelusi, and Giuseppe Pelusi
2008 Effects of Testosterone Undecanoate Administered Alone or in Combination with Letrozole or Dutasteride in Female to Male Transsexuals. Journal of Sexual Medicine 5:2442-2453.

Meyer, Jon K. and Donna J. Reter
1979 Sex Reassignment: Follow-up. Archives of General Psychiatry 36(9):1010-1015.

Meyer-Bahlburg, Heino F. L.
2009 From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants as Psychiatric Conditions. Archives of Sexual Behavior. Electronic document, doi:10.1007/s10508-009-9532-4.

Meyerowitz, Joanne
2004 How Sex Changed: A History of Transsexuality in the United States. Cambridge: Harvard University Press.
2006 A "Fierce and Demanding Drive." *In* The Transgender Studies Reader. Susan Stryker and Stephen Whittle, eds. Pp. 362-386. New York: Routledge.

Mezzich, Juan E.
2002 International Surveys on the Use of ICD-10 and Related Diagnostic Systems. Psychopathology 35:72-75.

Miles, Clare, Richard Green, Geoff Sanders, and Melissa Hines
1998 Estrogen and Memory in a Transsexual Population. Hormones and Behavior 34(2):199-208.

Miles, Clare, Richard Green, and Melissa Hines
2006 Estrogen Treatment Effects on Cognition, Memory, and Mood in Male-to-Female Transsexuals. Hormones and Behavior 50:708-717.

Miller, Daniel and Don Slater
2000 The Internet: An Ethnographic Approach. Oxford/New York: Berg.

Miner, Horace
1956 Body Ritual Among the Nacirema. American Anthropologist 58(3):503-507.

Moser, Charles
2009a A Response to Lawrence's (2009) *Erotic Target Location Errors*. Journal of Sex Research 46(5):383-384.
2009b Autogynephilia in Women. Journal of Homosexuality 56(5):539-547.
2009c When is an Unusual Sexual Interest a Mental Disorder? Archives of Sexual Behavior 38:323-325.

Nanda, Serena
1994 Hijras: An Alternative Sex and Gender Role in India. *In* Third Sex, Third Gender: Beyond Sexual Dimorphism in Culture and History. Gilbert Herdt, ed. Pp. 373-418. New York: Zone Books.
2000 Gender Diversity: Crosscultural Variations. Long Grove, IL: Waveland Press, Inc.

Narayan, Kirin
1993 How Native is a "Native" Anthropologist? American Anthropologist 95(3):671-686.

the National Center for Transgender Equality and the National Gay and Lesbian Task Force
2009 Preliminary Findings of the National Transgender Discrimination Survey. Electronic document, http://www.thetaskforce.org/downloads/reports/fact_sheets /transsurvey_prelim_findings.pdf, accessed March 6, 2010.

Newton, Esther
1979 Mother Camp: Female Impersonators in America. Chicago: University of Chicago Press.

Nuttbrock, Larry, Walter Bockting, Mona Mason, Sel Hwahng, Andrew Rosenblum, Monica Macri, and Jeffrey Becker
2009 A Further Assessment of Blanchard's Typology of Homosexual Versus Non-Homosexual or Autogynephilic Gender Dysphoria. Electronic document, doi:10.1007/s10508-009-9579-2.

Pfäfflin, Friedemann and Astrid Junge
1998 Sex Reassignment: Thirty Years of International Follow-up Studies After SRS: a Comprehensive Review, 1961-1991. Düsseldorf: Symposium Publishing.

Prosser, Jay
1998 Second Skins: The Body Narratives of Transsexuality. New York: Columbia University Press.

Purple Speaks
2009 What is Sick About What the TGs do? October 24. http://purplespeaks.wordpress.com/2009/10/24/what-is-sick-about-what-the-tgs-do, accessed February 20, 2010.

Raymond, Janice
1994[1979] The Transsexual Empire: The Making of the She-male. New York: Teachers College Press.

Reddy, Gayatri
2005 With Respect to Sex: Negotiating Hijra Identity in South India. Chicago: University of Chicago Press.

Resmini, Eugenia, Gabriella Andraghetti, Alberto Rebora, Renzo Cordera, Lara Vera, Massimo Giusti, Francesco Minuto and Diego Ferone
2008 Leptin, Ghrelin, and Adiponectin Evaluation in Transsexual Subjects During Hormonal Treatments. Journal of Andrology 29(5):580-585.

Reutrakul, S., B. Ongphiphadhanakul, N. Piaseu, S. Krittiyawong, S. Chanprasertyothin, P. Bunnag, and R. Rajatanavin
1998 The Effects of Oestrogen Exposure on Bone Mass in Male to Female Transsexuals. Clinical Endocrinology 49:811-814.

Riddell, Carol
2006[1980] Divided Sisterhood: A Critical Review of Janice Raymond's *The Transsexual Empire*. *In* The Transgender Studies Reader. Susan Stryker and Stephen Wittle, eds. Pp. 144-158. New York: Routledge.

Roscoe, Will
1991 The Zuni Man-Woman. Albuquerque: University of New Mexico Press.
1998 Changing Ones: Third and Fourth Genders in Native North America. London: Macmillan.

Roughgarden, Joan
2004 Evolution's Rainbow: Diversity, Gender, and Sexuality in Nature and People. Berkeley: University of California Press.

Sanchez, Nelson F., John P. Sanchez, and Ann Danoff
2009 Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City. American Journal of Public Health 99(4):713-719.

Sartre, Jean-Paul
1948 Anti-Semite and Jew. Paris: Schocken Books.

Sax, Leonard
2002 How Common is Intersex? A Response to Anne Fausto-Sterling. The Journal of Sex Research 39(3):174-178.

Scheper-Hughes, Nancy
1995 The Primacy of the Ethical: Propositions for a Militant Anthropology. Current Anthropology 36(3):409-440.

Schöning, Sonja, Almut Engelien, Christine Bauer, Harald Kugel, Anette Kersting, Cornelia Roestel, Pienie Zwitserlood, Martin Pyka, Udo Dannlowski, Wolfgang Lehmann, Walter Heindel, Volker Arolt, and Carsten Konrad
In press Neuroimaging Differences in Spatial Cognition Between Men and Male-to-Female Transsexuals Before and During Hormone Therapy. The Journal of Sexual Medicine.

Sinnott, Megan
2004 Toms and Dees: Transgender Identity and Female Same-Sex Relationships in Thailand. Honolulu: University of Hawai‘i Press.

Slagter, Margrita H., Louis J. G. Gooren, Andreas Scorilas, Constantina D. Petraki, and Eleftherios P. Diamandis
2006 Effects of Long-term Androgen Administration on Breast Tissue of Female-to-Male Transsexuals. Journal of Histochemistry & Cytochemistry 54(8):905-910.

Sosa M, E Jódar, E Arbelo, C Domínguez, P Saavedra, A Torres, E Salido, MJ de Tejada, and D. Hernández
2003 Bone Mass, Bone Turnover, Vitamin D, and Estrogen Receptor Gene Polymorphisms in Male to Female Transsexuals: Effects of Estrogenic Treatment on Bone Metabolism of the Male. Journal of Clinical Densitometry 6(3):297-304.

Star, Hedy Jo
1955 I Changed My Sex! Publisher unknown.

Stone, Sandy
1991 The *Empire* Strikes Back: The Posttranssexual Manifesto. *In* Body Guards: the Cultural Politics of Gender Ambiguity. Julia Epstein and Kristina Straub, eds. Pp. 144-158. New York: Routledge.

Stryker, Susan, and Stephen Wittle, eds.
2006 The Transgender Studies Reader. New York: Routledge.

Swaab, Dick F.
2004 Sexual Differentiation of the Human Brain: Relevance for Gender Identity, Transsexualism and Sexual Orientation. Gynecological Endocrinology 19:301-312.

Teh, Yik Koon
2002 The Mak Nyahs: Malaysian Male to Female Transsexuals. Singapore: Eastern University Press.

The Oblongs
2001 Pickles’ Little Amazons. Skip Jones, dir. 22 min. Film Roman. Burbank.

Toorians, A. W. F. T., M. C. L. G. D. Thomassen, S. Zweegman, E. J. P. Magdeleyns, G. Tans, L. J. G. Gooren, and J. Rosing
2003 Venous Thrombosis and Changes in Hemostatic Variables during Cross-Sex Hormone Treatment in Transsexual People. The Journal of Clinical Endocrinology & Metabolism 88(12):5723-5729.

Towle, Evan B. and Lynn M. Morgan
2002 Romancing the Transgender Native: Rethinking the Use of the "Third Gender" Concept. GLQ: A Journal of Lesbian and Gay Studies 8(4):469-497.

Tromovitch, Philip
2009 Manufacturing Mental Disorder by Pathologizing Erotic Age Orientation: A Comment on Blanchard et al. 2008. Archives of Sexual Behavior 38:328.

Valentine, David
2007 Imagining Transgender: An Ethnography of a Category. Durham, NC: Duke University Press.

van Kesteren, P. J., H. Asscheman, J. A. Megens, and L. J. Gooren
1997 Mortality and Morbidity in Transsexual Subjects Treated with Cross-sex Hormones. Clinical Endocrinology 47(3):337-343.

WPATH
2001 The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders. 6th edition. Electronic document, http://www.wpath.org/Documents2/socv6.pdf, accessed October 17, 2007.

Walters, William A.W. and Michael W. Ross, eds.
1986 Transsexualism and Sex Reassignment. Oxford: Oxford University Press.

Weston, Kath
1993 Lesbian/Gay Studies in the House of Anthropology. Annual Review of Anthropology 22:339-367.

Wilson, Rhoda, Carol Jenkins, Helen Miller, and Susan Carr
2006 The Effect of Oestrogen on Cytokine and Antioxidant Levels in Male to Female Transsexual Patients. Maturitas: The European Menopause Journal 55:14-18.

Wilson, Samuel M. and Leighton C. Peterson
2002 The Anthropology of On-line Communities. Annual Review of Anthropology 31:449-467.

Windsor, Elroi J.
2008 Accounting for Power and Academic Responsibility. Archives of Sexual Behavior 37(3):495-497.

Women Born Transsexual
2009c HBS? Count me Out. http://womenborntranssexual.com/2009/08/25/hbs-count-me-out, accessed February 20, 2010.

Wynn, Eleanor and James E. Katz
1997 Hyperbole Over Cyberspace: Self-presentation and Social Boundaries in Internet Home Pages and Discourse. The Information Society 13(4):297-327.

Young, Antonia
2000 Women Who Become Men: Albanian Sworn Virgins (Dress, Body, Culture). Oxford: Berg.

Zhou, Jiang-Ning, Michel A. Hofman, Louis J. G. Gooren, and Dick F. Swaab
1995 A Sex Difference in the Human Brain and its Relation to Transsexuality. Nature 387:68-70.

APPENDIX

Questionnaire Form

Thank you for taking the time to review the questions listed here. Your responses are extremely valuable and will help my study to demonstrate the diversity of experiences and opinions of individuals with atypical gender histories. Though these questions have been created to explore the specific issues that my study will examine, I welcome any additional comments that you find relevant or that you think deserve further exploration. Please read through the questions and answer all you feel comfortable with, but also feel free to answer questions I did not ask or to write answers that incorporate multiple questions at once if you prefer.

Do you identify as male or female? If neither, how do you identify?

Were you assigned at birth as male or female? If neither, what were the circumstances?

Do you identify as transgender? Why? If not, did you at one point in time? Is there another term that you prefer to be used?

What do you feel is your relationship to the larger transgender community, if any?

Do you believe that the terms "man" and "woman" are broad enough that all individuals can fit into either one of these categories or the other? Can your own gender identity be described by either word?

Which websites or forums have you found to be the most useful in obtaining information about gender identity and transition issues?

Do you attend any local transgender support groups? Have you in the past? Do you have a preference between participating in the transgender community online or "in real life?"

If you are seeing a doctor, are you satisfied with the availability and quality of care that you receive for gender-related services? Do you feel that your gender identity has had a negative impact on the way that you have been treated by health care professionals? If so, in what way?

In 1994, the Diagnostic Statistical Manual (DSM) of the American Psychological Association (APA) replaced the diagnosis "Transsexualism" with "Gender Identity Disorder" (GID). What is your opinion of the term "gender identity disorder" and how it is applied to individuals who were formerly diagnosed under the term "transsexual?" Do you identify as a person with gender identity disorder? Why or why not?

Do you believe that cross-gender identity is an intersex condition? Why or why not? What would you consider to be the origin, if any, of your atypical gender history?

Do you plan to or currently use hormone replacement therapy (HRT) to improve your comfort with your body? If you take hormones, how long have you done so? Have you always taken hormones under doctor's supervision? Why or why not?

If you use or have used hormones, do you feel satisfied with the changes to your body? Are there things that you wish would improve further?

Do you feel that it is preferable to have hormones and surgeries available through the approval of health care professionals, or a more on-demand system instead? Why?

What information sources did you or do you use to learn about hormones? Do you feel as well informed about cross-gender hormone treatment as your health care provider (if any)?

What role does surgery play in your transition? Do you intend to have gender-related surgeries, or have you already done so? Do you feel that surgery is necessary in transition?

Use this space for any questions or additional comments you'd like to make.