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Constructing the Transsexual: Medicalization, Gatekeeping, and the Privatization of Trans Healthcare in the U.S., 1950-2019

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Constructing the Transsexual: Medicalization, Gatekeeping, and the Privatization of Trans
Healthcare in the U.S., 1950-2019

Senior Project Submitted to
The Division of Social Studies
Of Bard College

By Erin Gifford

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Introduction

Freely circulating and collectively used testosterone is dynamite for the heterosexual regime.¹

My biopolitical options are as follows: either I declare myself to be a transsexual, or I declare myself to be drugged and psychotic.²

Last winter, I decided to start actively pursuing what is known as chest masculinization or “top surgery.” I called a plastic surgeon in New York to request a consultation. While we were trying to settle on a date, the secretary inquired of me:

“...and you’ve been on testosterone for at least one year, right?”

“No, do I have to be to schedule a consult?”

“Oh yes, the doctor won’t see you for a consultation unless you’ve been on testosterone for one year and have two letters of recommendation, one from your hormone provider, and one from a mental health professional.”

I tried to find another surgeon in New York that do the procedure without me fulfilling those criteria to no avail--the ones that would didn’t accept my insurance, so I would have had to pay between \$7,000-\$10,000 out of pocket if I wanted to see them. I requested some forms from my insurance provider to find out who else was in-network when I realized that my policy said the same thing: one year of hormone therapy and two letters of recommendation to get top surgery covered as a treatment for gender dysphoria.

I thought, *What the hell, I might as well start taking T (testosterone) if that’s the only way I can get top surgery.* During a visit with my primary care physician to start hormone therapy, I

¹ Paul B. Preciado. *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*. Feminist Press. 2013. 230.

² Paul B. Preciado. *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*. Feminist Press. 2013. 256.

realized as I was explaining what I wanted to her that she had never had a trans patient before. She had no answers to the questions that I asked about the effects of testosterone, how much it would cost, what options I had in terms of the form the medication would come in. I felt awkward sitting on the padded table explaining myself to her while she looked at me blankly. When I left with no prescription for testosterone, she referred me to a plastic surgeon who she said could perform top surgery. When I called the office phone, they said, “No, sorry, the doctor doesn’t do that kind of surgery.”

Fast forward a few months, and I’ve finally gotten a prescription for testosterone gel from a trans-friendly provider at a nearby reproductive health clinic. When I go to pick up the prescription, they tell me it will cost a few hundred dollars because my insurance has not covered it. After leaving the pharmacy without my prescription, I called my insurance provider and was on hold for about an hour until someone finally said they had not given a prior-authorization for the prescription. We exchanged calls more than 30 times over the next two months, and finally, I was able to pick up my prescription.

A year after being on testosterone, I finally made an appointment with a therapist in order to get a recommendation for my top surgery. Despite this therapist being trans himself, he required that I come in three times to talk about my relationship to my gender and my reasons for wanting surgery. As he was asking me about how long I’ve wanted to get top surgery during one of our 50-minute long sessions, I couldn’t help but wanting to talk about some other personal issues causing me stress. I was frustrated by this, particularly because I have been “living as” trans for well over four years now.

As I went through this process, I assembled the research that would become this project. Many of the materials that I encountered while researching were incredibly painful to look at, most notably arguments about transition regret and trans-exclusionary radical feminists. It was very important to me to continue writing this project, and helped me dispel the anxieties I was having about my choices to pursue hormone therapy and top surgery and be more sure of my decisions.

On March 13, 2019, I finally was able to get top surgery. My experience, although it was extremely frustrating and time-consuming, pales in comparison to what many other trans people go through in order to access the embodiment that they are seeking. Many trans people are not able to pursue procedures like top surgery precisely because it is so difficult to access. (Unless, of course, you pay out-of-pocket).

In writing this project, I wanted to speak to the reasons why materializing our desired embodiments is so inaccessible and difficult for many trans people. I offer an analysis of the relationship that trans people have to transition-related healthcare in the contemporary United States that is grounded in historical context, drawing both from the medical profession itself and the trans people who have interacted with it, placing a particular emphasis on centralizing the voices of trans people most affected by interlocking systems of oppression on the basis of their race, class, and sexuality. Chapter 1 focuses on the years between 1950-1979, during which gender variance was medicalized within medical and popular discourse as a pathology known as ‘transsexualism’ with a set treatment that consisted of counseling, hormone therapy, and surgery. I argue that endocrinologist Harry Benjamin and famous trans woman Christine Jorgensen were two figures central to constructing transsexual through invoking notions whiteness,

heterosexuality, and middle-class sensibility to render it intelligible. Chapter 2 deals with the standardization and professionalization of the treatment for this pathology that started with the closure of university-based gender identity clinics in 1979. I argue that the gatekeeping model of trans healthcare is aimed at controlling, disciplining, and regulating the expression of gender variance, thereby restricting access to those who can meet strict diagnostic criteria. Chapter 3 argues that privatization of these treatments, which started in the 1980s, and the simultaneous exclusion from coverage by most major health insurance plans separated the treatment from the pathology, and constructing medical care as a luxury that only few can afford to access. The conclusion seeks to imagine an alternative, in which gender variance is demedicalized and gender affirming care is freely accessible to all those that seek it.

Chapter 1

Inventing the Transsexual Phenomenon: Medicalizing Gender Variance in Mid-Twentieth Century U.S. Medical Discourse and Popular Culture

Being a true physician, Benjamin treated all these patients as people and by respectfully listening to each individual voice, he learned from them what gender dysphoria was about. These early patients must be lauded for their courage in seeking a description of and a solution to a phenomenon that had as yet no description and no solution. They discovered a physician who was willing to try to treat their unusual condition in a way that had never been attempted before.³

Personally, he only did girls he thought would pass. He only did white girls. Would help those girls. So taller girls like myself had to find other places. The black girls had to go to other places.⁴

During the later half of the twentieth century (1948-1979), gender variance was medicalized within medical discourse as a diagnosable condition known as ‘transsexualism,’ which had one legitimate treatment path. Medical professionals, such as Harry Benjamin, laid claims to expert knowledge about the ‘transsexual’ condition and dominion over its management. At the same time, stories and images of trans people emerged and circulated in newspapers and books, marking the first time that many people in the U.S. would hear about ‘transsexuals.’ How were the ‘symptoms’ of this condition constructed within medical discourse? What were the goals of treatment? What was at stake in medicalizing gender variance

³ Leah Cahan Schaefer and Connie Christine Wheeler, "Harry Benjamin's first ten cases (1938-1953): A clinical historical note." *Archives of Sexual Behavior* Vol. 24, no. 1, 73-93. March 1995. <https://doi.org/10.1007/BF01541990>.

⁴ Miss Major Griffin-Gracy interviewed by AJ Lewis, *New York City Trans Oral History Project*. Interview Date December 16, 2017. Transcript #054. <https://s3.amazonaws.com/oral-history/transcripts/NYC+TOHP+Transcript+054+Miss+Major+Griffin-Gracy.pdf>. Accessed April 30, 2019.

as ‘transsexualism’? How did its construction in media foreclose possibilities for certain bodies to be intelligible as ‘transsexuals’ and access this world of meaning?

Biopower, Problematization, and Medicalization

In order to ground this chapter, I open with Michel Foucault’s concept of medicalization, which “...describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.”⁵ The concept is typically applied when to critically analyze a phenomenon which someone is arguing ought not to have been medicalized, rather than simply stating that something has become medical. Sociologist Peter Conrad writes that the thrust of medicalization lies in the power of definitions: Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it.⁶ These definitions, exhibited by diagnostic criteria, symptoms, and treatment options, render social and bodily phenomenon into pathologies that must be understood and managed through social control.

Foucault’s concept of ‘biopower,’ the “administration of bodies and the calculated management of life”⁷ is best characterized by the “power to qualify, measure, appraise, and hierarchize”⁸ on the part of social institutions like medicine. Foucault notes that the key sites of medical biopower and knowledge are sex, race, and gender, which had to be subjected to

⁵ Peter Conrad, “Medicalization and Social Control” in *Annual Review of Sociology*, Vol. 18, 209-232. Annual Reviews. 1992. <https://www.jstor.org/stable/2083452>. 209.

⁶ Peter Conrad, “Medicalization and Social Control,” 211.

⁷ Michel Foucault. “Right of Death and Power over Life” in *The History of Sexuality, Volume I*. Random House. 1978. Available online through <http://home.ku.edu.tr/~mbaker/CSHS503/FoucaultHistorySex.pdf>. 262.

⁸ Foucault, “Right of Death and Power over Life,” 266.

biopower in order to maintain production relations under capitalism. He writes on sex, “Power delineated it, aroused it, and employed it as *the proliferating meaning that had always to be taken control of again lest it escape.*”⁹ Biopower, then, is exercised by all the institutional bodies and figures that exert social control over gender variance. Its goal is to maintain and manage life, providing access to medical services only through the mediation and control of medical professionals, who monitor, scrutinize, and evaluate who is allowed to access transition-related care and under what conditions.

Trans activist and attorney Dean Spade writes that the medicalization of gender variance, and thereby the normalization of biological sex and gender, constructs it as an visible social problem to be controlled and suppressed:¹⁰

...medicine produces it [a fiction of natural gender] not through a description of the norm, but through a generalized account of the norms transgression by gender deviants. By instructing the doctor/parent/teacher to focus on the transgressive behavior, the diagnostic criteria for GID¹¹ establishes surveillance and regulation effective for keeping both non-transsexuals and transsexuals in adherence to their roles.¹²

If gender variance were to be understood as a normal social phenomenon consisting of existing outside, in-between, and/or in opposition to binary sex and gender, the sex/gender system, supposedly rooted in innate biological differences between ‘men’ and ‘women,’ would be destabilized. By theorizing gender variance as an inherent pathology, medicalization has functioned to allow only those who purport to uphold this system to access transition-related hormonal interventions and surgery, thereby upholding the binary sex/gender system through maintaining that gender variants are an errant, uncontrollable, medical phenomenon.

⁹ Foucault. “Right of Death and Power over Life,” 260. Emphasis added.

¹⁰ Dean Spade, “Resisting Medicine, Re/modeling Gender” in *Berkeley Women’s Law Journal*, Vol. 15, 15-27. <http://www.deanspade.net/wp-content/uploads/2010/07/resisting.pdf>. 2003. 25.

¹¹ Gender Identity Disorder.

¹² Dean Spade, “Resisting Medicine, Re/modeling Gender,” 25-26.

Dr. Harry Benjamin Invents the Transsexual

Dr. Harry Benjamin (1885-1986) is often canonized¹³ as the father of transsexualism.¹⁴ His pioneering contributions single-handedly shaped much of the contemporary geography of trans healthcare. Benjamin was a German-American sexologist and endocrinologist, widely remembered for his groundbreaking work on ‘transsexualism’ between 1948-1979 in the U.S.. He was not the first nor the only doctor¹⁵ in the U.S. to provide gender-affirming services to trans people, however, his work has had a strong impact on mainstreaming and standardizing trans healthcare and thus deserves substantial attention. Benjamin defied the cultural and medical norms of his U.S. contemporaries by constructing transness as a medical condition that should be treated with hormones and surgery, rather than psychotherapy, thereby cracking open a new world in which some trans people could more readily access the embodiments they desired. At the same time, other possibilities were foreclosed, such as non-medical and self-determined conceptions of trans identity that went beyond the white, heteronormative, binary conception.

Perhaps the defining feature of Benjamin’s work was that he advocated providing gender variant people, or as he called them, ‘transsexuals,’ with hormones and surgery because he believed that cross-gender identification had somatic causes.¹⁶ Benjamin stood out amongst his American contemporaries for his radical views on sexuality,¹⁷ sex, and gender, expressing “contempt for what he saw as prudery and hypocrisy”¹⁸ in American medicine, particularly on

¹³ Julian Gill-Peterson. *Histories of the Transgender Child*. University of Minnesota Press. 2018. 19.

¹⁴ See Schaefer and Wheeler, “Harry Benjamin’s first ten cases,” and Richard Elkins, “Science, Politics, and Clinical Intervention: Harry Benjamin, Transsexualism, and the Problem of Heteronormativity” in *Sexualities Vol 8, Issue 3*, 306-328. SAGE. 2005.

¹⁵ Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States*. Harvard University Press. 2002. 41-45.

¹⁶ Meyerowitz, *How Sex Changed*, 46.

¹⁷ See Meyerowitz, *How Sex Changed*, 45-46 for more.

¹⁸ Meyerowitz, *How Sex Changed*, 46.

the part of psychologists. Benjamin writes about the prudish morality of American doctors and their taboo¹⁹ on providing hormonal and surgical interventions to people who requested them to alter their appearances:

The forces of nature, however, know nothing of this taboo [the inviolability of sex/gender], and facts remain facts. Intersexes exist, in body as well as in mind. I have seen too many transsexual patients to let their picture and their suffering be obscured by uninformed albeit honest opposition. Furthermore, I felt that after fifty years in the practice of medicine, and in the evening of life, I need not be too concerned with a disapproval that touches much more on morals than on science.

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Many American medical professionals argued against the existence of ‘transsexualism’, arguing that people who experienced cross-gender identification were experiencing psychotic delusions that could be remedied through rigorous psychological counseling.²¹ Take, for example, this recollection from Christine Jorgensen, a trans woman, who describes an interaction with a psychiatrist in 1948 after explaining to him that she wanted to ‘be’ a woman: “‘I can’t guarantee you anything,’ he said. ‘but I’d like you to start a series of psychoanalytic treatments. About thirty, I would imagine.’”²² Jorgensen continues, “‘He then explained to me that through these treatments, he would try to guide me away from these ‘feminine inclinations.’” This psychiatrist’s reaction was typical of U.S. doctors at midcentury, who did not see hormonal or surgical intervention as a treatment for this condition. Indeed, historian Joanne Meyerowitz goes as far to say that “sex-reassignment surgery did not exist” during this period, with a few exceptions.²³

¹⁹ “Any interference with the sacrosanct stability of our sex is one of the great taboos of our time. Therefore, its violation is strongly resented with emotions likely to run high, even among doctors.” Harry Benjamin, *The Transsexual Phenomenon*. The Julian Press. 1966. Available online at <http://www.mut23.de/texte/Harry%20Benjamin%20-%20The%20Transsexual%20Phenomenon.pdf>. 9.

²⁰ Benjamin, *The Transsexual Phenomenon*, 5.

²¹ U.S. sexologist David O. Cauldwell and sex researcher Alfred Kinsey advocated strongly against surgery as a ‘treatment’ for transsexuality. See Meyerowitz, 44-48.

²² Christine Jorgensen. *Christine Jorgensen, A Personal Autobiography*. Bantam Books. 1967. 66.

²³ Meyerowitz, *How Sex Changed*, 49.

Between 1938-1953, Benjamin, in his sixties, saw the first ten ‘transsexual’ patients of his career, who came to him when no such formal diagnosis existed.²⁴ Historian Joanne Meyerowitz reminds us, “They did not need the label ‘transsexual’ or ‘transgender’ to articulate a request to change sex. They tried to identify their problem with whatever labels they had, and then they asked for help.”²⁵ For these first patients, Benjamin simultaneously functioned as an endocrinologist, counselor, reference for plastic surgeons, and helped link transgender people with others like them.²⁶ Richard Elkins notes that this period of Benjamin’s work “...predates the period of a sophisticated terminology of sex, sexuality and gender. There is no language of gender identity or gender dysphoria for Benjamin to draw on.”²⁷ By creating his own terms, definitions, diagnostic criteria, and treatments, Benjamin assumed a massive amount of medical authority and took the first steps to medicalize gender variance as a condition known as ‘transsexualism.’ Benjamin would later write in 1966, “There is a challenge as well as a handicap in writing a book on a subject that is not yet covered in the medical literature. Transsexualism is such a subject.”²⁸ Embedded within this statement is Benjamin’s presupposition that ‘transsexualism’ was, in fact, a medical problem that needed to be covered in medical discourse, and that he was the one qualified to take the first steps to make this happen.

Constructing the Symptoms

²⁴ Schaefer and Wheeler, “Harry Benjamin’s first ten cases”.

²⁵ Meyerowitz, *How Sex Changed*, 36.

²⁶ Schaefer and Wheeler, “Harry Benjamin’s first ten cases”.

²⁷ Richard Elkins, “Science, Politics, and Clinical Intervention: Harry Benjamin, Transsexualism and the Problem of Heteronormativity” in *Sexualities Vol. 8, no. 3*, pp. 306-328. 2005.

²⁸ Benjamin, *The Transsexual Phenomenon*, 4.

Benjamin's construction of transsexuality as a medical problem rested on defining its symptoms. Although the term "transsexual" had been in use since in the U.S. since at least 1949 when Dr. David O. Cauldwell wrote "Psychopathia Transsexualis," Benjamin popularized the term "transsexual" in the early 1950s.²⁹ Many of his early patients³⁰ described experiencing gender-confusion early in life,³¹ distress about their bodies³² characterized by a desire to be rid of them, and an inability to function in society the way that 'normal' people did.³³ Benjamin, upon hearing this information, decided that these would constitute the symptoms of 'true' transsexuality, a concept he first invoked through differentiating between the three different 'types' of transsexuals, 1, 2, and 3, with 3 showing the highest "degree of sex and gender role confusion," and a "much deeper emotional disturbance." Benjamin writes, "He lives only for the day when his "female soul" is no longer being outraged by his male body, when he can function as a female - socially, legally, and sexually."³⁴ He also considered this group to be largely asexual: "...he is often asexual or masturbates on occasion, imagining himself to be female."³⁵ It was this group that Benjamin advocated treating with hormone therapy and surgical intervention.

In 1949, Benjamin met his first "true"³⁶ transsexual patient, Val Barry, a 23-year-old patient referred to him by sex researcher Alfred Kinsey, who met Barry while taking sex

²⁹ Susan Stryker, *Transgender History*, 38.

³⁰ It is important to note that 8/9 patients were male-to-female, while only one was female-to-male; all were socioeconomically middle-class (3 were raised in upper-class backgrounds); 9 received hormonal therapy, with 6 undergoing genital surgery. No information about the racial/ethnic makeup of this group was provided. Schaefer and Wheeler, "Harry Benjamin's first ten cases".

³¹ See Benjamin, *The Transsexual Phenomenon*, 37, and Schaefer and Wheeler, "Harry Benjamin's first ten cases", 73.

³² "The transsexual (TS) male or female is deeply unhappy as a member of the sex (or gender) to which he or she was assigned by the anatomical structure of the body, particularly the genitals...their sex organs, the primary (testes) as well as the secondary (penis and others) are disgusting deformities that must be changed by the surgeon's knife." Benjamin, *The Transsexual Phenomenon*, 11.

³³ Schaefer and Wheeler, "Harry Benjamin's first ten cases".

³⁴ Benjamin, *The Transsexual Phenomenon*, 13-14.

³⁵ Ibid.

³⁶ Schaefer and Wheeler, "Harry Benjamin's first ten cases", 76.

histories in San Francisco in 1948.³⁷ Barry was desperately seeking feminizing hormones and surgery to alter her body. Benjamin could provide estrogen therapy, not surgery; but he urged her to pursue it in Europe. Benjamin inquired³⁸ of California's district attorney, Edmund G. Brown, about the legality of castration in the state, to which Brown replied the procedure would constitute a violation of so-called "mayhem statutes," laws dating back to English common law in the middle ages which criminalized the willful disabling or destruction of the healthy tissue of another person.³⁹ Psychiatrist Karl Bowman and sex researcher Alfred Kinsey decided not to endorse surgery for Barry, opined that surgery would not cure Barry's psychological condition. Benjamin continued to assist Barry, eventually helping her to find a doctor willing to do her genital surgery in Sweden in 1953.⁴⁰

Interesting in regards to Barry's story is how she is described as a 'true transsexual'.⁴¹ Schaefer and Wheeler write retrospectively about Barry, emphasizing that she dressed as a girl consistently in her early childhood, even while at school. Reviewing her institutional records, they write that she had a "desire from childhood to be a girl and from puberty to change physically", so that she "could marry, have a house and children."⁴² Her desire to alter her embodiment to align more with a 'female' body, then, seemed to stem from a pathology that took hold early in her life, and was also bolstered by her aspirations to become a housewife. The consistency of her gender expression and identification is further taken by Schaefer and Wheeler as evidence of symptoms characteristic of 'transsexuals.' Barry's "ideas, interests, and modes of

³⁷ Schaefer and Wheeler.

³⁸ "Annoyed, Benjamin replied: 'it is difficult to reconcile my common sense with the fact that statutes based on the requirements of English kings in the middle ages should still be valid...'" Meyerowitz, *How Sex Changed*, 47.

³⁹ Stryker, *Transgender History*, 62.

⁴⁰ Meyerowitz, *How Sex Changed*, 48.

⁴¹ Schaefer and Wheeler, "Harry Benjamin's first ten cases", 76.

⁴² Schaefer and Wheeler, "Harry Benjamin's first ten cases", 77.

thought were consistently feminine,” and she "denied ever having an erection (nocturnal or otherwise) and...ever masturbating.”⁴³ Benjamin’s idea of the true transsexual as asexual and in a pure state devoid of sexuality creates a subject stripped of eroticism and desire, unable to experience sexuality lest they be seen as homosexual or not truly experiencing a desire to be of another gender. Possibilities for expressing sexuality pre-transition was threatening to the idea that gender preceded sexuality, a common idea in the post-war United States.⁴⁴

Benjamin’s idea of the ‘true transsexual’ was predicated on the ability and desire of the person to ‘pass’ as a person with binary gender. Miss Major, a black trans woman and trans rights activist who was born in 1942, recounted her life as a street queen during the late 1950s in Chicago over the course of an interview with trans historian Susan Stryker. Major obtained her hormones through the black market, paying an unnamed private doctor on the North side of Chicago \$25 per shot of estrogen with money she earned through hooking.⁴⁵ When she moved to New York City in 1960, she tried to get hormones from Benjamin to no avail. She recounted the experience in an interview with the New York City Trans Oral History Project:

Girl, we tried, child, we tried. We went there and the receptionist was very polite and very sweet but very no. [laughs] Yeah, “he’s not seeing you”. And at the time, any girl that went to him, you had to go to him “done”. You couldn’t go to him in boy’s clothes because you were out running around during the day time. You had to be “done”. You had to be dressed. You had to have your shit together. So that means you got dressed at home, you jumped in a cab, cause you couldn’t go anywhere in public, we couldn’t take that chance. Directly to his office. Have the cab stop in front, run inside, have the cab meet you when you went to leave and then go home.⁴⁶

⁴³ Schaefer and Wheeler, "Harry Benjamin's first ten cases", 77.

⁴⁴ Michael David Franklin, "Calculating Risk History of Medicine, Transgender Oral History, and the Institutional Review Board" in *Queer Twin Cities*. Twin Cities GLBT History Project. University of Minnesota Press. 2010. 30.

⁴⁵ Miss Major interviewed by Susan Stryker. GLBT Historical Society. Interview Date January 29, 1998. http://docs.glbthistory.org/oh/Major1-29-1988_web.pdf. Accessed April 25, 2019.

⁴⁶ Miss Major Griffin-Gracy interviewed by AJ Lewis. *New York City Trans Oral History Project*. Interview Transcript #054. December 16, 2017. <https://s3.amazonaws.com/oral-history/transcripts/NYC+TOHP+Transcript+054+Miss+Major+Griffin-Gracy.pdf>. Accessed April 26, 2019.

‘True transsexuals,’ it seemed, had to perform gender to such an extent that they put their safety⁴⁷ in jeopardy in order to meet the medical criteria for a diagnosis. For many trans people, this was not possible in day-to-day life. It is apparent from Major’s statement that Benjamin thought of the ability to successfully pass as the desired gender as a prerequisite for undergoing hormone therapy and possible surgical interventions. People he thought could pass not was not allowed to access hormones through a legitimate medical venue. In the 1963 edition of *Sexology* magazine, an anonymous trans person wrote to Benjamin asking about what they could do to “end” their “misery.”⁴⁸ In order to determine if a ‘sex change’ was appropriate to recommend, one of his questions in response was,

Is your general appearance and physical build such that you can pass as a woman, or is it possible you will look more like a man dressed up as a woman? Don’t ask the mirror, take the word of an objective outsider.⁴⁹

By this logic, a major consideration in a person’s decision to pursue transitioning had to be the viability of ‘success’ in the desired gender. However, the agency of the trans person to decide this for themselves is displaced by the word of the “objective outsider,” who must determine if they could, in fact, pass. The sentiment that trans people are not ‘objective enough’ to determine whether they are trans or pass as their desired gender is strange, especially since there still to this day has been no successful diagnostic test that can conclusively determine if someone is

⁴⁷ Many trans people do not sufficiently ‘pass’ prior to undergoing hormonal and surgical interventions, thereby exposing them to social control and discipline for their gender transgressions in the form of extra legal (and legal) violence from strangers and law enforcement. This kind of violence did not fall on trans people indiscriminately; when asked about encounters with law enforcement and institutionalization, Miss Major replied: “...It happened to..well, not exactly ALL of us...there were a few that skated through, come from, you know money. So they do a lot, they do better than the rest of us. They actually get to be an older person without a record, or fingerprints or abuse from the police.” Miss Major Griffin-Gracy interviewed by AJ Lewis. *New York City Trans Oral History Project*.

⁴⁸ Harry Benjamin, “I Want to Change My Sex!” in *Sexology: Modern Guide to Sex Knowledge*. Gernsback. December 1963. 292.

⁴⁹ Harry Benjamin, “I Want to Change My Sex!,” 293-294.

transgender. Medical authority, then, is positioned as the objective outside eye that can discern the appropriateness of transition for trans people.

Intrinsic to the success of medicalization is upholding the fiction that doctors and experts are objective outsiders that are immune from subjective thoughts, biases, and emotions. It is obvious, however, that Benjamin's medical 'objectivity' was not such. Miss Major reflects on her impression of Benjamin:

Personally, he only did girls he thought would pass. He only did white girls. He only did girls who were between, no one taller than 5'6". Would help those girls. So taller girls like myself had to find other places. The black girls had to go to other places. Stuff like that.⁵⁰

Major's remarks beg the question: why did the doctor withhold treatment from black trans people who went to his office? Why did he not consider that these people were worthy of his medical care and attention? Trans historian Julian Gill-Peterson writes, "...the abstract whiteness projected onto the white trans body justified the attention given by doctors. Black trans and trans of color patients were much rarer because they were by design not welcome within that discourse."⁵¹ The medical discourse created by Benjamin about transness had little space to accommodate the 'treatment' of Black trans people. Benjamin made choices, rooted in racism, about who was to be given access to a transition under the supervision of professionals. He made value judgments on the worthiness of Black trans people to receive medical attention.

His decisions to deny access to hormone therapy and referrals for surgery had material effects on Black trans people's lives and created no legitimate path for them to materialize the embodiment they desired. They were not going to stop pursuing hormone therapy, as evidenced by Miss Major's words '...the black girls had to find other places.'⁵² They looked to the black

⁵⁰ Miss Major Griffin-Gracy interviewed by AJ Lewis. New York City Trans Oral History Project.

⁵¹ Julian Gill-Peterson, *Histories of the Transgender Child*, 27.

⁵² Miss Major interviewed by Susan Stryker, GLBT Historical Society.

market⁵³ to self-administer the care that the medical profession was unwilling to provide to them, thereby creating an alternate means of materializing their desired embodiment outside of the dominant medical framework. In being forced to resort to obtain hormones outside of legitimate medical avenues, Black trans people were disenfranchised from accessing medical recognition as transsexual and subsequent understanding as such. The possibility that Black people were, in fact, trans at all was withheld by the medical model. Gill-Peterson writes, "...the whiteness of medicine interfere[s] with the intelligibility and livelihood of black, brown, indigenous, and other marginal trans people..."⁵⁴ Intelligibility, on the one hand, is a function of medicalization, and its ability to make understandable and categorizable aids in the social control and discipline of trans people. On the other hand, it also facilitates access to a certain level of safety in pursuing a medical transition. Self-administering very strong drugs that need to be carefully monitored in the blood in order to ensure that damage is not done to organs such as the liver and heart is not optimal in terms of maintaining a healthy life, especially at a time when so little was known about them. Ceyenne Doroshow, a Black trans woman who lived in New York City in the early 1970s, recounts the story of her role model, an older Black trans woman, who showed her how to inject estrogen and gave her her first dose.⁵⁵ This role model, who had been taking hormones illegally for 30 years, died due to organ failure that was caused by unmonitored use of high doses of estrogen.⁵⁶ Black trans people were thus left to navigate the uncertainty of the black market for hormones and surgical interventions.

⁵³ "Well there's, there's a black market. Hah! Anything you need and you want and have the money, you can get it." Miss Major Griffin-Gracy interviewed by AJ Lewis. New York City Trans Oral History Project.

⁵⁴ Julian Gill-Peterson. *Histories of the Transgender Child*. University of Minnesota Press. 2018. 28.

⁵⁵ Ceyenne Doroshow Interviewed by Cyd Nova, New York City Trans Oral History Project. Interview Date February 19, 2017. <http://oralhistory.nypl.org/interviews/cayenne-doroshow-ejpsvu>. Accessed April 30, 2019.

⁵⁶ Ibid.

The idea of ‘true’ transsexuality conferred a belief that the narratives Benjamin’s patients presented stemmed from real lived experience rather than a selective and highly performative re-reading of past events in one’s life. Schaefer and Wheeler write,

Even without any books to read, without any other source of information, with or without childhood conditioning, with or without dystonic families, assuming that he or she was alone and unlike anyone else in the world, Benjamin's earliest patients came to him self-diagnosed, in that they described symptoms and conditions *exactly as his patients continued to describe themselves throughout his 30-year practice; and exactly as we continue to hear them describe themselves.*⁵⁷

This assumes that Benjamin’s first patients exhibited some fundamental truth about the nature of transness. They completely overlook the fact that trans people had access to information, albeit limited, about their ‘condition’. Many read works published about transness and emulated the narratives and information that they found contained within⁵⁸ when talking to others, particularly to medical professionals. In the next section, I will turn to a discussion about narratives and tropes surrounding trans identity in popular culture during mid-century.

Christine Jorgensen, Trans Normativity, and ‘Leaving it to the Experts’

At the same time that medicalized trans identity was being formulated, the media circulation of Christine Jorgensen’s story brought ‘transsexuality’ to the attention of the larger U.S. public for the first time.⁵⁹ Jorgensen, a white trans woman, underwent hormone therapy and a series of genital surgeries during the early 1950s in Denmark under the supervision of Danish endocrinologist Dr. Christian Hamburger. She attracted a storm of mainstream media attention

⁵⁷ Schaefer and Wheeler, Emphasis added.

⁵⁸ Meyerowitz, *How Sex Changed*, 47.

⁵⁹ Emily Skidmore, “‘Constructing the ‘Good Transsexual’: Christine Jorgensen, Whiteness, and Heteronormativity in the Mid-Twentieth-Century Press” in *Feminist Studies, Vol. 37, No. 2, Race and Transgender Studies*, 270-300. Feminist Studies, Inc. 2011. 270.

beginning in 1952 when she the story of her ‘sex change’ was leaked to the press,⁶⁰ and maintained it well into the early 1970s.⁶¹ Jorgensen’s story popularly introduced the idea in the U.S. of a non-psychological treatment path for the problem of transsexuality.⁶² Jorgensen’s whiteness, in conjunction with her hypervisibility in media, contributed to solidifying transsexualism as something that could only be intelligible when it was exhibited through whiteness. As historian Joanne Meyerowitz writes, Jorgensen was hyper-feminine, heterosexual, and blonde, “the hallmark of 1950s white feminine glamour.”⁶³ As her image circulated around the world, in arguably the first instance of a trans person that was this highly publicized, people came to associate achieving “convincing and conventional”⁶⁴ white femininity with a successful transition.⁶⁵ Thus, a successful medical transition was characterized by achieving and ever striving towards normative white femininity. Feminist theorist Emily Skidmore writes, “...white transwomen were able to articulate transsexuality as an acceptable subject position through an embodiment of the norms of white womanhood, most notably domesticity, respectability, and heterosexuality.”⁶⁶ In other words, key to the process of establishing someone as an intelligible ‘transsexual’ was to construct them, apart from the fact of their transsexuality, as just like ‘everyone else.’ To aspire to white feminine ideals (for trans women) was to aspire to achieve medicalized transsexual subjectivity, rendered socially acceptable and respectable by merit of its proximity to whiteness.

⁶⁰ Joanne Meyerowitz, *How Sex Changed*, 66.

⁶¹ Emily Skidmore, “Constructing the ‘Good Transsexual,’” 270.

⁶² Meyerowitz, *How Sex Changed*, 73.

⁶³ Meyerowitz, 62.

⁶⁴ Meyerowitz, 63.

⁶⁵ Susan Stryker, *Transgender History*, 47.

⁶⁶ Emily Skidmore, “Constructing the ‘Good Transsexual,’” 271.

For Jorgensen, creating *the* trans story involved a process of creating negative space against which to define herself. Jorgensen's memoir, *Christine Jorgensen: A Personal Autobiography* published in 1967, distances herself from queerness. Any suspicions the reader might have that she had queer desires were thwarted in her memoir, which is very explicit that she was straight. She writes,

During the months in service, I had seen a few practicing homosexuals, those whom the other men called 'queer.' I couldn't condemn them, but I also knew that I certainly couldn't become like them...⁶⁷

Faced with accusations that she was actually a gay man or a drag queen from the mainstream press, Jorgensen worked tirelessly to distance herself from queerness, and reassert again and again that she was not queer. I am not doubting the veracity of her sexuality; I am merely trying to point out that she contrasted herself, the 'good' transsexual, with the other, bad trannies and queers who violated social and sexual taboos. In her memoir, she recounts "with shock and disgust"⁶⁸ a man who made an unwanted advance on her before her transition, and writes, rather dramatically, "I spun away from his lumbering figure and pushed blindly through the crowd of young people into the darkness outside, heading for the beach...I leaned over the edge of the pier and vomited."⁶⁹ While part of her reaction certainly had to do with the feeling of being subjected to an unwelcome flirtation, the severity of the disgust she describes is mostly related to the fact that it was a queer encounter. She tries to explain away the encounter with an appeal to the innateness of her femininity, wondering, "Was it my slight build, my blonde complexion? But what did bone-structure have to do with it? ...there had to be some physical explanation for my difficulty."⁷⁰ In so doing, she constructs herself as heterosexual and reifies her white femininity,

⁶⁷ Christine Jorgensen. *Christine Jorgensen, A Personal Autobiography*. Bantam Books. 1967. 33.

⁶⁸ Jorgensen, *A Personal Autobiography*, 74-75

⁶⁹ Jorgensen, 75.

⁷⁰ *Ibid*, 75-76.

in a way intentioned to gain sympathy from mainstream heteronormative society and assert that trans people were not homosexual.

Christine's story of pursuing "life and the freedom to live it,"⁷¹ in other words, the ability to be understood as transsexual so that she could access her desired embodiment, can be directly contrasted with the construction of black trans people's lives during this time period. Indeed, Jorgensen's narrative and public persona carefully contrasted her respectability against social deviants who deserved moral condemnation.⁷² Black trans historian C. Riley Snorton's book *Black on Both Sides* tells the stories of black trans people whose stories emerged during the same time as Jorgensen's, but largely remained confined to the black press. Snorton writes that telling these narratives does not simply 'add' the stories of Black trans people at mid-century, but "disrupt[s] the teleology of medicalized transsexuality as corporeal freedom."⁷³ Carlett Brown, a Black trans woman whose story emerged in the Black press in 1953, was characterized as a 'mimicker' of Jorgensen by the press.⁷⁴ Brown's life as a shake dancer, a stigmatized occupation, was not welcome or accommodated for within the medical trans identity. She pursued a medical transition in Europe, but her plans were ultimately stunted by the federal government, which forbade her to leave the U.S. until she paid a \$1,200 federal income tax debt. Regardless of if she actually underwent such a surgery, Brown and other Black trans women faced police harassment on a daily basis.⁷⁵ Thus, Snorton writes, "...Jorgensen's spectacularized transsexual 'freedom'

⁷¹ Jorgensen, *A Personal Autobiography*, 90.

⁷² Jorgensen displays her feelings towards prostitutes: "I don't see why you should feel anything toward her. Those people make me sick. It's all right as long as they get away with what they're doing, but once they get caught they weep and plead for mercy. She had her fun--now she has to pay the price." Roy Ald, "Christine Jorgensen," *True Confessions*, September 1954, 64, as quoted by Skidmore in "Constructing the 'Good Transsexual,'" 277.

⁷³ C. Riley Snorton, *Black On Both Sides: A Racial History of Trans Identity*. University of Minnesota Press. 2017 Kindle Cloud Edition.

⁷⁴ Snorton, *Black On Both Sides*.

⁷⁵ Snorton, *Black On Both Sides*.

was tethered to equally robust representations of radicalized unfreedom...⁷⁶ Many Black trans women were not intelligible as feminine or as real women in the way that Jorgensen was, because of their categorical distance from normative white femininity, and were thus left to be disciplined and controlled by law enforcement and errant violence alongside the freaks and anomalies that Jorgensen sought to distance herself from.

Subjective experiences of trans identity at mid-century were not entirely tethered to the medical model; many people lived tangible and satisfying lives in non-assigned genders in ways that did not depend on the clinic. Take, for example, Ava Betty Brown, a black trans woman whose story emerged in a 1957 edition of black newspaper *The Chicago Defender* after she was arrested for wearing women's clothes. While she was being tried, she defended her identity as a woman by asserting that everyone in her life knew her as such. She said, "Everything I own is in the name of Betty Brown...If I am a man, I don't know it."⁷⁷ While the paradigm of transexuality as an exclusively medical phenomenon ascended, Black trans people did, in fact, assert a claim to a trans existence by using "an alternative set of relations--that of black sociality--as the site for her gender articulation..."⁷⁸ As evidenced by an article published 12 years later detailing an arrest--again for crossdressing--revealed that police violence and harassment still animated Brown's day-to-day life. Her plans to obtain surgery in Denmark were "indefinitely deferred."⁷⁹ Thus, her claim to trans identity would remain in the social fabric of black life, never recognized as trans by the broader public or the medical establishment.

⁷⁶ Snorton, *Black On Both Sides*.

⁷⁷ "Double-Sexed' Defendant Makes No Hit with Jury," *Chicago Daily Defender*, April 4, 1957, as quoted by Snorton in *Black On Both Sides*.

⁷⁸ Snorton, *Black On Both Sides*.

⁷⁹ Snorton, *Black On Both Sides*.

Jorgensen's narrative helped reinforce the notion that transness was in fact a medical condition, the understanding of which should be left up to medical professionals and experts. In her memoir, she affectionately refers to the doctors she associated with, even going so far as to change her name to Christine, the feminine iteration of Christian, the first name of her endocrinologist in Denmark, Dr. Hamburger.⁸⁰ After her final surgery, she writes, "I felt at last that I'd completed the transition to womanhood, and except for the inability to bear children, was as complete a person as I'd dreamed of being, both emotionally and physiologically."⁸¹ Only once her genital surgery was 'complete' did she feel that she was a true woman, implying that the only way for trans people to achieve their desired gender identity was to undergo a 'complete' surgical and hormonal transformation. She concludes her memoir on a positive note, remarking on the opening of the first gender identity clinic at Johns Hopkins University in 1966 and the steady progress of medicine in relation to 'transsexualism'. In a move to completely surrender her autonomous knowledge about her identity, she writes, "This book, then, is not meant to be a history of transsexualism or a study of its medical management. I leave that to the experts."⁸² In the following section, I turn to the university-based gender identity clinics as a site for the construction of gender.

The Gender Identity Clinic as a Site for the Construction of (trans)Gender

Gender identity clinics adopted the medicalized model of transness, which institutionalized the standards, diagnostic criteria and treatments on a national scale, laying the groundwork for the professionalization of trans healthcare as a legitimate medical field. Between the late 1960s and the early 1970s, several university-based gender identity clinics cropped up

⁸⁰ Jorgensen, *A Personal Autobiography*, 109.

⁸¹ Jorgensen, *A Personal Autobiography*, 228.

⁸² Jorgensen, *A Personal Autobiography*, 297.

around the U.S., and used Benjamins' 1966 book *The Transsexual Phenomenon* as "their standard reference".⁸³ The Johns Hopkins University Gender Identity Clinic opened in 1966, making it the first hospital in the United States to surgically treat 'transsexuals' through gender affirmation surgeries, including bottom surgery.⁸⁴ The team consisted of plastic surgeons, psychologists, psychiatrists, urologists, gynecologists, and one pediatrician.⁸⁵ Reed Erickson, a transgender man and millionaire philanthropist, provided substantial funding to the gender identity clinics.⁸⁶ Gender identity clinics substantially increased the mainstream availability of hormones and surgery in the U.S. and provided a legitimizing force for the professionals who provided such treatments for transness. The primary goal of such clinics, according to the head plastic surgeon of the clinic at Johns Hopkins, Dr. John Hoopes, was finding "a sound means of alleviating the problem of gender identification and of fostering public understanding of these extremely unfortunate individuals."⁸⁷ This ultimately culminated in the production of a standardized medical model for treating transsexualism.⁸⁸

Gender identity clinics engaged in a project of "grafting intelligibility onto the transsexual"⁸⁹ as a distinct medical disorder that could be treated only through hormone therapy and surgical interventions intentioned to render the trans person as passing as possible. Part of

⁸³ Sandy Stone, *The Empire Strikes Back: A Posttranssexual Manifesto*. Published 1987. <https://sandystone.com/empire-strikes-back.pdf>. Accessed April 30, 2019.

⁸⁴ Meagan Day, "How one of America's best medical schools started a secret transgender surgery clinic." Timeline. Published Nov. 14, 2016. <https://timeline.com/americas-first-transgender-clinic-b56928e20f5f>. Accessed April 27, 2019.

⁸⁵ Meagan Day, "How one of America's best medical schools started a secret transgender surgery clinic."

⁸⁶ Genny Beemyn, "Transgender History in the United States" in *Trans Bodies, Trans Selves: A Resource for the Transgender Community*. Oxford University Press. https://www.umass.edu/stonewall/sites/default/files/Infoforandabout/transpeople/genny_beemyn_transgender_history_in_the_united_states.pdf. 2014. 16.

⁸⁷ Dr. Hoopes as quoted by Jorgensen in *A Personal Autobiography*, 296.

⁸⁸ Joanne Meyerowitz, *How Sex Changed*, 224.

⁸⁹ Michael David Franklin, "Calculating Risk History of Medicine," 29.

this process involved developing objective criteria beyond Benjamin's that could reliably 'diagnose' transsexualism. Trans author and activist Sandy Stone argues that these criteria functioned to actually produce gendered subjects, writing "The criteria constituted a fully acculturated, consensual definition of gender, and *at the site of their enactment we can locate an actual instance of the apparatus of the production of gender.*"⁹⁰ Of roughly 2000 applications received in the first two years that the Johns Hopkins clinic was open, only 24 were able to meet the criteria developed by these clinics.⁹¹ After getting on a waiting list (the clinic only accepted 2 patients per month), trans people had to undergo extensive psychological and physical examinations, as required by the clinic, prior to receiving any kind of care.⁹² "Only those who show no signs of psychosis and appear to have a degree of insight into their condition are accepted..."⁹³ Patients were required to exhibit gender dysphoria at an early age, be attracted to the "same biological sex," have tried and failed to live in their assigned sex, be able to "pass" successfully if treatment is administered, and undergo a 'real-life test' of one year living as the desired gender.⁹⁴ Patients were expected to remain "heterosexual" after their gender-affirming surgery was completed, and eventually marry.⁹⁵ Dana Beyer, a trans activist who went to the Hopkins clinic in the 70s, remarked: "No one said this explicitly, but they certainly implied it, that the whole purpose of this was to get a vagina so you could be penetrated by a penis."⁹⁶

⁹⁰ Sandy Stone, *The Empire Strikes Back: A Posttranssexual Manifesto*.

⁹¹ Genny Beemyn, "Transgender History in the United States," 24.

⁹² "The Johns Hopkins Hospital has quietly begun performing sex change surgery" *The New York Times*. November 21, 1966, as quoted by Jorgensen in *A Personal Autobiography*, 295.

⁹³ *Ibid.*

⁹⁴ Dallas Denny as quoted by Genny Beemyn in "Transgender History in the United States," 17.

⁹⁵ Gianna E. Israel, Donald E. Tarver, and Joy Diane Shaffer. *Transgender Care: Recom Guidelines, Practical Info*. Temple University Press. <http://www.jstor.org/stable/j.ctt1bw1hmt>. 1977.

⁹⁶ Rachel Witkin. "Hopkins Hospital: a history of sex reassignment." *The Johns Hopkins News-Letter*. Published May 1, 2014. <https://www.jhunewsletter.com/article/2014/05/hopkins-hospital-a-history-of-sex-reassignment-76004/>. Accessed April 15, 2019.

Through creating criteria and conditions for treatment, the gender identity clinics defined further that ‘transsexualism’ was a label that would only be given to those who cooperated with medicine to reproduce normative gender in otherwise gender deviant persons.

This highly selective process, rather than having the result of successfully ‘diagnosing’ transness, facilitated the exercise of medical control and regulation over the socially contentious force that was transness. Trans historian Michael David Franklin writes that the clinics careful production of transsexual subjects was intentioned to “...discipline the nonconformity that galvanized political ferment and to diagnose the insurgencies that convulsed the nation and undermined authority.”⁹⁷ Indeed, by constructing what counted as legitimately trans, these clinics also constructed what did not constitute a trans subject along the lines of race, class, nationality, and sexuality. Trans historian Julian Gill-Peterson critiques the gender identity clinics, writing,

The overwhelming majority of trans patients seen at institutions of medicine were white. Even in the most pathologizing and disenfranchising medical models, the abstract whiteness projected onto the white trans body justified the attention given by doctors. Black trans and trans of color patients were much rarer because they were by design not welcome within that discourse.⁹⁸

The Black and trans of color people who were excluded from treatment at Johns Hopkins and other gender identity clinics were denied access to the medical trans identity because they did not aid in its project of producing successful patients who would uphold the normative gender, sexuality, and whiteness. Good transsexuals would ultimately become productive citizens who contributed to society through respectable lives that involved legal employment,⁹⁹ marriage, and social intelligibility.

⁹⁷ Franklin, “Calculating Risk,” 28.

⁹⁸ Gill-Peterson, *Histories of the Transgender Child*, 27.

⁹⁹ Franklin, “Calculating Risk,” 31.

The ultimate goal in the treatment of transsexualism was to produce subjects that were visually and socially legible in their binary gender of choice. Sandy Stone, discussing the gender identity clinic at Stanford, writes that staff selected candidates for surgery based on an “individual *sense*” of the suitability of each patient for passing as their desired gender.¹⁰⁰ She quotes Dr. Norman Fisk, head of the clinic as saying, “I now admit very candidly that...in the early phases we were avowedly seeking candidates who would have the best chance for *success*.”¹⁰¹ Rather than the goal being a successful, meaning without complications, surgery, success is defined in terms of achieving passing status on the part of the trans person. This particular clinic functioned as a “charm school” in that it sought to teach patients how to “behave like” women, “...i.e. *gendered* females.”¹⁰² Indeed, these clinics understood very well that gender was, in fact, learned. Harry Benjamin, responding to an anonymous trans person seeking medical intervention in 1963, gave the following advice on passing:

When you have recovered from the pain and the after-effects of the operation, after a few weeks or months, your real work begins—to change into a ‘woman.’ You have to learn how to behave like a woman, how to walk, how to use your hands, how to talk, how to apply make-up and how to dress.¹⁰³

Defining success in terms of passing profoundly restricted the possibilities for trans people who could not or did not want to pass to access medical services under the newly emerging professional model of treatment.

The obstacles set up by the gender identity clinics were put in place with the intention of only providing access to those trans people who fit their criteria. Some trans people, however, found creative ways of getting around this model and achieving the embodiment they desired.

¹⁰⁰ Stone, *The Empire Strikes Back*.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Benjamin, “I Want to Change My Sex!,” 294.

Joanne Meyerowitz illustrates that some trans women in the late 1960s, who had adopted a “casual, unisex, hippie style”¹⁰⁴ advised each other on how to get around the system.

...their transsexual friends told them they had to dress up as conventionally feminine women...[t]hey also warned one another to refrain from mentioning certain details about their sex lives, especially if they took pleasure from their genitals or intended to live as homosexuals after their surgery.¹⁰⁵

Many of the researchers who kept hearing the same stories and seeing the same types of people over and over again, “whose behavior matched up gratifyingly with Benjamin’s criteria,”¹⁰⁶ took this to mean that they had finally discovered some inherent truth about transsexuality. Trans people, simply wanting to access hormones and surgery, sought to get around this system, telling the researchers exactly what they wanted to hear. Stone writes that this cyclical pattern “seems a recipe for an uneasy adversarial relationship”¹⁰⁷ between trans people and medical professionals. This relationship remains uneasy to this day.

Gender identity clinics were closed down following the 1979 publication of a much discredited study¹⁰⁸ by Dr. Jon K. Meyer and Donna J. Reter of Johns Hopkins that concluded trans people who received surgical interventions were not more well adjusted to life postoperatively as compared to transgender people who did not receive surgery. Dr. Meyer was a psychologist that maintained the belief that the phenomenon of transness was an inherently psychological problem that could not be solved through hormonal or surgical therapies. Meyer told the *New York Times* in 1979, “My personal feeling is that surgery is not proper treatment for a psychiatric disorder, and it’s clear to me that these patients have severe psychological problems

¹⁰⁴ Meyerowitz, *How Sex Changed*, 226.

¹⁰⁵ Ibid.

¹⁰⁶ Stone, *The Empire Strikes Back*.

¹⁰⁷ Ibid.

¹⁰⁸ John K. Meyer and Donna J. Reter, “Sex Reassignment Follow-up,” *Archives of General Psychiatry*. 36, no. 9. 1010–1015. <https://doi.org/10.1001/archpsyc.1979.01780090096010>. 1979.

that don't go away following surgery."¹⁰⁹ The study measured adjustment through the post-op trans person's adherence to a heteronormative lifestyle following surgery. The researchers assigned each subject a score in order to measure their adjustment; things that earned positive points were improvements in job level and heterosexual marriage/cohabitation, while arrests, jail sentences, decline in job level, psychiatric treatment, and "nongender appropriate cohabitation or marriage."¹¹⁰ Meyer's study reinforced the notion that the goal of treating trans people was to produce productive subjects that aligned with normative gender, sexuality, middle-class values, and whiteness. The study, though it was widely criticized by doctors and researchers alike, however, this study was all that was needed to topple the gender identity clinic system that had emerged only 13 years earlier.

In the next chapter, I turn to the emergence of professional associations that implemented a standardized model for the medical management of transness following the closure of gender identity clinics.

¹⁰⁹ Witkin. "Hopkins Hospital: a history of sex reassignment."

¹¹⁰ Meyerowitz, *How Sex Changed*, 268.

Chapter 2

Gatekeeping Trans Healthcare: Passing the Diagnostic Test/Passing in the Streets

“How do you know you want rhinoplasty, a nose job?” he inquires, fixing me with a penetrating stare.

“Because,” I reply, suddenly unable to raise my eyes above his brown wingtips, “I’ve always felt like a small-nosed woman trapped in a large-nosed body.”

“And how long have you felt this way?” He leans forward, sounding as if he knows the answer and needs only to hear the words.

“Oh, since I was five or six, doctor, practically all my life.”

“Then you have rhino-identity disorder,” the shoetops state flatly. My body sags in relief. “But first,” he goes on, “we want you to get letters from two psychiatrists and live as a small-nosed woman for three years . . . just to be sure.”

111

Introduction

The standardization of trans healthcare that took place between the 1980s and the current moment institutionalized and refined the model of care developed by Harry Benjamin and his associates at the university-based gender identity clinics. Now referred to as the gatekeeping model, it functions to sort those who meet the diagnostic criteria from those who do not, thereby regulating access to transition-related healthcare. What are the politics of installing a gatekeeping mechanism in the form of a mental health professional? How is gender dysphoria diagnosed? How can we balance maintaining access to care within a pathological framework? What modes of existence are allowed to be considered diagnosably trans? Why are authentic narratives of the self illegitimate under this model? I argue that the gatekeeping model is aimed at controlling,

¹¹¹ Riki Anne Wilchins, *Read My Lips: Sexual Subversion and the End of Gender*, 63, as quoted by Dean Spade in “Resisting Medicine, Re/modeling Gender” in *Berkeley Women’s Law Journal*, Vol. 15, 15-27. <http://www.deanspade.net/wp-content/uploads/2010/07/resisting.pdf>. 2003. 15.

disciplining, and regulating the expression of gender variance and restricting trans people's ability to access the embodiment they desire under the care of a medical professional.

Standardizing Trans Medicine in the Private Sphere

With the closure of gender identity clinics in 1979, the medical management of trans people largely relocated to the sphere of private practices. In 1978, medical professionals who worked in the budding field of trans healthcare established the Harry Benjamin International Gender Dysphoria Association (HBIGDA).¹¹² HBIGDA released the first professional guidelines on treating 'transsexuals' in 1979, the same year that the clinics began closing. The Standards of Care (SOC) were created in order to standardize the medical treatment provided by professionals at private practices,¹¹³ who were now expected to follow the "minimal requirements"¹¹⁴ outlined in the standards. While these standards were not legally binding, they established that uniform professional standards in the treatment of 'transsexuals' were necessary to provide appropriate 'care'. By creating this document, the HBIGDA constructed itself as the leading medical authority on transness and the sole professional group authorized to determine how treatment was to be rationed.

By adopting the psychiatric diagnosis "transsexualism" from the 1980 DSM-III, the SOC solidified that there was to be a regulatory mechanism, a gatekeeper, that rationed out the 'treatment' in a way that reinforced medicalized transness and binary gender. The original SOC required people who sought 'sex reassignment' to acquire multiple recommendations from clinical behavioral scientists with extensive credentials in order to access hormones and surgery.

¹¹² Meyerowitz, *How Sex Changed*, 255.

¹¹³ *Standards of Care*, Harry Benjamin International Gender Dysphoria Association, 1981.

¹¹⁴ *Ibid*, 2.

¹¹⁵ These mental health professionals were to be gatekeepers, tasked with sorting, classifying, and diagnosing transsexualism in suitable candidates. The decision to write a recommendation letter largely centered around how well a person matched the DSM-III diagnosis for ‘transsexualism,’ which outlined the diagnostic criteria as follows: experiencing a “sense of discomfort...about one’s anatomic sex,” a “wish to be rid of one’s own genitals and live as a member of the other sex,” “the disturbance has been continuous...for at least two years,” and is exhibited in the “absence of physical intersex or genetic abnormality, and is “not due to another mental disorder, such as schizophrenia.”¹¹⁶ Whether or not a person met these criteria was to be established during a therapeutic relationship, which needed to last “at least three months”¹¹⁷ prior to starting hormone therapy and “at least six months”¹¹⁸ prior to genital/breast surgery. Surgical access was to be more heavily regulated; in addition to at least 6 months of counseling prior to making a diagnosis and recommendation, the initial decision to allow access to surgery was to be subject to “peer review” by another independent clinical behavioral scientist.¹¹⁹ Clearly, the authors of the SOC felt that it was important to have several roadblocks in place, in particular emphasizing time and careful professional decision-making when selecting an appropriate candidate to receive treatment.

The SOC were especially concerned with guarding against ‘hormones on demand,’ or access to ‘treatment’ on the transsexual’s terms, which was to be avoided at all costs. The third version of the Standards, published in 1980, read, “[h]ormonal and surgical sex reassignment are procedures requiring justification and are not of such minor consequence as to be performed on

¹¹⁵ *Standards of Care*, 1981, 4-6.

¹¹⁶ *Ibid*, 9.

¹¹⁷ *Ibid*, 12.

¹¹⁸ *Ibid*, 14.

¹¹⁹ *Ibid*, 13.

an elective basis.”¹²⁰ By emphasizing that trans people do not have the capacity to make important decisions about their bodies and lives, the gatekeeping model sought to ensure that each candidate was scrutinized as thoroughly as possible in order to prevent trans people from making a rash or misguided decision. The first standard in the original SOC reads as follows:

Hormonal and/or surgical sex reassignment on demand (i.e., justified simply because the patient has requested such procedures) is contraindicated.¹²¹ It is herein declared to be professionally improper to conduct, offer, administer or perform hormonal sex reassignment and/or surgical sex without careful evaluation of the patient’s reasons for requesting such services and evaluation of the beliefs and attitudes upon which such reasons are based.¹²²

Medicalizing trans identity as a disorder was predicated upon solidifying the notion that it could not be understood or diagnosed by lay-people: professionals had to maintain authority over the power to diagnose. Speech act theory posits that words are capable of doing things or bringing things into reality: for example, when a justice of the peace says, “I now pronounce you husband and wife,” those two people are now married by virtue of that statement. The positionality of the speaker matters because only words that come from certain mouths have the power to accomplish certain acts. To diagnose oneself is an oxymoron: it is simply not possible to diagnose yourself because diagnosis is only made possible through the removal of autonomous sources of knowledge about the self. By establishing a gatekeeping mechanism, trans people were rendered unable to perform the ‘speech act’ of declaring themselves trans in any meaningful sense within a medical context. Allowing trans people to simply request and receive the medical procedures they desired would allow those whose very existence threatened the

¹²⁰ “In recent decades, the demand for sex reassignment has increased as have the number and variety of possible psychologic, hormonal and surgical treatments.” Ibid, 6-7.

¹²¹ Contraindicated, in medical terms, means that a procedure or treatment is inadvisable due to other factors, such as a preexisting condition or circumstance.

¹²² Ibid, 7.

binary to pass through, threatening the very stability of the medicalized framework that was built to control and discipline deviant gender expression.

The early SOC included a standard that required individuals seeking ‘sex reassignment’ to undergo a ‘real-life test’ by living full-time in the gender of choice. It reads, “Genital sex reassignment shall be preceded by a period of at least 12 months during which time the patient lives full-time in the social role of the genetically other sex.”¹²³ This assumes that only once the trans person has consulted with a therapist will they actually begin navigating the world ‘full-time’ as another gender. Not only does this preclude possibilities for expressions of gender deviance outside of the medical framework, it also reifies binary gender by implying that the person must have a consistently binary gender expression at all times for a full year.

Additionally, there are many factors that would make it difficult for people to live “full-time” as another gender other than the legitimacy of their transness, namely: employment discrimination, familial relationships, violence on the street upon being clocked, or simply not wanting to do that because their gender expression was fluid.

Professional medical associations other than HBGDA also participated standardizing the diagnosis and treatment of transness. The American Psychiatric Association (APA) developed its first diagnostic criteria for ‘transsexualism’ in 1980. The DSM, the diagnostic manual produced by the APA, is the authoritative text used by medical professionals to diagnose and treat mental and behavioral health disorders. The DSM-III, published in 1980, included the diagnosis ‘transsexualism’ and categorized it under psychosexual disorders.¹²⁴ By 1994, the DSM shifted

¹²³ Ibid, 14.

¹²⁴ Jack Drescher, “Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in the DSM and ICD” in *International Review of Psychiatry, Vol. 27 Issue 5*, 386-395. Taylor & Francis. October 2015. 390.

to using the diagnosis ‘gender identity disorder.’¹²⁵ The most recent version, the DSM-5, was published in 2013 with the updated diagnosis of “gender dysphoria.”¹²⁶ Looking in the table of contents for the DSM-5, nestled under a whole host of diagnostic terms for mental disorders such as “Obsessive Compulsive and Related Disorders” and “Dissociative Disorders,” lies “Gender Dysphoria” as its own category of disorder.¹²⁷ In order to activate access to gender-related hormones and/or surgery, people seeking these procedures must often obtain a diagnosis for gender dysphoria from a qualified mental health professional. They describe gender dysphoria as, “...the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender...many are distressed if the desired physical interventions by means of hormones and/ or surgery are not available.”¹²⁸ In the diagnostic features for adolescents and adults, which is separate from the ones for children,¹²⁹ it reads that the “core component” of gender dysphoria is experiencing a “marked incongruence” between the gender assigned at birth and the person’s “experienced/expressed gender.”¹³⁰ This incongruence is marked by a “strong desire to be rid of one’s primary and/or secondary sex characteristics” and a “strong desire for the primary and/or secondary sex characteristics of the other gender.”¹³¹

¹²⁵ Drescher, “Queer diagnoses revisited,” 390.

¹²⁶ The American Psychiatric Association uses the DSM-5 definition of Gender Dysphoria, which “involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender. People with gender dysphoria may often experience significant distress and/or problems functioning associated with this conflict between the way they feel and think of themselves (referred to as experienced or expressed gender) and their physical or assigned gender.” See <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> for more information.

¹²⁷ American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association. Arlington, VA. 2013.

¹²⁸ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 451.

¹²⁹ Ibid.

¹³⁰ Ibid, 453.

¹³¹ Ibid, 452.

While the DSM-5 was being written, the APA created the DSM-5 Work-group on Sexual and Gender Identity Disorders to deal with the contested diagnosis of gender identity disorder. LGBTQ activists demanded that the APA eliminate all gender diagnoses on the grounds that they were pathologizing and subjected trans people to unnecessary stigma.¹³² The work-group, on the other hand, was concerned that this would reduce access to care because health insurance providers refuse to reimburse for treatment without a diagnosis. One of the people in the work-group, Jack Drescher, reflects on the deliberation process:

In an effort to balance these conflicting concerns between stigma and access to care, this author cautioned ‘first do no harm.’ In following this approach, APA’s decision to retain the DSM gender diagnoses appears justified and it has had the intended effect of improving access to care.¹³³

This tension between pathologization and maintaining access to care is central to the politics of trans healthcare. How do we balance these two concerns in a context where gender variance must be pathologized in order to facilitate access to hormone therapy and surgical interventions? When do we prioritize one over the other?

WPATH and Gatekeeping Today

HBIGDA was renamed the World Professional Association for Transgender Health (WPATH) in 2006 and remains the leading medical authority on trans health issues in the world.¹³⁴ It has since released 7 updated standards of care that have evolved alongside and in concert with the DSM, substantially relaxing the criteria¹³⁵ to access a diagnosis and treatment for what is now known as gender dysphoria, particularly when it comes to accessing hormone therapy. It

¹³² Drescher, “Queer diagnoses revisited,” 392.

¹³³ Drescher, “Queer diagnoses revisited,” 393.

¹³⁴ *Mission and Vision*, World Professional Association for Transgender Health. <https://www.wpath.org/about/mission-and-vision>. Accessed April 30, 2019.

¹³⁵ DSM-5, 451-459.

still maintains the gatekeeping model that emerged in the original standards, recommending that trans people seeking medical services must first consult with a mental health professional. If the mental health professional diagnoses the person with gender dysphoria, they must write a referral letter for the person's desired physician or surgeon.¹³⁶ One referral from a mental/behavioral health professional is required to start hormone therapy and/or chest/breast surgery, while genital surgery requires two referrals, 12 months of continuous hormone therapy, 12 months of the 'real-life' test,¹³⁷ and strongly recommends regular mental health counseling.¹³⁸

By placing gender dysphoria in the DSM-5 as a mental disorder, all of the 'symptoms' of the disorder are rendered internal struggles that are due to an inherent pathology present in the trans person. Professor of psychology Sarah Schulz argues that the DSM-5's description of gender dysphoria as being characterized by "...clinically significant distress or impairment in social, occupational, or other important areas of functioning,"¹³⁹ rules out the reality that this distress is not due to an inherent condition or pathology, but "...society's *response* to nonnormative gender presentation."¹⁴⁰ Kristen P. Lovell, a black trans woman who grew up in Yonkers, NY, speaks to this in an interview with the *Trans Oral History Project* as she recounts her experiences being bullied and suspended from elementary and middle school:

...when we are grappling with these things, we are the problem. And so, they put me in a classroom for 'emotionally disturbed children.' But it was just like, I'm

¹³⁶ Sarah L. Schulz, "The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria" in *Journal of Humanistic Psychology*, Vol. 58, Issue 1, 72-92. Sage. 2017. DOI: 10.1177/0022167817745217. 74.

¹³⁷ The 'real-life' test involves living 'full-time' as the desired gender identity. It has been widely criticized as unnecessary.

¹³⁸ Standards of Care, Version 7. World Professional Association for Transgender Health. Published 2011. <https://www.wpath.org/publications/soc>. Accessed April 30, 2019.

¹³⁹ DSM-5, 453.

¹⁴⁰ Schulz, "The Informed Consent Model of Transgender Care," 77.

not really emotionally disturbed. I'm disturbed by the fact that I'm being constantly being harassed on a daily basis...I have no choice but to lash out.¹⁴¹ By segregating Lovell into a 'special classroom,' her teachers maintained that the reason that she lashed out at the children who bullied her was because she had some pathological emotional issue. The distress she experienced as a result of her harassment by other children's was thus taken to be her fault, rather due to the harassment that she underwent because of their reactions to her nonnormative gender presentation. This logic is profoundly disempowering for trans people and fails to correctly attribute the source of the 'distress and impairment in social functioning' that many experience. Schulz problematizes this, writing, "...transgender identity itself is not necessarily a cause of distress, but instead is a *valued* life experience among transgender individuals who see being transgender as a way to live a satisfying and meaningful life."¹⁴²

Gatekeeping forces trans people to present self-narratives rooted in distress and selectively read back on their lives through a lens of pathology, rather than explaining their true lived experience. Trans activist and attorney Dean Spade reflects on his own experiences navigating the gatekeeping model,

So now, faced with these questions, how do I decide whether to look back on my life through the tranny childhood lens, tell the stories about being a boy for Halloween, about not playing with dolls? What are the costs of participating in this selective recitation? What are the costs of not participating?¹⁴³

By forcing trans people to participate in a 'selective recitation' of their lives, gatekeepers actually force them to pathologize themselves. Those who do not are not legible as trans, and are thus excluded from this category, thereby rendering access to mainstream hormones and surgery

¹⁴¹ Kristen P. Lovell interviewed by Michelle Esther O'Brien. NYC Trans Oral History Project. Date of Interview April 4, 2019. <http://oralhistory.nypl.org/interviews/kristen-p-lovell-de9cdr>. Accessed April 28, 2019.

¹⁴² Schulz, "The Informed Consent Model of Transgender Care," 78-79.

¹⁴³ Spade, "Resisting Medicine, Re/modeling Gender," 20.

all but impossible. Additionally, it puts trans people into a position where they are coerced into performing distress, impairment, and binary gender aspirations in order to be allowed to access this “world of meaning.”¹⁴⁴ Not only does this enforced narrative obscure the trans person’s true desires and goals for their embodiment, it also renders the therapeutic relationship completely ineffective as a form of counseling. The goal of any therapeutic relationship should be to build a relationship based on trust, honesty, and respect for the patient’s autonomy. Here, it is more interested in perpetuating the gender binary and maintaining medicalization of the trans experience.

In order to successfully analyze the narratives that trans patients put forth in the therapeutic setting, mental health professionals often rely on their own subjective understandings of how gender and transness operate. James Whitehead et al. conducted a study of 35 “trans positive” therapists in San Francisco and Portland, Oregon and focused on the instances in which they denied access to hormones or surgery to trans people who came to them seeking recommendations. One therapist recalled when she denied a letter to a client:

The first time she had come in to see me she says ‘you know, I met a female-to-male transsexual last week, and I knew instantly that I was a, I needed to do the same thing. I needed to be a man’. And it never occurred to her before that. And here she was in her late twenties. Nobody I had ever seen before told me that, had told me that things occurred in a few hours. I stayed with it for a while, what I kept trying to get her to do was to talk about her full life with this issue. And, she kept arguing with me that the forces of the universe were telling her that she needed to transition. And my alarm’s going off right away that this is not a standard case, this person needs to not go there. This was a woman; she was a woman and should stay that way for her own good. And eventually she got fed up with me because I kept asking her for some particulars about what it must feel like to be a man; what her history has been.¹⁴⁵

¹⁴⁴ Spade, “Resisting Medicine, Re/modeling Gender,” 22.

¹⁴⁵ Jaye Cee Whitehead, Jennifer Thomas, Bradley Forkner and Dana LaMonica, “Reluctant gatekeepers: ‘Trans-positive’ practitioners and the social construction of sex and gender” in *Journal of Gender Studies*, Vol. 21, no. 4, 387-400. December 2012.

When people enter into a situation with a mental health gatekeeper and do not provide the scripted narrative that is expected of them, this creates uncertainty on the part of the mental health professional. Because the gatekeeper felt alarmed by her lack of certainty on the validity of the claims this client made and their non-standard narrative, she doubled down on her authority and role as a gatekeeper and blocked access to the desired treatment. What's more, she decided that this patient "was a woman" and should "stay that way for her own good," completely dismissing that there was any reality to the claims to transness that this client was making.

One justification for maintaining the gatekeeping model is to ensure that people do not regret their decision to transition, either as a result of a misdiagnosis or a poor decision, and hold the provider liable. In one study, 74% of providers interviewed were concerned about trans patients suing them who regretted their decision to pursue transition-related care.¹⁴⁶ Jamison Green, former president of WPATH and trans man himself, remarks on the necessity of a therapist's evaluation: "This is a complex and difficult thing, and if someone wants surgery it can be important that they slow down just a bit and think about what they're doing."¹⁴⁷ This logic is animated partially by the medical doctrine of non-maleficence, which contains the utmost principle that medical professionals should follow: 'first do no harm.' Gatekeeping suggests that if trans people wait an appropriate amount of time and talk to mental health professionals, then they will make a better and more prepared decision regarding whether or not to pursue surgery,

¹⁴⁶ Stef M. Shuster, "Performing informed consent in transgender medicine" in *Social Science & Medicine* Vol. 226, 190-197. 2019. 194.

¹⁴⁷ Evan Urquhart, "Gatekeepers vs. Informed Consent: Who Decides When a Trans Person Can Medically Transition?" *Slate*. Published March 11, 2016. <https://slate.com/human-interest/2016/03/transgender-patients-and-informed-consent-who-decides-when-transition-treatment-is-appropriate.html>. Accessed April 28, 2018.

thus preventing possible regret. Diagnosis is also seen to play a role in preventing regret: if the patient is carefully evaluated, then information might surface indicating that the person is not trans and avoid a misdiagnosis that could potentially lead to a mistaken decision to undergo a transition. This works in line with the logic that transness itself is something that can actually be diagnosed. In sum, prevention of regret is thus prioritized over all else, including the wellbeing of the trans person seeking the medical care.

Paddy McQueen, an ethicist and political theorist, problematizes the notion that regret is somehow linked to flawed decision-making and is to be avoided at all costs. He argues that withholding medical treatment for fear that a patient might later regret the decision disregards the autonomy of the patient. “Part of respecting a person’s autonomy is allowing them to make decisions that could later be regretted, so long as the decision can be justified at the time it is made.”¹⁴⁸ Trans people are thus deprived of a fundamental facet of adult life, which is the power to make decisions for oneself. Part of being human is to make decisions that we regret. Further, the anxiety about trans people regretting a decision to undergo hormone or surgical interventions ignores the fact that the vast majority of trans people do not experience post-transition regret. Regret rates amongst trans people who undergo hormone therapy are low, with one study pointing to a .08% prevalence of regret in a group of 1,944 patients, just 17 people, and only 3 of them took steps to reverse their transitions.¹⁴⁹ None who regretted their decision took legal action against the providers.¹⁵⁰

¹⁴⁸ Paddy McQueen, “The Role of Regret in Medical Decision-making” in *Ethical Theory and Moral Practice*, Vol. 20, no. 5. 1051-1065. <https://doi.org/10.1007/s10677-017-9844-8>. Nov 2017.

¹⁴⁹ Madeline B. Deutsch, “Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics” in *International Journal of Transgenderism*, Volume 13, pp. 140-146. Routledge. 2011. DOI:10.1080/15532739.2011.675233. 141.

¹⁵⁰ Ibid.

The therapist-patient relationship does not occur within a vacuum. Race, class, and gender all inform and shape interactions that take place between the therapist and patient. Researchers B. Mitchell Peck and Sonya Conner conducted a study that found “...doctor-patient interactions will be most physician-centered between white physicians and non-white patients, male physicians and female patients, and for patients from lower socioeconomic backgrounds.”¹⁵¹ Black trans and trans of color people who seek medical care under the gatekeeping model are thus subjected to higher levels of medical authority and paternalism in the decision-making process about their suitability to access transition-related medical services. Sociologist Emily Allen Paine quotes Corey, a Black 32-year-old nonbinary trans man, “I think there are interactions where it’s really difficult to tell what’s affecting the treatment...I don’t know what problem you’re having with me, but you’re having a problem.”¹⁵² This confusion and dissonance on the part of the patient puts them in a position where they are constantly uncertain about what it is about them that the therapist is attempting to discipline.

Gatekeeping precludes the possibility of fostering an actual therapeutic relationship between the mental health professional and the trans patient. In other words, the goal of this therapy is not to provide counseling or guidance for trans people that they might actually benefit from. Therapists, because their role is to scrutinize, discern, and diagnose, often do not trust their trans patients and suspect that they are being dishonest.¹⁵³ Riley, a Filipino-American trans man,

¹⁵¹ B. Mitchell Peck and Sonya Conner, “Talking with Me or Talking at Me? The Impact of Status Characteristics on Doctor-Patient Interaction” in *Sociological Perspectives*, Vol. 54, No. 4 (Fall 2011), 547-567. SAGE. Fall 2011. <https://www.jstor.org/stable/10.1525/sop.2011.54.4.547>. 552.

¹⁵² Emily Allen Paine, “Embodied Disruption: ‘Sorting Out’ gender and nonconformity in the doctor’s office” in *Social Science and Medicine*, Volume 221, 352-358. Elsevier. 2018.

¹⁵³ Shuster, “Performing informed consent in transgender medicine,” 194.

describes his encounter with a mental health professional who had never seen a trans client before:

...it felt like she was going line by line, asking me about my relationship to my body, my sex life...by that reasoning, concluded that I was actually not trans. Because I let partners touch me and because I can shower. And her way of describing to me that she didn't believe me was that like, well these people do this and this, and these people can barely do this and that, and so I do not think that this is what you're going through.¹⁵⁴

As we can see from Riley's encounter, honesty is dangerous when interacting with gatekeepers, because no matter how often or how convincingly trans patients explain that they are trans, unless they reciting the medical trans script they will not be believed by the gatekeeper. Emily Paine quotes Dana, a 25-year-old Black non-binary person, who reflects on their experiences not being taken seriously or believed by healthcare providers. "I wonder if the reasons why my pain is not believed is maybe because of my class background, my race, and the gender that they're perceiving me as."¹⁵⁵ Black and trans of color people have a harder time convincing gatekeepers that they are trans because their lives are not as intelligible as trans under the medical paradigm. Whatever the reasons why Dana's healthcare providers do not believe them, their lack of trust for Dana has a serious impact on Dana's health and wellbeing. What's more--distrust for trans people on the part of gatekeepers creates situations in which access to hormones and surgery can be refused based on a disbelief in the patient's self-proclaimed gender identity.

Trans people seeking hormone therapy or surgery are very aware of the gatekeeping model and have adapted to life under a severe regulatory mechanism for enforcing binary gender. They recognize that they are being tested and evaluated, so they lie to the best of their ability. They lie to 'pass' the test, successfully convincing the therapist that their ultimate goals

¹⁵⁴ Paine, "Embodied Disruption," 356.

¹⁵⁵ Ibid.

from treatment is ‘passing’ in the streets. Since Benjamin’s publication of *The Transsexual Phenomenon*, trans people have been educating themselves and rehearsing performing what medical professionals expect them to say.¹⁵⁶ Trans author Claudine Griggs wrote in 1998, “I’ll lie my ass off to get what I have to.”¹⁵⁷ When the costs of not lying are so severe that one’s desired embodiment could be withheld from them, how could they not? Whether it be through friends, partners, or the internet, Sarah Schulz writes that trans people know what the diagnostic criteria are and are often “...ready to say what is expected of them to get the letter from the therapist...”¹⁵⁸ Gatekeeping produces highly performative narratives of transness that are intentioned to satisfy arbitrary diagnostic criteria. As Spade writes, trans people have to “...lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want.”¹⁵⁹

Informed Consent

In recent years, trans activists and health care activists have been pushing for uniform adoption of the informed consent model as a patient-centered alternative to the gatekeeping model. Informed consent is grounded in the idea that patient autonomy should be respected in the decision-making process about whether or not to pursue transition-related care, and therefore the

¹⁵⁶ “...when the first transsexuals were evaluated for their suitability for surgery, their behavior matched up gratifyingly with Benjamin’s criteria...It took a surprisingly long time--several years--for the researchers to realize that the reason the candidates’ behavioral profiles matched Benjamin’s so well was that the candidates, too, had read Benjamin’s book, which was passed from hand to hand within the transsexual community, and they were only too happy to provide the behavior that led to acceptance for surgery.” Sandy Stone, *The Empire Strikes Back: A Posttranssexual Manifesto*. Originally Published 1987. <https://sandystone.com/empire-strikes-back.pdf>. Accessed April 15, 2019.

¹⁵⁷ Claudine Griggs, *S/He: Changing Sex and Changing Clothes*, 1998, 32 as quoted by Dean Spade in “Resisting Medicine, Re/modeling Gender,” 23.

¹⁵⁸ Schulz, “The Informed Consent Model of Transgender Care,” 79.

¹⁵⁹ Spade, “Resisting Medicine, Re/modeling Gender,” 23.

involvement of a mental health professional is not necessary. In terms of how it looks, the patient, after hearing benefits, risks, and alternatives associated with a given treatment path, makes their own decisions about the care they would like to receive. Ruben Hopwood, the Transgender Health Program Coordinator at Fenway Health, a LGBTQ health clinic in Boston, described informed consent to a Rewire reporter as follows: “access to medical treatment and care, individualized and appropriate to that person, without the [prerequisite] requirement of a mental health professional’s evaluation to access medical care.”¹⁶⁰ Informed consent is already being used in trans healthcare, typically by clinics¹⁶¹ in urban settings¹⁶² such as LGBT health clinics or Planned Parenthood, rather than private or solo practices. Timothy Cavanaugh et al. advocate for the informed consent model as more “...respectful of the patient’s sense of agency”¹⁶³ than the gatekeeping model. They argue that transgender patients should have complete autonomy in assessing the type of treatment they would like to pursue.

The ideological origins of informed consent can be traced back to The Nuremberg Code, the result of the Nuremberg trials of Nazi war criminals under international law at the end of WWII, which sought to establish an end to physicians and scientists’ experimenting on patients without their consent.¹⁶⁴ Its first principle states that in scientific research, “The voluntary consent of the human subject is absolutely essential.”¹⁶⁵ Under this principle, the document states

¹⁶⁰ S. E. Smith, “Does Informed Consent Mean ‘Hormones on Demand’ for Trans People? Not So Much.” *Rewire News*. Published Jul 10, 2018. <https://rewire.news/article/2018/07/10/informed-consent-mean-hormones-demand-trans-people-not-much/>. Accessed April 16, 2019.

¹⁶¹ In a study by Madeline B. Deutsch, of 12 sites utilizing the informed consent model, only 16.7% were solo/private practices. Deutsch, “Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics.”

¹⁶² Of 12 sites utilizing the informed consent model, 75% were in urban settings. *Ibid.*

¹⁶³ Cavanaugh et al., “Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients.”

¹⁶⁴ Shuster, “Performing informed consent in transgender medicine,” 191.

¹⁶⁵ *The Nuremberg Code*. Available online at https://www.baruch.cuny.edu/hrpp/documents/nuremburg_code.pdf. 1947.

the patient should, "...have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

Informed consent, then, is founded on the principle that a patient must be able to legally consent to a given treatment, procedure, or test, and in order to do this must also have "sufficient knowledge and comprehension" about the risks and benefits of all available relevant treatments. The Nuremberg Code and other subsequent attempts to advance informed consent are all intended to increase patient autonomy, "an ideological principle that patients and test subjects should have the right to self-determination in health-related matters, and the opportunity to make free and informed choices about their bodies, health, and lives."¹⁶⁶

Informed consent, although it has clear ethical principles, seems to be difficult for doctors to follow in practice when it comes to providing treatment to trans patients. Many seem to misunderstand what informed consent entails.¹⁶⁷ One provider who claimed to be using this model said in an interview with sociologist Stef Shuster,

...you also want to make sure that the person has the capacity to make decisions about their lives. And with trans people, that becomes a little tricky because sometimes they don't want to hear about the risks involved in starting hormone therapy and how that is going to make their lives difficult.¹⁶⁸

This provider was expressing doubt about the capacity that trans people have to make decisions about their care because they have already decided that they want to pursue a particular treatment path. But if a person has already dedicated a considerable amount of time to their decision to pursue a given treatment, their decision has already been made. This doctor is expressing a desire to be more involved in the decision-making process and have control over its outcome, thereby rendering "'autonomy' a conditional concept" and making it difficult for the trans person to

¹⁶⁶ Shuster, "Performing informed consent in transgender medicine."

¹⁶⁷ Ibid.

¹⁶⁸ Ibid, 193.

make a fully autonomous decision concerning a given treatment.¹⁶⁹ Additionally, he is separating trans people from all other categories of people with the phrase, "...with trans people, that becomes a little tricky..." and participating in the reification of pathologized trans identity in which trans people are inherently characterized by their desire to pursue a transition.

Doctors still utilize their subjective judgment and opinions of their patients under the informed consent model in order to withhold access to treatment. Shuster quotes another provider, a family physician, who questioned whether or not her new patient, a trans man who had been on testosterone for ten years and was seeking a refill, was actually listening to the information she provided during the appointment. "I was concerned about what was his level of understanding in the consent I was reading to him, and with him? He was nodding along but I just wasn't sure he was really listening." Ultimately, she denied his request to refill his prescription for testosterone. These types of suspicions are grounded in the providers' subjective feelings about whether or not this person is making an appropriate decision to pursue hormone therapy or surgery. Another provider expressed concerns that his patients were lying to him:

If I'm concerned about trans men because their testosterone levels are really high, and they're taking - **if I believe them** - regular doses, I'll take a look....So then I wonder if my patient is taking more than he says he is.¹⁷⁰

This providers' incredibly paternalistic attitude towards his patients effectively squashes his patient's autonomy and reinforces his role as a discerning eye that catches disobedience to medical authority and disciplines it by withholding access to treatment.

In the next chapter, I discuss the various financial barriers to accessing transition-related care and how privatization of trans healthcare constructs treatment as a product that is separate

¹⁶⁹ Ibid.

¹⁷⁰ Ibid, 194.

from the diagnosis of gender dysphoria, and functions to distribute access to this product on the basis of ability to pay.

Chapter 3

The Politics of Coverage: Privatization, Health Insurance, and Medical Necessity

In the American market economy, the quest for self-expression increasingly involved the purchase of goods and services that promised a better life. For the American transsexual, surgery was such a commodity, a desperately desired consumer item, available only to those who could afford it.¹⁷¹

Desire, sex, and gender resemble neither the earth nor manufactured products. Desire, sex, and gender are, in reality, closer to information as an embodied technosemiotic system. They are living codes. Like information, they defy ownership because my possession of a fragment (of information, desire, pleasure, sex, gender) doesn't take it away from you.¹⁷²

Accessing transition-related services in the U.S. has always been a matter of whether or not one is able to afford them; after all, medical care in the U.S. has the highest price tag of any country in the world.¹⁷³ By the early 1980s, doctors in the private sphere realized that providing 'treatment' for trans people, particularly surgical treatment, was extremely profitable. With the standards of care to guide and legitimate their work, private practitioners began offering counseling, hormones, and surgery for trans populations nationwide. The 'treatment' for transsexualism thus became a commodity to be purchased on the free market that was separated from the diagnosis.

The raising prices of transition-related care functioned to render these services virtually inaccessible to those who could not afford to pay out of pocket or are uninsured. Privatization of

¹⁷¹ Meyerowitz, *How Sex Changed*, 141.

¹⁷² Paul B. Preciado, *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*. Feminist Press. 2013. 277.

¹⁷³ Jessica Glenza, "Sky-high prices of everything make US healthcare the world's most expensive," *The Guardian*. Published March 13, 2018.

<https://www.theguardian.com/us-news/2018/mar/13/us-healthcare-costs-causes-drug-prices-salaries>. Accessed March 25, 2019.

trans healthcare in a country that does not provide basic universal health insurance coverage unevenly distributes life chances across populations, leaving low-income trans people with few options to access care. It is not surprising, then, that health insurance is one of the main deciding factors in determining access to hormones and surgery. First, there is the issue that trans people are disproportionately uninsured, primarily as a result of employment discrimination, rendering transition-related care all but inaccessible through mainstream medical channels. Second, even when trans people do have health insurance, it operates as a regulatory mechanism that defines what constitutes medically necessary treatment for gender dysphoria, and, in the process, actually constructs gendered bodies. In what ways did privatization transform the availability of treatment, and why? How do the politics of health insurance coverage construct medically necessary treatments? What are the consequences of separating the diagnosis ‘gender dysphoria’ from the treatment? Why, to this day, are insurers so reluctant to offer coverage for transition-related medical care?

Health Insurance

During the age of university-based gender identity clinics, which charged roughly \$1,600 total for psychological evaluations, surgery, and hospital care, public and private health insurance¹⁷⁴ provided spontaneous and sporadic coverage for transition-related care, especially towards the mid to late 1970s.¹⁷⁵ As these clinics closed, the 1979 Meyer/Reter study¹⁷⁶ brought

¹⁷⁴ Christine Jorgensen, *A Personal Autobiography*, 295.

¹⁷⁵ Sr. Mary Elizabeth, *Legal Aspects of Transsexualism*. International Foundation for Gender Education. 1990. 31.

¹⁷⁶ John K. Meyer and Donna J. Reter, “Sex Reassignment: Follow-up” in *Archives of General Psychiatry. The Journal of the American Medical Association*, Vol. 36, Issue. 9, 1010-1015. 1979. doi:10.1001/archpsyc.1979.01780090096010.

about a wave of federally-funded research¹⁷⁷ aimed at proving the ineffectiveness of hormonal and surgical interventions as treatments for ‘transsexualism,’ which private insurance companies used as a justification not to cover surgery.¹⁷⁸ Following this study, a strange alliance formed between the Reagan administration, trans exclusionary radical feminists, and conservative doctors to push policy that would deny coverage for “sex reassignment,” a practice that was facing mounting pushback from both the left and right by this time.¹⁷⁹ In 1981, the National Center for Healthcare Technology (NCHT), a federally-funded agency that advised the Department of Health and Human Services on scientific evidence, colluded with anti-trans feminist Janice Raymond,¹⁸⁰ to release a scientific report recommending that ‘transsexual surgery’ be excluded from coverage under federally-funded plans.¹⁸¹ Following the NCHCT report, many public and private insurance plans began explicitly excluding ‘transsexual surgery’ from coverage on the grounds that it was “experimental”. The report concludes:

There is a lack of well controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism. There is evidence of a high rate of serious complications of these surgical procedures. The safety and effectiveness of transsexual surgery as a treatment of transsexualism is not proven and is questioned. Therefore, transsexual surgery must be considered still experimental.¹⁸²

Many things are happening within this statement that ultimately create a separation between the pathologized transsexual condition and its treatment. First, there is a very questionable

¹⁷⁷ Sr. Mary Elizabeth, *Legal Aspects of Transsexualism*, 32-33.

¹⁷⁸ *Ibid*, 31.

¹⁷⁹ Stryker, *Transgender History*, 140.

¹⁸⁰ Raymond is a lesbian feminist who has equated the practice of transsexuality with rape, the patriarchal oppression of women, and nazism. She advocated for limiting access to transition-related care whenever possible and treating transsexualism with gender reorientation therapy. For more on Raymond, see Stryker, *Transgender History*, 132-138, and Meyerowitz, *How Sex Changed*, 260-265.

¹⁸¹ Sr. Mary Elizabeth, *Legal Aspects of Transsexualism*, 32.

¹⁸² Decision No. 2576; NCD 140.3; Transsexual Surgery. Department of Health and Human Services Departmental Appeals Board, Appellate Division. May 30, 2014. <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf>. Accessed April 30, 2019.

preoccupation with the ‘safety’ of trans people who undergo these procedures, implying that they care about the safety of trans people who undergo treatment, while at the same time not recognizing the reality that many trans people undergo medical transitions partially in order to ensure against violence and discrimination. Further, many studies had in fact shown that these procedures had very low rates of complications. Second, how can we measure the “effectiveness” of these procedures? In the same way that the 1979 Meyer/Reter study measured the successful adjustment of post-op trans people by how much their lives conformed to heterosexist, classist, and racist ideologies? By concluding that “transsexual surgery” was not in fact an effective treatment for “transsexualism,” this NCHCT report left trans people simultaneously pathologized and without a claim to the procedures that they desired.

The 1980s brought about a world of care in which trans people were faced with, as Dean Spade describes it, a “double bind,”¹⁸³ simultaneously medicalized while their medical care was excluded from coverage. By 1989, Health and Human Services (HHS) issued National Coverage Determination (NCD) 140.3 explicitly excluding ‘transsexual surgery’ as a treatment for ‘transsexualism’ from coverage under Medicaid on the ground that it was experimental and therefore not medically necessary.¹⁸⁴ Unable to afford the treatment for their condition, many trans people were and still are indefinitely prevented from accessing the status of ‘good’ transsexuals, the only version intelligible as deserving of sympathy, forever trapped in a state of unaccepted gender variance that is subjected to constant discipline, control, and punishment. Trans people was thus established as a condition for which treatment would be inaccessible to all

¹⁸³ Dean Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates,” in *Seattle Journal for Social Justice: Transgender Issues and the Law*, Vol. 8, no. 2, 497-514. 2010. 502.

¹⁸⁴ See footnote 12.

except those who could afford it, putting all those who could not in a permanent state of limbo, weighed down by the financial realities that prevented them from accessing the embodiment they desired.

Private Industry Capitalizes on ‘Transsexual Surgery’

As discussed in a previous chapter, by 1980, trans healthcare was transferred out of the university clinic setting into the hands of private practices that mainstreamed the use of the HBGDA standards of care. Take, for example, Dr. Stanley Biber, who turned his hometown of Trinidad, Colorado into the “Sex Change Capital of the World” by the mid 1980s, operating primarily at San Rafael Hospital.¹⁸⁵ His practice, as detailed in a letter to famous gay trans man and activist Lou Sullivan, followed the standards of care for all patients who sought surgery.

Biber writes,

We require that you have lived, worked and dressed in the male role for a period of at least one year. We must have a psychiatric evaluation plus we must have one additional single evaluation either by another psychiatrist or a psychologist.¹⁸⁶

As this quote exemplifies, Biber and other private surgeons enforced the use of the standards of care in the world of private practices. Meyerowitz argues that this was largely performative professionalism to advance their financial interests: “If they adhered to these guidelines, private practitioners could protect their professional standing and distinguish themselves from ‘chop shop’ doctors...”¹⁸⁷ Maintaining professional standing was in the best financial interests of these doctors, who charged \$6,225 a pop for vaginoplasty, \$3,650 for double mastectomy, and as

¹⁸⁵ S.J. Guffey, “Colorado town is sex-change world capital,” *New Orleans Times-Picayune*. Published Jan 27, 1985. Transas City.

http://transascity.org/files/news/1985_01_27_New_Orleans_Times-Picayune_B2. Accessed April 29, 2019.

¹⁸⁶ Correspondence from Stanley Biber to Lou Sullivan, Feb 3, 1986.

<https://www.digitaltransgenderarchive.net/files/sj139204g>. Accessed April 29, 2019.

¹⁸⁷ Meyerowitz, *How Sex Changed*, 273.

much as \$14,300 for phalloplasty. With doctors such as Biber performing up to 100 such surgeries every year (with vaginoplasty being by far the most common procedure),¹⁸⁸ upholding professional standards allowed them to charge high fees and make the most profit. One trans woman Biber operated on recalled her reasons for choosing this particular doctor, “Dr. Biber has a very good record,” she continues, “If I’m going to take the step, I want the best.”¹⁸⁹

Transition-related medical care thus became a highly sought after and expensive commodity with a niche consumer base that bolstered its claims to legitimacy. Having the kind of patients that can afford to pay out of pocket for your treatments constructs these doctors as especially sought after and offering the best standard of care, key marketing tactics meant to sell their product.

Though the standards of care provided the illusion of objectivity, doctors’ subjective decision-making often overrode formal criteria and took precedence over all else. Dr. Biber was concerned about misdiagnosing his patients, fearful that they might actually be schizophrenics, extremely feminine homosexuals, or transvestites, rather than true transsexuals.¹⁹⁰ In order to avoid this, he enforced the standards of care for every patient that came in requesting surgery as a preliminary sorting method. However, as a 1985 New-Orleans Picayune article describes, “Even after that, Biber goes by his gut feeling and some get turned away.” His gut feeling is anchored in his years of professional experience: he remarks, “I’ve seen so many that I can almost count on my gut feeling when they walk through the door.”¹⁹¹ Ultimately, the decision of whether or not to grant access to care depended on whether Dr. Biber had a bad feeling in his gut about a certain patient the moment they walked through the door and he was able to scan their

¹⁸⁸ S.J. Guffey, “Colorado town is sex-change world capital.”

¹⁸⁹ Ibid.

¹⁹⁰ Ibid.

¹⁹¹ Ibid.

appearance and mannerisms for the gendered embodiments he was looking for. As Paul Preciado writes, “The unveiling of gender depends on an optical ontology: the real is what you can see.”¹⁹² Gut feelings, as most people understand, are not grounded in scientific knowledge, professional standards, or expertise: they are the product of personal beliefs, opinions, and prejudices. What does a true transsexual ‘look’ like, in Dr. Biber’s objective opinion? What do they act like, walk like, sound like?

In order to maximize profits from transition-related medical care, doctors often required cash payments up-front to avoid dealing with the unwillingness of health insurance to cover these procedures. Public insurance, such as Medicare and Medicaid, ruled in 1981 that ‘sex reassignment’ was cosmetic, elective, and experimental, and thus was to be excluded from coverage. Most private insurance companies during this time refused to provide coverage for transition-related surgeries, and even the ones who did provide it were “inconsistent and at times arbitrary.”¹⁹³ Dr. Biber remarked in 1989, “...general insurers are giving us a really hard time and are giving our patients a hard time too.”¹⁹⁴ Transition-related care, embodied in the form of sex and gender, is thus constructed as a marketable, tangible product that consumers would go to great lengths to pay for, even in the absence of assistance from health insurance. To become a man or woman, one must “buy” a sex change in order to satisfy this desire. This creates a scenario in which only trans people who could afford high out-of-pocket prices were able to

¹⁹² Preciado, *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*, 102.

¹⁹³ MTF activist Dallas Denny wrote in 1994, “...insurers are very inconsistent and arbitrary, paying in some states but not others, in some years but not others, and for some persons but not others.” Dallas Denny, *Identity Management in Transsexualism: A Practical Guide to Managing Identity on Paper*. Creative Design Services. 1994. 56.

¹⁹⁴ Wendy Pierce, “An Interview with Dr. Stanley H. Biber” in *Twenty Minutes: Anniversary Issue*, 5-7. The XX Club. October 1989. Digital Transgender Archive. <https://www.digitaltransgenderarchive.net/files/d791sg26z>. April 29, 2019.

access quality surgical interventions from reputable doctors like Dr. Biber, and all others will either have to do without or obtain through illicit channels.

In the next section, I discuss the contemporary landscape of health insurance exclusion for trans people in the U.S., and how the privatization of trans healthcare laid the groundwork for a reality in which low-income, Black and Latinx trans people are barred from accessing such services.

Health Insurance and the Distribution of Life Chances

Health insurance, as with all forms of insurance, is a “technology of risk”¹⁹⁵ that allows us to have a sense of security about future uncertainties that might result in loss or harm to our bodies and possessions. In order to acquire health insurance, one must be able to pay monthly premiums in order to prepare for unspecified future risk. Colombia professor Geeta Patel argues that people often form social or political groups based on the risks they face as a group.¹⁹⁶ Trans people, in addition to the risks of violence, death, and unemployment, face the risk of not being able to access the embodiment in which they imagine themselves living happy and fulfilling lives.¹⁹⁷ Many health insurance plans, it seems, are generally unwilling to insure against this risk and provide trans people with a measure of security against the uncertainty this arouses within us and the dangers it subjects us to. Trans people who are unable to buy into an investment against

¹⁹⁵ Geeta Patel, “Imagining risk, care and security: Insurance and fantasy” in *Anthropological Theory*, Vol. 7, no. 1, 99-118. Sage. <https://journals.sagepub.com/doi/pdf/10.1177/1463499607074297>. 2007. 99.

¹⁹⁶ Patel, “Imagining risk, care and security: Insurance and fantasy,” 109.

¹⁹⁷ “‘Being at risk’: a phrase that is familiar to people who live in the USA and who engage with issues around race, disability or sexuality. Being at risk: for losing one’s life if one is a young black or Native American Man, for losing one’s rights to healthcare if one works for a corporation that is downsizing. Women of color become bonded to each other, stand surety for each other perhaps, because they are at risk for not getting access to the kind of life that is made through the labor of producing a good life--whether that is via education or a job or access to a breast examination or welfare or to medication for HIV.” Geeta Patel, “Imagining risk, care and security: Insurance and fantasy,” 109.

future risk are faced with extreme levels of uncertainty unaided. “For someone who is financially strapped, money that might go unnoticed, automatically subtracted from a paycheck to provision insurance policies, pension funds or social security, is money that becomes extraordinarily visible.”¹⁹⁸ In the U.S., access to health insurance typically falls along the lines of race and class: this is also true of the trans population. Of the 14%¹⁹⁹ of trans people who reported being uninsured in the 2015 US Transgender Survey, the sub-populations with the highest rates of being uninsured were Black (20%), American Indian (18%), and Latino/a (17%).²⁰⁰ Left to face the uncertainty of being a living person with a body and no health insurance, these populations are faced with little to no feeling of security in their futures, and at any moment something could happen with their health that they would not be able to afford treatment for out of pocket. For these populations, in the absence of health insurance, they are subjected to power that functions to “distribute life chances across populations,” a kind of power Dean Spade calls “population management.”²⁰¹

One of the most striking features of the aforementioned “double-bind”²⁰² is that trans people are often trapped in a cycle, unable to afford the treatment (particularly hormones, laser hair removal, and face feminization) that they need to find suitable employment with sustainable wages. Most of the general U.S. population (56% in 2015)²⁰³ accesses health insurance through employers, with the remainder having some form of public insurance or being uninsured. Trans

¹⁹⁸ Patel, “Imagining risk, care and security: Insurance and fantasy,” 100.

¹⁹⁹ Compared to 11% in the general population. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: *National Center for Transgender Equality*. 2016. 94.

²⁰⁰ Ibid, 94.

²⁰¹ Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law*. South End Press. 2011. 110.

²⁰² Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates,” 501.

²⁰³ Herman et al., *The Report of the 2015 U.S. Transgender Survey*, 94.

people often have a hard time finding jobs, receiving promotions,²⁰⁴ and maintaining jobs,²⁰⁵ not least because many states require medical documentation showing proof that a trans person has undergone surgery in order to change a gender marker on their ID.²⁰⁶ Consider Santos Arce, a 49-year-old Latino trans man, who reflected in an interview about having a hard time finding work prior to transitioning medically: “...showing up as a young butch to a job interview and giving those signals, you’re often not going to get the job as a secretary.”²⁰⁷ The inability to access the very thing that they need to afford to pay out of pocket for transition-related care thus leaves many trans people, particularly Black trans people, trapped in a state of constant deferral. Some engage in criminalized sex work or drug dealing in order to pay for medical care from illicit sources, further subjecting them to violence, incarceration, and risk from unmonitored hormone use or botched surgeries.²⁰⁸

Excluded and Denied

The landscape of coverage has changed significantly since the the 1980s and 1990s, with more and more plans offering coverage for transition-related care based on the mounting medical and legal consensus that it is medically necessary, including Medicaid and Medicare.²⁰⁹ Starting in 2005 with California, a new wave of state legislation increasingly banned health insurance discrimination against clients based on their gender identity or expression--meaning, if a plan covers treatments for other medical conditions, such as a double mastectomy as a treatment for

²⁰⁴ 2015 *U.S. Transgender Survey*, 151.

²⁰⁵ *Ibid*, 149.

²⁰⁶ Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People,” 499.

²⁰⁷ Santos Arce Interviewed by Lorenzo Van Ness. *New York City Trans Oral History Project*. Date of Interview July 14, 2017. <http://oralhistory.nysl.org/interviews/santos-arce-nx3hjo#55:30>. Accessed April 30, 2019.

²⁰⁸ Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People,” 499.

²⁰⁹ Keren Landman, “Fresh Challenges To State Exclusions On Transgender Health Coverage,” *NPR*. Published March 2, 2019.

<https://www.npr.org/sections/health-shots/2019/03/12/701510605/fresh-challenges-to-state-exclusions-on-transgender-health-coverage>. Accessed April 30, 2019.

breast cancer, then they must cover those same treatments for gender dysphoria. Currently, 21 states and Washington D.C. have laws banning blanket trans exclusion clauses by private insurance companies.²¹⁰ With healthcare discrimination based on gender identity being legal in 29 states,²¹¹ many trans people routinely²¹² experience denial of coverage for claims related to transition-related care: 55% of trans people reported having a claim for surgery denied, and 25% reported being denied coverage for hormone therapy.²¹³ Take, for example, Arkansas BlueCross BlueShield’s policy as of January 2017. It reads, “Coverage eligibility of Gender Reassignment Surgery for Gender Dysphoria is a contract-specific benefit issue. When benefits for gender reassignment surgery are available, coverage may vary and under some plans may be excluded.”²¹⁴ Because private plans are not legally required to cover the care in Arkansas,²¹⁵ largely, the decision about whether or not to provide coverage rests with employers, who can choose plans that cover the services or not. In more conservative states such as Arkansas, Mississippi, and Alabama, increased levels of religiosity and social conservatism animate the majority of the pushback against offering coverage for transition-related healthcare.²¹⁶

Medical Necessity

The logic of denying coverage is grounded in the notion of “medical necessity,” which political theorist Daniel Skinner notes “serves as the primary gatekeeper for the utilization of

²¹⁰ See http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.

²¹¹ 2015 U.S. Transgender Survey.

²¹² 13% report denial of coverage for claims related to transition-related care occurs frequently. Ibid.

²¹³ Ibid, 95.

²¹⁴ Gender Reassignment Surgery for Gender Dysphoria. Arkansas BlueCross Blue Shield. Last updated October 2018. <https://www.arkansasbluecross.com/members/report.aspx?policyNumber=2016024>. Accessed April 30, 2019.

²¹⁵ See footnote 40.

²¹⁶ Sarah Alexandra Marshall, Mary Kathryn Allison, Mary Kathryn Stewart, Noel D. Thompson, and Dani S. Archie, “Highest Priority Health and Health Care Concerns of Transgender and Nonbinary Individuals in a Southern State” in *Transgender Health, Vol. 3.1*. Mary Ann Leibert, Inc. 2018. P. 191.

health care services.”²¹⁷ The concept is used by health insurance plans in order to differentiate between necessary and unnecessary medical care through defining the boundaries of medical care and cosmetic, elective, or experimental procedures, “in the name of ensuring that patients receive treatment that is appropriate and medically indicated while also controlling costs.”²¹⁸ This division between necessary and unnecessary medical care brings us into murky moral territory. What are medically necessary procedures necessary for bodies to undergo? What does it mean to say that the same procedures are necessary for certain bodies but not trans bodies? Medical treatments for less politically charged pathologies, such as insulin for type I diabetes, are administered with the goal of achieving a certain result that is related to the condition, like maintaining healthy blood sugar levels to prevent complications and/or death--in essence, to sustain life. Treating gender dysphoria with hormone therapy and/or surgery does not necessarily directly prevent death in the same way, although it has been shown to improve psychological outcomes.²¹⁹ Instead, the goal of such a treatment, at least for the trans person, is to enhance quality of life and achieve their desired embodiment. When insurance plans argue that these treatments are not medically necessary, they are also arguing that enhancing the quality of life in this population is not urgent or necessary. Transition-related surgeries are thus categorically defined by insurers that exclude them from coverage as being in the realm of the cosmetic or elective, and therefore, not urgent for the person seeking them.

²¹⁷ Daniel Skinner, “Medical Necessity under the Patient Protection and Affordable Care Act” in *Public Administration Review*, Vol. 73, *The Health Care-Crucible Post-Reform: Challenges for Public Administration*, s49-s59. Wiley. September/October 2013. s49.

²¹⁸ Ibid.

²¹⁹ Dana Holle, “Health is Health: Section 1557 of the Affordable Care Act and Transgender Healthcare Rights in Wisconsin and the United States” in *Wisconsin Journal of Law, Gender & Society*, Vol. 32, no. 2, 239-259. 2017.

The Food and Drug Administration (FDA) has not, as of yet, approved hormones as medications to be used in the treatment of gender dysphoria, despite the fact that numerous professional associations, including the APA, AMA, and WPATH, have released statements approving these treatments as “medically necessary,”²²⁰ and therefore, not experimental. When insurance companies deny coverage for hormone therapy on the grounds that it is experimental, they point to the lack of approval from the FDA for these medications as treatments for gender dysphoria. One nurse remarked to sociologist Stef Shuster, “You have to realize contextually this is *weird medicine*. We’re using non-FDA approved drugs, in non-FDA approved ways.”²²¹ Maintaining the idea that hormone therapy is somehow strange, weird, and experimental affects trans people twofold, simultaneously stigmatizing the care that they seek and justifying arguments in favor of withholding coverage.

Further, procedures and treatments that many trans people desire and seek out are explicitly excluded on the grounds that they are ‘cosmetic’ by providers that do actually offer coverage for hormones and/or surgery as treatments for gender dysphoria. In so doing, providers are participating in the construction of gendered bodies. For example, Aetna excludes the following procedures, among many others, from coverage as treatments for gender dysphoria on the grounds that they are cosmetic: voice modification surgery, body contouring, hair removal, and facial masculinization or feminization.²²² By only offering coverage for hormone therapy,

²²⁰ Ibid, 253.

²²¹ Shuster, “Performing informed consent in transgender medicine,” 194. Emphasis added.

²²² “Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.” Medical Policy Bulletin on Gender Reassignment Surgery, Number 0615. Aetna. Last updated January 11, 2019. http://www.aetna.com/cpb/medical/data/600_699/0615.html. Accessed April 30, 2019.

chest/breast surgery, and/or genital surgery, Aetna is participating in constructing what elements of the body are most essential to alter for trans people to achieve successful embodiment as men or women, thereby reducing gender to chest, genitals, and blood levels of testosterone or estrogen. However, as trans political historian Paul Preciado argues,

...the beard and the voice, and not the penis and the vagina or X and Y chromosomes, are the dominant cultural public signifiers of gender in our society. Let us cease to speak about men and women and simply say hairy body or smooth body, body with a high voice or with a low voice.²²³

For transfeminine people who undergo estrogen therapy, the timbre of their voice does not change as it does for transmasculine people taking testosterone. Similarly, estrogen does not alter the presence of existing facial or body hair. Dean Spade writes, “For surviving daily life--work, school, street interactions--these external markers of gender are far more important than genital appearance, which is usually only known to one’s closest intimates.”²²⁴ Through denying coverage for hair removal or voice therapy/surgery as treatments for gender dysphoria on the grounds that they are cosmetic, insurance plans construct these things as inessential to realizing embodied gender, that is, a vagina makes a woman, not a hairless face or a soft voice. In doing so, they simultaneously construct themselves as experts on what constitutes gender and gender itself.

As discussed in a previous chapter, the WPATH standards of care and the DSM-5 gender dysphoria diagnosis function as gatekeeping mechanisms that ration out care to trans people. These gatekeeping mechanisms have become embedded within the language of many insurance plans; Schulz writes, “[t]he Standards of Care...have also been institutionalized at the policy level by managed-care insurance companies and court systems.”²²⁵ Ilhan, a trans man living in

²²³ Preciado, *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*, 227.

²²⁴ Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People,” 499.

²²⁵ Schulz, “The Informed Consent Model of Transgender Care,” 75.

New York City, reflects on gatekeeping from his health insurance, which he has through a unionized job:

I'm still definitely going to be covered, which is great. The only issue is that to qualify for these procedures I need to jump through a lot of hoops. I need to have two letters from mental health providers...one of them is supposed to have a specialty in gender therapy, which is really hard to find someone who has explicitly a speciality in that. I also have to get a letter from a physical healthcare specialist...²²⁶

Despite the New York law mandating that insurance providers cover transition-related medical care, trans people like Ilhan, who has already had top surgery and been on hormones for quite some time, still constantly face barriers to accessing care. He continues, “[t]he really hard thing has been dealing with the mental health stuff...”²²⁷ Many insurance plans, as per WPATH guidelines, require a mental health professional to sign off that they meet the requirements for gender dysphoria prior to accessing care. Schulz writes,

...mental health practitioners...may not feel comfortable granting access to health services outside of the context of a longer term therapeutic relationship. Therefore, the length of therapy may range from a few sessions to months in therapy, and this length depends largely on how long the mental health practitioner deems it necessary for the client to attend therapy, not necessarily the client's therapeutic goals.²²⁸

Trans people like Ilhan are thus in a situation where their ability to even get diagnosed in order to access the care is complicated by financial constraints. They might be able to afford a small monthly co-payment for hormones, but not the higher co-pays for counseling sessions with licensed therapists that could potentially extend for months. Many trans people might not be able to take time off from their lives in order to travel to and from a therapist and attend a 50-minute counseling session.

²²⁶ Ilhan N. Interviewed by Tyler M. Date of Interview August 25, 2018. *New York City Trans Oral History Project*. <http://oralhistory.nysl.org/interviews/ilan-n-ku0e9m>. Accessed April 30, 2019.

²²⁷ Ibid.

²²⁸ Schulz, “The Informed Consent Model,” 81.

When coverage for hormone therapy and surgery is denied on the basis that it is not medically necessary, it is brought into the realm of an individual responsibility, one that the trans person must bear the financial burden of alone. David Goldhill, writing for the Atlantic, reflects on arguments related to medical necessity by using the example of the statin he takes for his high cholesterol.

It's worth thinking about my personal decision for a moment. When I chose a statin, society subsidized that choice at the point of purchase through the tax advantages afforded insurance and my health saving account. If I were a Medicare or Medicaid beneficiary, society's subsidy would have been more direct. Since we all ultimately pay for these subsidies, we should all care about the choices our policies encourage.²²⁹

In Goldhill's words, we get to the heart of why Americans care so much about whether or not health insurance plans provide coverage for transition-related medical care. By framing the 'choice' to pursue a certain medical procedure or treatment as an individual choice, he invokes narratives that are very salient in U.S. culture about personal financial responsibility. Since taxpayers are subsidizing our healthcare, whether indirectly or directly, society should get to decide what is covered and what is not, and treatments that should not be covered are those treatments which are cosmetic or elective, or a matter of individual choice. Taxpayers, he reasons, should not have to take financial responsibility for the individual choices of people who refuse to play their part by paying their individual financial responsibilities.

One might think that the answer lies in an attempt on the part of health insurance companies to cut costs across the board by minimizing the number of procedures they cover irrespective of the diagnosis or the person seeking them. However, this does not seem to be the

²²⁹ David Goldhill, "Who Defines 'Medical Necessity'?" *The Atlantic*. Published January 8, 2014. <https://www.theatlantic.com/health/archive/2014/01/who-defines-medical-necessity/282500/>. Accessed April 30, 2019.

case: a 2008 study showed that a total annual cost of as little as 17.3¢ per resident and 6.6¢ to employers would be added if health insurance plans provided coverage for transition-related care.²³⁰ Similarly, a complaint filed by a student at University of Wisconsin School of Medicine in 2016 over denial of coverage for her gender confirmation surgery noted that state consultants estimate the total yearly cost for covering such procedures for all trans people on public insurance in Wisconsin would range between \$100,000-\$250,000, “less than two-tenths of 1 percent of the health program budget at most.”²³¹ Trans people are a relatively small population, and so few actually choose to pursue surgical care or hormone therapy in a given year. Providing coverage for these services, it has been argued, may act as a form preventative care for trans people, who often experience symptoms associated with having an unmet need for care, such as anxiety, depression, and suicidality,²³² thereby proving more cost-effective in the long-run for everyone involved.

What is the reason, then, that insurance providers continue to argue in favor of denying coverage for transition-related care? Dean Spade argues that the power of the major societal institutions such as education, medicine, insurance, functions not necessarily through “prohibition or permission but rather through the arrangement and distribution of security and insecurity.”²³³ Through denying coverage for transition-related care, insurance companies produce insecure conditions for trans people in their day-to-day lives, leaving them unable to get accurate IDs, unable to find jobs, and without safe access to the care they are seeking. Spade

²³⁰ Mary Ann Horton, *Cost of Transgender Health Benefits, Out & Equal Workplace Summit*. September 2008. <http://www.tgender.net/taw/thbcost.html#thbcost>. Accessed March 31, 2019. 1.

²³¹ Samantha Allen, “Wisconsin Pulls Plug on Trans Health Care,” *The Daily Beast*, February 7, 2017, as quoted by Dana Holle in “Health is Health: Section 1557 of the Affordable Care Act and Transgender Healthcare Rights in Wisconsin and the United States,” 255.

²³² Spade, “Medicaid Policy & Gender-Confirming Healthcare for Trans People.”

²³³ Spade, *Normal Life*, 110.

writes, “Because they are marginalized in employment, and may feel that such healthcare is urgent, many transgender people engage in criminalized activities such as sex work in order to raise money to purchase hormones from informal sources.”²³⁴ Black trans woman Kristen P. Lovell recounted her experiences as a sex worker in the late 1990s on Christopher street, including accessing street hormones. She remembers,

We used to go down to Chi-Chi’s to get it. There was a person at the door, you would give them some coin, they would take a list and then they would come back with the Premarin pills, you’d come back in the next few days to see if your “prescription” was ready.

While Kristen was forced into a position where she had to rely on street hormones she funded through sex work, this can cause a whole host of problems, particularly health-related, as using these medications without medical supervision can result in HIV, hepatitis, organ failure, and/or nerve damage, among other conditions that result from unsupervised injections and unsanitary needles.²³⁵ Black, Latinx, and low-income trans people are disproportionately exposed to these risks.

Limits of the Non-Discrimination Approach to Trans Exclusionary HealthCare

What the future bodes for legislation on health insurance coverage of transition-related care is uncertain at the moment, but it is not a steady march towards inclusion. Many have argued for fighting for coverage at a state or local-level through using non-discrimination law.²³⁶

²³⁴ Spade, “Medicaid Policy,” 499.

²³⁵ Ibid.

²³⁶ “We do not think that a federal legislative strategy would be helpful at this time. We think that locally-based strategies will be most effective and that people in those communities are best situated to evaluate whether litigation, legislative, regulatory, or other approaches will be most effective in their state. Community organizing can also be important in this work and community accountability is always vital.” Dean Spade. “Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates” in *Seattle Journal for Social Justice*, Vol 8. Issue 2. 2010. p. 508.

At the state level, where the vast majority of decisions about healthcare policy are made, there is a positive trend towards outlawing discriminatory health insurance policies, but in many states employers are still free to purchase plans that exclude or deny coverage for transition-related care. The federal situation is also complex: section 1557 of the Affordable Care Act, passed in 2010, banned any plan that received federal funds from discriminating on the basis of sex, which has been interpreted as covering discrimination on the basis of gender identity. Section 1557 does not require insurers to provide coverage for any particular treatments commonly used for gender dysphoria. Non-discrimination law seeks to eliminate explicit discrimination from insurance providers on the basis of diagnosis, rather than targeting the systemic barriers to accessing healthcare faced by trans people. As previous sections of this chapter have already argued, even when plans provide coverage there are still major systemic barriers to access built into health insurance plans. The Trump administration is currently making moves to overturn the ACA. In late 2018 conservative Texas federal district judge Reed O'Connor requested and was granted a nationwide prohibition on the enforcement of the rule. HHS is expected to reverse the regulation on Section 1557 to “redefine discrimination “on the basis of sex” to eliminate protections based on gender identity and termination of pregnancy.”²³⁷

Moving forward, activists and lawyers need to focus on eliminating the intersecting vectors of oppression that cause systemic barriers for trans people accessing care. There should be a focus on uniform recognition of transition-related care as medically necessary, as well as expanding access to health insurance coverage through adoption of a universal single-payer healthcare system. A non-discrimination approach does little to protect trans people who have no

²³⁷ Katie Keith, “More Courts Rule On Section 1557 As HHS Reconsiders Regulation,” *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20181002.142178/full/>. Published October 2, 2018. Accessed March 26, 2019.

health insurance in the first place. Already in the preliminary campaigning for the 2020 election, many candidates are pushing for universal single-payer healthcare. It is likely that the U.S. will have to grapple with the growing demand for a new healthcare system in the coming years.

Conclusion: Demedicalizing Transitions

Is it possible to imagine a different reality in which transition-related care is free and easy to access? Or, better yet, where gender variance is not pathologized? Many trans authors and activists have taken part in dreaming that pathologization, gatekeeping, and insurance denial are things of the past, or, better yet, never existed in the first place. What would a trans subjectivity look and feel like in this context? Feminist trans scholar Sandy Stone, who catalyzed a wave of trans theory and scholarship with her 1987 *Posttranssexual Manifesto*, writes,

The highest purpose of the transsexual is to erase h/erself, to face into the ‘normal’ population as soon as possible. Part of this process is known as constructing a plausible history--learning to lie effectively about one’s past. What is gained is acceptability in society. What is lost is the ability to authentically represent the complexities and ambiguities of lived experience...²³⁸

Trans people who cannot access the material embodied existence that they desire are hypervisible. For those who can, narratives and lives are erased and subsumed by a narrative of distress and self-hatred that seeks to erase any semblance of gender variance. Stone then asks, “How, then, can the transsexual speak? If the transsexual were to speak, what would s/he say?”²³⁹ How can we move outside of the pathologized position that has been carved out for us, and imagine our own futures in ways that are not bound to oppressive and binary gender systems rooted in racism?

Katherine Collins, a trans woman writing in 1994, reflects on the immense gravitational pull that the desire for surgery has had in her life, bringing with it the sense of “walking toward a brilliantly lit altar.”²⁴⁰ Once she actually undergoes the procedure, however, reality fell short of

²³⁸ Sandy Stone, *The Empire Strikes Back: A Posttranssexual Manifesto*. Published 1987. <https://sandystone.com/empire-strikes-back.pdf>. Accessed April 30, 2019.

²³⁹ Ibid.

²⁴⁰ Katherine Collins. "Silent and Transfixed in the Transsexual Factory" in *Transsexual News Telegraph*, Spring 1996. 26.

her expectations. "...the result of this assembly-line process is that the initial spiritual impact of the event is completely nullified. One arrives here with a certain defensiveness, bearing her letters, hard-won from a suspicious and begrudging world, and one almost expects to be turned away at the last minute on some technicality."²⁴¹ Trans people are cheated from the potentially amazing experience of surgically altering your body to reflect the way you see yourself thriving in the world. Medicalizing this process has completely removed the possibility that it might be enjoyable and even fun for the person who undergoes it. Profoundly, Collins asks, "...what might it be like, how much better for all concerned--for all society--if SRS and all medical procedures were accompanied by an air of spirituality?"

Can we imagine the potential of a demedicalized experience of transition, one that is democratized and made safe and available to all those who seek to disrupt their gendered embodiment? She continues,

To take the transsexual process out of the realm of strictly medical, and into the spiritual realm, would be to entirely eliminate the adversarial obstacle-course that many transsexuals encounter. To make it a question not of who is crazy and who is not, and instead to invest it with a series of spiritual counselings, investigations, and ceremonies, would lead the final SRS initiate to the moment of ritual "blood sacrifice" with a sense of deep awe and wonder and privilege and responsibility. What possibilities exist for claiming ownership over this process and reasserting our claims to our bodies? So many possibilities, both in terms of the experiential and the multiplication of bodies that do not claim one gender or the other. Transitioning, rather than a movement from one gender to another, could be a means of experimenting and exploring our many possibilities of self-actualization.

²⁴¹ Ibid.

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