

The Transgender Studies Reader

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Mutilating Gender

DEAN SPADE

IN “MUTILATING GENDER,” LEGAL ACTIVIST AND THEORIST DEAN SPADE uses the work of Michel Foucault to examine the relationship between gender normativity and technologies of gender-related bodily alteration. Although Spade is critical of medical discourse, practices, and institutions that undermine transgender access to body-modifying procedures, he side-steps some of the usual acrimony between service-seekers and service-providers by focusing instead on the regimes of normalization that inform both sides of the power-imbalanced, asymmetrical negotiations over bodily modification.

Spade makes explicit use Foucault’s notion of power as a productive and enabling force, rather than merely a repressive one, as well as Foucault’s view of governance and discipline as a mesh of power relations that increasingly insinuate themselves, in capillary fashion, into ever-more intimate aspects of life. Spade shows not only how certain social forces say “no” to transgender requests for bodily alteration in order to prop up a naturalized version of the sexual binary, but also how saying “yes” to such requests can likewise support and sustain standard forms of gender and embodiment. Such a move frustrates any simple attempt to link transgender activism, and the demand for increased availability of gender-related body-altering practices, with progressive, subversive, radical, or liberatory political ideals. Transgender consumers, as well as transgender service providers, are implicated in relations of power that produce and enforce the norms of gender.

In a rhetorical move of which Foucault would have approved, Spade combines intellectually legitimated forms of analysis and critique with a narrative account of his own quest for nonnormativizing body-alteration. His refusal to feign a disinterested distance from the topic of his analysis, his explicit articulation of his embodied stake in the matter at hand, and the knowledge gained from his own embodied situation all exemplify important methodological hallmarks of transgender studies.

“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.”^[1]

In 1958, a woman named Agnes presented her self to doctors at the Department of Psychiatry of the University of California, Los Angeles seeking plastic surgery to “remedy an apparent endocrine abnormality.”^[2] The doctors were engaged in a study of intersexed patients, and were interested to find that Agnes appeared a “feminine” woman, with female secondary sex characteristics, but also

had a fully developed penis and atrophic scrotum. Agnes explained that she had been brought up as a boy, but had always felt she was a girl and had developed female characteristics at puberty. The medical team diagnosed Agnes with “testicular feminization syndrome,” speculating that her feminine characteristics came from estrogens produced by her testes.^[3] They performed surgery to remove her penis and testes in order to correct this “natural mistake.”

Five years after Agnes obtained surgery, and eight years after first came to the UCLA clinic, she revealed to the doctors that she had not spontaneously developed female secondary sex characteristics, but had engineered a feminine appearance by taking her mother’s estrogen beginning at the age of twelve. Hausman comments, “Agnes’s ‘passing’ from man to woman turns out to have been based on another kind of ‘passing’ altogether.”^[4] Agnes achieved her surgical goals by fooling the doctors into believing that she was intersexed—the criteria for receiving such surgery in their program.

What is the significance of the necessity for and execution of Agnes’s deception of the doctors? How should gender theorists, feminists, and trans people understand the long-standing practice amongst gender variant people of strategically deploying medically-approved narratives in order to obtain body-alteration goals?

This essay examines the relationship between individuals seeking sex reassignment surgery (SRS)^[5] and the medical establishments with which they must contend in order to fulfill their goals. My starting point for this analysis is Foucault’s understanding of power as productive rather than repressive, and of governance as occurring not primarily through repressive law but through disciplinary forces which exist in “diverse, uncoordinated agencies.”^[6] Using Foucault’s models of power and governance, I look carefully at the diagnosis and treatment of Gender Identity Disorder (GID) from the perspective of persons seeking SRS, examining how the creation of the subject position “transsexual” by the medical establishment restricts individuals seeking body alteration and promotes the creation of norm-abiding gendered subjects.

Throughout this essay, I draw on my own experience of attempting to find low-cost or free counseling in order to begin the process of getting a double mastectomy. The choice to use personal narrative in this piece comes from a belief that just such a combination of theoretical work about the relationships of trans people to medical establishments and gender norms and the experience of trans people is too rarely found. Riki Anne Wilchins describes how trans experience has been used by psychiatrists, cultural feminists, anthropologists, and sociologists “travel[ling] through our lives and problems like tourists . . . [p]icnicking on our identities . . . select[ing] the tastiest tidbits with which to illustrate a theory or push a book.”^[7] In most writing about trans people, our gender performance is put under a microscope to prove theories or build “expertise” while the gender performances of the authors remain unexamined and naturalized. I want to avoid even the appearance of participation in such a tradition, just as I want to use my own experience to illustrate how the requirements for diagnosis and treatment play out on individual bodies. The recent proliferation of academic and activist work on trans issues has created the impression in many people (mostly non-trans) that problems with access to services for trans people are being alleviated, and that the education of many specialists who provide services to trans people has made available sensitive therapeutic environments for trans people living in large metropolitan areas who can avail themselves of such services. My unsuccessful year-long quest for basic low-cost respectful counseling services in Los Angeles, which included seeking services at the Los Angeles Gender Center, the Los Angeles Gay and Lesbian Services Center and Children’s Hospital Los Angeles is a testament to the problems that still remain.^[8] This failure suggests the larger problems with the production of the “transsexual” in medical practice, and with the diagnostic and treatment criteria that made it impossible for the professionals from whom I sought care to respectfully engage my request for gender-related body alteration.

I hope that the use of my experience in this paper will provide a grounding illustration of the regulatory effects of the current diagnosis-treatment scheme for GID and resist the traditional framing of transsexual experience which posits trans people as victims or villains, insane or fascinating. Instead, I hope to be part of a project already taken up by Riki Anne Wilchins, Kate Bornstein, Leslie Feinberg, and many others which opens a position for trans people as self-critical, feminist, intellectual subjects of knowledge rather than simply case studies.

I. GOVERNANCE: PASSING AS A TRANSSEXUAL

Here's what I'm after: a surgically constructed male-appearing chest, no hormones (for now—maybe forever), no first-name change, any pronouns (except "it") are okay, although when it comes to gendered generics I happen to really like "Uncle" better than "Aunt," and definitely "Mr. Spade."^[9] Hausman writes, "transsexuals must seek and obtain medical treatment in order to be recognized as transsexuals. Their subject position depends upon a necessary relation to the medical establishment and its discourses."^[10] I've quickly learned that the converse is also true, in order to obtain the medical intervention I am seeking, I need to prove my membership in the category "transsexual"—prove that I have GID—to the proper authorities. Unfortunately, stating my true objectives is not convincing them.

In their essay, "The Socio-Medical Construction of Transsexualism: An Interpretation and Critique," Billings and Urban examine the development of transsexualism as a disease, and sex-change surgery as its treatment. They argue that transsexualism is socially constructed by medical practice, and is maintained by profiteer doctors who gain wealth, fame, and surgical expertise through the diagnosis and treatment (which the authors call "mutilation") of a variety of sexual deviants incorrectly labeled "transsexuals."^[11] Many of the conclusions of their essay contradict the basic premises of this paper: that sexual and gender self-determination and the expression of variant gender identities without punishment (and with celebration) should be the goals of any medical, legal, or political examination of or intervention into the gender expression of individuals and groups. However, many of their theoretical understandings of the operation of medical authority with regard to gender reassignment are valuable.^[12]

Billings and Urban are concerned with the "domination of daily life and consciousness by professional authority . . . [and] the extent to which many forms of deviance are increasingly labeled 'illness'" as well the possibility that "[s]ex-change surgery privatizes and depoliticizes individual experiences of gender-role distress."^[13] They argue that transsexualism is constructed by and only exists through medical practice, which has invented it as a psychological entity, a problem in the minds of patients. Instead, Billings and Urban suggest that "transsexualism is a relational process sustained in medical practice and marketed in public testimony."^[14]

Billings' and Urban's critique of the invention of the "transsexual" as a medical anomaly, a mentally ill person requiring treatment, offers a useful point of departure for an analysis of the treatment and diagnosis of GID that questions the terms upon which individuals seeking body alteration may receive such care. Understanding physical and mental health care as social processes with regulatory effects, we can examine the standards by which such alteration is restricted.^[15]

Foucault describes a notion of productive power that instructs a critical analysis of the regulatory effects of medical diagnosis and treatment. Foucault rejects what he terms "the repressive hypothesis" as a way of viewing the history of sexuality since the 16th century.^[16] He argues that the history of sexuality is not characterized by repression, but by an "incitement to speak" about sex.^[17] He describes how the imperative has been to speak about sex, to accumulate detailed knowledge of it, to identify and classify it, and to seek out the origins of sexual behavior and desire. Sexuality has become the

locus of the “true self”—to know the self is to know one’s sex, sexuality, and desire. In this model, sex is figured not as the thing that must not be spoken, but as a public problem needing to be managed by an increasingly large group of medical, psychiatric, and criminal justice specialists.^[18]

Foucault demands that the project of asking whether approaches to sex are repressive or permissive be replaced by a project of examining how sex is put into discourse. His model of power as productive requires that power does not just say “no” and enslave free subjects, but rather produces knowledge, categories and identities that manage and regulate behavior. Foucault’s favored example is the invention of homosexuality. He argues that the sexologists who first discussed homosexuality were not identifying a pre-existing identity, but rather were inventing the homosexual.^[19]

Foucault’s theory of power requires a conception of governance which goes beyond the a juridico-discursive model where power exists in law, which represses and forbids.^[20] Instead Foucault demonstrates how governance occurs through disciplinary power, located in diverse, uncoordinated agencies, including educational, medical, and psychiatric institutions. Hunt and Wickham describe disciplinary power:

Discipline, rather than being constituted by ‘minor offences,’ is characteristically associated with ‘norms,’ that is, with ‘standards,’ that the subject of a discipline comes to internalise or manifest in behaviour, for example standards of tidiness, punctuality, respectfulness, etc. . . . These standards of proper conduct put into place a mode of regulation characterised by interventions designed to correct deviations and to secure compliance and conformity. . . . It is through the repetition of normative requirements that the ‘normal’ is constructed and thus discipline results in the securing of normalisation by embedding a pattern of norms disseminated throughout daily life and secured through surveillance. . . . ‘[E]xercises’ and the repetition of tasks characterise the disciplinary model of []power.^[21]

Disciplinary, productive power constitutes governance in the sense that it “structures the possible field of actions of others.”^[22] A central element of this governance is the production, dissemination, and utilization of knowledge.^[23] In this understanding of the workings of domination, law is replaced or supplemented by psychiatry, psychology and medicine, which create categories of dangerous individuals, subject positions that operate as regulatory instruments.

Foucault’s model of power lends to a critique of the creation of categories of illness that serve, through diagnosis and treatment, to regulate gender expression. When such an analysis is applied to transsexuality, we must ask what will be the mediating principle behind the analysis. For Billings and Urban, the principle is that the treatment of distress in gender roles through surgery is fundamentally opposed to a liberating and politicized project of gender equality. They trace the invention of the category “transsexual” by doctors, examining how medical practice has established a childhood, a sexuality, a detailed life narrative for the “transsexual” that sexual deviants of many types have mimicked and/or internalized^[24] as norms in order to relieve or explain gender distress. They correctly assert that this narrative shores up traditional notions of gender dichotomy and compulsory heterosexuality.^[25] However, because their mediating principle is that body alteration is *always* a privatizing and depoliticizing response to gender role distress, they paint transsexuals as brainwashed victims who have failed to figure out that they are only undermining a revolution that seeks to save them. Billings and Urban arrive at this principle by creating an arbitrary line between technology and the body that they place at sex-change procedures. They fail to include in their analysis the fact that people (transsexuals and non-transsexuals) change their gender presentation to conform to norms with multiple other technologies as well, including clothing, make-up, cosmetic surgery not labeled SRS, training in gender-specific manners, body building, dieting, and countless other practices. Like other theorists

“picknicking” on transsexual identity, their work to undermine trans alteration stabilizes exercises of normative gender production, even while they suggest that gender destabilization is their goal.

An approach that recognizes the possibility of a norm-resistant, politicized, and feminist desire for gender-related body alteration need not reject the critique of medical practice regarding transsexuality nor embrace the normalizing regulations of the diagnostic and treatment processes. An alternate mediating principle for a critical analysis is possible. Such an analysis requires seeing the problem not as fundamentally lying in the project of gender change or body alteration, but in how the medical regime permits only the production of gender-normative altered bodies, and seeks to screen out alterations that are resistant to a dichotomized, naturalized view of gender. An alternative starting point for a critique of the invention and regulation of transsexualism is a desire for a deregulation of gender expression and the promotion of self-determination of gender and sexual expression, including the elimination of institutional incentives to perform normative gender and sexual identities and behaviors. This understanding suggests that the problem with the invention of transsexualism is the limits it places on body alteration, not its participation in the performance of body alteration.^[26]

Starting from this presumption, a Foucauldian critique of the diagnosis and treatment of transsexualism exposes how the invention of this “disorder” and its purported therapy do, indeed, function to regulate gender performance. Containing gender distress within “transsexualism” functions to naturalize and make “healthy” dichotomized, birth-assigned gender performance. It casts the critical eye on the gender performance of those transgressing gender boundaries, and produces a norm that need not be criticized. Similarly, this model establishes a structure for addressing violations of gender rules that individualizes, privatizes and depoliticizes the meaning of those transgressions. It is “in the minds of the ill” that gender problems exist, not in the construction of what is “healthy.”

Similarly, the disciplinary power exercised by the gatekeepers (doctors, surgeons, psychiatrists, therapists) of SRS requires the repetitive, norm producing exercises to which Foucault refers. The “successful” daily performance of normative gender is a requirement for receiving authorization for body alteration.^[27] Similarly, the successful recitation of the transsexual narrative in meeting after meeting with medical professionals, and in session after session with counselors and psychiatrists, is essential to obtaining such authorization. The next sections will deal specifically with these practices.

The next two sections look in detail at how some of the prerequisites for SRS serve to maintain normative gender performance and contain gender dysphoria in the realm of transsexuality. The final sections will examine the costs and benefits of strategic use of the transsexual subject position by persons seeking SRS, and question the meanings frequently assigned by non-trans theorists and medical practitioners to such strategic performances.

II. THE TRANSEXUAL CHILDHOOD

“When did you first know you were different?”^[28] the counselor at the L.A. Free Clinic asked. “Well,” I said, “I knew I was poor and on welfare, and that was different from lots of kids at school, and I had a single mom, which was really uncommon there, and we weren’t Christian, which is terribly noticeable in the South. Then later I knew I was a foster child, and in high school, I knew I was a feminist and that caused me all kinds of trouble, so I guess I always knew I was different.” His facial expression tells me this isn’t what he wanted to hear, but why should I engage this idea that my gender performance has been my most important difference in my life? It hasn’t, and I can’t separate it from the class, race, and parentage variables through which it was mediated. Does this mean I’m not real enough for surgery?

I’ve worked hard to not engage the gay childhood narrative—I never talk about tomboyish behavior as an antecedent to my lesbian identity, I don’t tell stories about cross-dressing or crushes on girls, and I

intentionally fuck with the assumption of it by telling people how I used to be straight and have sex with boys like any sweet trashy rural girl and some of it was fun. I see these narratives as strategic, and I've always rejected the strategy that adopts some theory of innate sexuality and forecloses the possibility that anyone, gender-troubled childhood or not, could transgress sexual and gender norms at any time. I don't want to participate in an idea that only some people have to engage a struggle of learning gender norms in childhood either. 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, not playing with dolls? What is the cost of participation in this selective recitation? What is the cost of not participating?

Rachel Pollack writes:

What sense does it make to label some people as true transsexuals, and others as secondary, or confused, or imitation? Whom does such an attitude serve? I can think of no one but the gatekeepers, those who would seize the power of life and death by demanding that transsexuals satisfy an arbitrary standard. To accept such standards, to rank ourselves and others according to a hierarchy of true transsexuality, to try to recast our own histories to make sure they fit the approved model, can only tear us down, all of us, even the ones lucky enough to match that model.^[29]

Anne Bolin quotes an MTF she spoke with: “[Psychiatrists and therapists] . . . use you, suck you dry, and tell you their pitiful opinions, and my response is: What right do you have to determine whether I live or die? Ultimately the person you have to answer to is yourself and I think I'm too important to leave my fate up to anyone else. I'll lie my ass off to get what I have to.”^[30]

Symptoms of GID in the Diagnostic and Statistical Manual (DSM-IV)[31] describe at length the symptom of childhood participation in stereotypically gender inappropriate behavior. Boys with GID “particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. . . . They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks.” Girls with GID do not want to wear dresses, “prefer boys’ clothing and short hair,” are interested in “contact sports, [and] rough-and-tumble play.”[32] Despite the disclaimer in the diagnosis description that this is not to be confused with normal gender non-conformity found in tomboys and sissies, no real line is drawn between “normal” gender non-conformity and gender non-conformity which constitutes GID.[33] The effect is two-fold. First, normative childhood gender is produced—normal kids do the opposite of what kids with GID are doing. Non-GID kids can be expected to: play with children of the own sex, play with gender appropriate toys (trucks for boys, dolls for girls), enjoy fictional characters of their own sex (girls, specifically, might have GID if they like Batman or Superman), play gender appropriate characters in games of “house,” etc. Secondly, a regulatory mechanism is put into place. Because gender nonconformity is established as a basis for illness, parents now have a “mill of speech,”^[34] speculation, and diagnosis to feed their children’s gender through should it cross the line. As Foucault describes, the invention of a category of deviation, the description of the “ill” behavior that need be resisted or cured, creates not a prohibitive silence about such behavior but an opportunity for increased surveillance and speculation,^[35] what he would call “informal-governance.”^[36]

The Diagnostic Criteria for Gender Identity Disorder names, as a general category of symptom, “[a] strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).”^[37] This criterion suggests the possibility of a gender categorization not read through the cultural gender hierarchy. This requires an imagination of a child wanting to be a gender different from the one assigned to hir^[38] without having that desire stem from a cultural understanding of gender difference defined by the “advantaging” of certain gender behaviors and identities over others. To use an illustrative example from the description of childhood GID

symptoms, if a child assigned “female” wants to wear pants and hates dresses, and has been told that this is inappropriate for girls, is that decision free from a recognition of cultural advantages associated with gender? Since a diagnosis of GID does not require a child to state the desire to change genders, and the primary indicators are gender inappropriate tastes and behaviors, how can this be separated from cultural understandings of what constitutes gender difference and gender appropriateness? If we start from an understanding that gender behavior is learned, and that children are not born with some innate sense that girls should wear dresses and boys shouldn’t like Barbie or anything pink, then how can a desire to transgress an assigned gender category be read outside of cultural meaning? Such a standard does, as Billings and Urban argue, privatize and depoliticize gender role distress. It creates a fictional transsexual who just knows in hir gut what man is and what woman is, and knows that sie is trapped in the wrong body. It produces a naturalized, innate gender difference outside power, a fictional binary that does not privilege one term.

The diagnostic criteria for GID produces a fiction of natural gender, in which normal, non-transsexual people grow up with minimal to no gender trouble or exploration, do not crossdress as children, do not play with the wrong-gendered kids, and do not like the wrong kinds of toys or characters. This story isn’t believable, but because medicine produces it not through a description of the norm, but through a generalized account of the transgression, and instructs the doctor/parent/teacher to focus on the transgressive behavior, it establishes a surveillance and regulation effective for keeping both non-transsexuals and transsexuals in adherence to their roles. In order to get authorization for body alteration, this childhood must be produced, and the GID diagnosis accepted, maintaining an idea of two discrete gender categories that normally contain everyone but occasionally are wrongly assigned, requiring correction to reestablish the norm.

It’s always been fun to reject the gay childhood story, to tell people I “chose” lesbianism, or to over articulate a straight childhood narrative to suggest that lesbianism could happen to anyone. But not engaging a trans childhood narrative is terrifying—what if it means I’m not “real”? Even though I don’t believe in real, it matters if other people see me as real—if not I’m a mutilator, an imitator, and worst of all, I can’t access surgery.

Transsexual writer Claudine Griggs’ book takes for granted that transsexuality is an illness, an unfortunate predicament, something fortunate, normal people don’t have to go through. She writes: “Fortunately, most people, though they strive to become a certain kind of woman or man, never question their foundational gender. . . . A person with gender dysphoria is crippled emotionally and socially, which accounts for part of the transsexual compulsion for body alteration.”^[39] On the first page of the preface she writes,

I am not an advocate of sex change procedures. I know that sex reassignment is necessary for some individuals with gender dysphoria in much the same way as a radical mastectomy is necessary for some individuals with breast cancer, but I hope that such treatment is undertaken only when no other effective prescription exists. The best recommendation, though pointless, is don’t get cancer and don’t be a transsexual.^[40]

This is precisely the approach I want to avoid as I reject the narrative of a gender troubled childhood. My project would be to promote sex reassignment, gender alteration, temporary gender adventure, and the mutilation of gender categories, via surgery, hormones, clothing, political lobbying, civil disobedience, or any other means available. But that political commitment itself, if revealed to the gatekeepers of my surgery, disqualifies me. One therapist said to me, “You’re really intellectualizing this, we need to get to the root of why you feel you should get your breasts removed, how long have you felt this way?” Does realness reside in the length of time a desire exists? Are women who seek breast enhancement required to answer these questions? Am I supposed to be able to separate my political convictions about gender,

my knowledge of the violence of gender rigidity that has been a part of my life and the lives of everyone I care about, from my real “feelings” about what it means to occupy my gendered body? How could I begin to think about my chest without thinking about cultural advantage?

III. CHOOSING PERSPECTIVE: PASSING “FULL-TIME”

From what I’ve gathered in my various counseling sessions, in order to be deemed real I need to want to pass as male all the time, and not feel ambivalent about this. I need to be willing to make the commitment to “full-time” maleness, or they can’t be sure that I won’t regret my surgery. The fact that I don’t want to change my first name, that I haven’t sought out the use of the pronoun “he,” that I don’t think that “lesbian” is the wrong word for me, or, worse yet, that I recognize that the use of any word for myself—lesbian, transperson, transgender butch, boy, mister, FTM fag, butch—has always been/will always be strategic is my undoing in their eyes. They are waiting for a better justification of my desire for surgery—something less intellectual, more real.

I’m supposed to be wholly joyous when I get called “sir” or “boy.” How could I ever have such an uncomplicated relationship to that moment? Each time I’m sirred I know both that my look is doing what I want it to do, and that the reason people can assign male gender to me easily is because they don’t believe women have short hair, and because, as Garber has asserted, the existence of maleness as the generic means that fewer visual clues of maleness are required to achieve male gender attribution.^[41] This “therapeutic” process demands of me that I toss out all my feminist misgivings about the ways that gender rigidity informs people’s perception of me.

Leslie Feinberg writes about the strategic use of gender categories, “Outside the trans communities, many people refer to me as “she,” which is also correct. Using that pronoun to describe me challenges generalizations about how “all women” act and express themselves. In a non-trans setting, calling me “he” renders my transgender invisible.”^[42] Similarly, I do not want to forfeit the ability to utilize gender categories to promote social change. I want to keep open my ability to reject the use of some categories in some contexts because of the presumptions that underlie their definitions.

In “A ‘Critique of Our Constitution is Colorblind,’” Neil Gotanda writes about how the terms of American dialogues about race are set by racism. He describes racial difference is understood through the rule of “hypodescent,” which dictates that any person with a known trace of African ancestry is black. “[H]ypodescent imposes racial subordination through its implied validation of white racial purity.” As a result, the uncritical proclamation “I am white” is a racist statement, because it reaffirms the definition of white that is grounded in a dichotomy of racial purity and impurity.^[43] The terms of gender difference operate differently, but are similarly problematic—to declare membership in a static gender category affirms a regulatory system of dichotomous gender. What kind of “health” does such “treatment” restore me to, if it compels me to make such a declaration?

Perhaps the most overt requirement for transsexual diagnosis is the ability to inhabit and perform “successfully”^[44] the new gender category. Through my own interactions with medical professionals, accounts of other trans people, and medical scholarship on transsexuality, I have gathered that the favored indication of such “success” seems to be the gender attribution of non-trans people. Because the ability to be perceived by non-trans people as a non-trans person is valorized, normative expressions of gender within a singular category are mandated.

Griggs’ narrative exemplifies this paradigm of gender legibility. Her stories assume that gender identity is fundamentally about gender attribution: your *real* gender is the one that people can see on you. She argues that there is no “perceptual middle ground between male and female” which means that “transsexuals cannot fade gently” between genders.^[45] For Griggs, the project of changing genders fundamentally concerns the perception of non-trans people that she is a born woman. She writes,

I have always had a feminine gender, yet I became a woman not because I changed my driver's license, took estrogens, applied makeup, grew long hair, or had genital surgery, but because on 1 July 1974, a man opened the door for me as I entered my 8:00 a.m. class. . . . Society must see a woman; otherwise, sex-change surgery or not, one cannot be a woman.^[46]

Griggs fails to engage any feminist analysis of the act of accepting, uncritically, the entirety of the subject position “woman” (including the premises which underlie acts of chivalry). In door-opening story, the performance of coherent oppositional gender norms secures Griggs' own self-perception of femaleness. Griggs also tells a story about meeting a man at a bar who assumed her to be a man during a long conversation, and then discovered that she was a woman after the bartender addressed her. She describes that the rest of their interaction included him buying her drinks and saying things like

“Gee, I'm sorry . . . I feel terrible. Now that I see you, I don't know how I could possibly have thought . . . But maybe you shouldn't sit so rough, like. You have a beautiful figure . . . And if you didn't put your elbows on the bar, a guy could see And maybe, . . . a little makeup would soften you up . . . You could fix your hair.”^[47]

In response to this overt policing of her performance of femininity, Griggs writes, “After a while, even I began to wonder if I had carried the ‘butch’ thing too far.”^[48] Just like many medical practitioners, Griggs accepts that a successful transition hinges upon full participation in the normative, sexist, oppressive performance of “woman.”

Judith Halberstam points out a similar operation in the desire of some female-to-male transsexuals (FTMs) and, I would add, of professionals “treating” FTMs, to distinguish FTMs from butch lesbians at any cost.^[49] Halberstam describes that butch and FTM bodies are always read against and through each other—commonly through a continuum model that seeks to find a defining difference between the two.^[50] She asserts that such a construction stabilizes butch lesbians as “women” and erases the disruptive work that butch identity engages on dichotomous gender categorization. She points to the lists of “passing tips” that are commonly shared between FTMs on the internet and at conferences.^[51] Many such tips focus on an adherence to traditional aesthetics of masculinity, warning FTMs to avoid “punk” hair cuts that may make you look like a butch lesbian, and to avoid black leather jackets and other trappings associated with butch lesbians. A preppy, clean cut look is often suggested as the best aesthetic for passing. Again, this establishes the requirement of being even more “normal” than “normal people” when it comes to gender presentation, and discouraging gender disruptive behavior. The resulting image, with the most “successful” FTMs exiting as khaki-clad frat boy clones, leaves feminist gender-queer trannies with the question, why bother?

The “passing” imperative, which begins from the moment a SRS-seeker enters a medical office and is sized up by a professional who will decide hir “realness” and seriousness at least in part based on the success of the presentation of a gender norm, is an essential regulating aspect of the process of “transsexual” (and “non-transsexual”) production. Wilchins notes:

Current practice in sex-change surgery assumes, even requires, “real-looking” genitals. . . . That is why so many doctors, while proudly showing off how “their vagina” can even fool OB/gyns, are reduced to muttering “no guarantees” and “we can't be certain” when asked about the pleasure potential of their work. It's also part of why many transwomen don't have a lot of erotic sensation after surgery.^[52]

This framework erases the possibility that someone might not prioritize how their genitals will look to others, or might even wish for genitals that do not conform, aesthetically, to the culturally specified norms, is not even imagined in this framework. As Wilchins points out, an admission that a patient

might want intersex genitals would fall on the deaf ears of doctors who only seek to produce genitals that fit into one of two narrowly-defined options.

What if the “success of transition was not measured by (non-trans) normative perceptions of true femininity and masculinity in trans people? I imagine that, like me, some people have a multitude of goals when they seek gender-related body alteration, such as access to different sexual practices, ability to look different in clothing, enhancement of a self-understanding about one’s gender that is not entirely reliant on public recognition, public disruption of female and male codes, or any number of other things.^[53] Some birth-assigned “men” might want to embody “woman” as butch lesbians—in a way that meant they enjoyed occasionally being “sirred” and only sometimes “corrected” the speaker. Some birth-assigned “women” might want to take hormones and become sexy “bearded ladies” who are interpreted a variety of ways but feel great about how they look. When the gatekeepers employ dichotomous gender standards, they foreclose such norm-resistant possibilities.

Marjorie Garber talks about how transsexuals see our bodies “theoretically.” She describes how the FTM with a chest scarred by reconstruction sees a male chest.

In spite of . . . unaesthetic results transsexual patients often go barechested, displaying what doctors call a “poor reality” sense along with their flattened chests. Another way of describing this, and a less condemnatory one, might be to say that the patient is regarding his new body *theoretically*; it is, he is, *male*, however attractive or unattractive the appearance.^[54]

While I would argue that everyone sees their body theoretically, and everyone’s self image is mediated through gender fictions and expectations, Garber’s point describes a pleasure lost in the passing imperative. Most of the trans people I have talked to do not imagine themselves entering a realm of “real manness” or “real womanness,” even if they pass as non-trans all the time, but rather recognize the absence of meaning in such terms and regard their transformations as freeing them to express more of themselves, and enabling more comfortable and exciting self understandings and images. However, recognizing that trans people make fine pleasures and benefits apart from the ability to conform to gender norms raises the threat discussed earlier that, indeed, trans people might be engineering ourselves.

The therapist asked me about “coming out” to my family about my surgery/GID. She was disconcerted when I described that my sister knew, but I doubted I would tell my foster parents any time too soon, and might not ever tell them, since it would likely be better for our relationship and they were not my intended audience. I felt there was nothing to gain by entering this conversation with them, and much to lose, and that any educational work that disclosure could achieve was best left with their understanding of me as a “lesbian.” I’m skilled in dressing to downplay chest noticeability, so I imagined that for the time being, even after surgery, I would continue such a strategy when I saw them unless I decided it wasn’t worth the benefits, or unless I decided to take hormones which would significantly change my appearance. This only further convinced her (we’d already covered my going by “Jane”) that I lacked the proper commitment to this transition. How could I really need this surgery if I could stand to be perceived, for even a minute, to not have had it? “How do you know you want to do this? Why do you want to do this if it’s not to pass as a man?” [I give some responses.] “Stop intellectualizing and tell me how you feel.”

IV. MAYBE I’M NOT A TRANSSEXUAL

The counselor at the L.A. Free Clinic decided I wasn’t transsexual during the first (and only) session. When I told him what I wanted, and how I was starting counseling because I was trying to get some letters that I could give to a surgeon so that they would alter my chest, he said, “You should just go get breast reduction.” Of course, he didn’t know that most cosmetic surgeons won’t reduce breasts below a C-cup (I

wouldn't even qualify for reduction), and that breast reduction is a different procedure than the construction of a male-looking chest. I also suppose that he wasn't thinking about what happens to gender deviants when they end up in the hands of medical professionals who don't have experience with trans people.

Some surgeons have strong reactions to transsexual patients, and often, if the surgery is done in a teaching hospital, the surgeon turns out to be a resident or staff member who is offended by the procedure. "In one case, with which I am familiar," writes a doctor, "the patient's massive scars were probably the result of the surgeon's unconscious sadism and wish to scar the patient for going against nature."^[55]

To this counselor, my failure to conform to the transsexuality he was expecting required my immediate expulsion from that world of meaning at any cost. My desire couldn't be for SRS because I wasn't a transsexual, so it must be for cosmetic surgery, something normal people get.

All my attempts at counseling, and all those experience of being eyed suspiciously when I suggested that I was trans, or told outright I was not by non-trans counselors, made me expect that I would get a similar reception from trans people in activist or support contexts. This has not been the case. I've found that in trans contexts, a much broader conception of trans experience exists. The trans people I've met have, shockingly, believed what I say about my gender. Some have a self-narrative resembling the medical model of transsexuality, some do not. However, the people I've met share with me what my counselors do not: a commitment to gender self-determination and respect for all expressions of gender. Certainly not all trans people would identify with this principle, but I think it makes better sense as a basis for identity than the ability to pass "full-time" or the amount of cross-dressing one did as a child. Wilchins posits an idea of identity as "an effect of political activism instead of a cause." I see this notion reflected in trans activism, writing, and discussion, despite its absence in the medical institutions through which trans people must negotiate our identities.

Feinberg writes:

Once I figured out that "transgendered" was someone who transcended traditional stereotypes of "man" and "woman," I saw that I was such a person. I then began a quest for finding words that described myself, and discovered that while psychiatric jargon dominated the discourse, there were many other words, both older and newer, that addressed these issues. While I accepted the label of "transsexual" in order to obtain access to the hormones and chest surgery necessary to manifest my spirit in the material world, I have always had a profound disagreement with the definition of transsexualism as a psychiatric condition and transsexuals as disordered people.^[56]

V. TELLING STORIES: STRATEGIC DEPLOYMENT OF THE TRANSEXUAL NARRATIVE

Billings and Urban, when tracing the history of the invention of transsexualism and its diagnosis and treatment, describe how physicians in the 1970's began recognizing that "transsexuals had routinely and systematically lied."^[57] One "expert" in treating transsexuality complained, "Those of us faced with the task of diagnosing transsexualism have an additional burden these days, for most patients who request sex reassignment are in complete command of the literature and know the answers before the questions are asked."^[58] Billings and Urban describe:

Since the reputable clinics treated only "textbook" cases of transsexualism, patients desiring surgery, for whatever personal reasons, had no other recourse but to meet this evaluation standard. The construction of an appropriate biography became necessary. Physicians reinforced this demand by rewarding compliance with surgery and punishing honesty with an unfavorable evaluation.^[59]

A patient grape-vine emerged, through which patients informed each other of the best ways to pass the necessary requirements to surgery. There were even stories being passed between doctors of post-operative transsexuals posing as mothers of pre-ops in order to add credibility to the testimony of the patients in the eyes of the doctors.^[60] Patients omitted information which would disrupt the version of normative femininity or masculinity that they were presenting to the doctors, including homosexuality and enjoyment of sex practices in the unaltered body.^[61]

Billings and Urban describe that in response to the outbreak of stories of people lying to get SRS, the diagnostic structure was changed, so that the term “transsexual” was replaced with “gender dysphoria syndrome.” However, they point out that this change was inconsequential, because “behavioral criteria” is still stressed by doctors. “ ‘Indeed, for prognosis, it is probable that the diagnostic category is of much less importance than the patient’s pre-operative performance in a one-to-three year therapeutic trial of living in the gender of his choice.’ ”^[62] Billings and Urban include an anecdote from a doctor who had performed over 100 sex-change operations, describing his method of verifying the “realness” of a patient’s transsexuality. “[He] told us he diagnosed male-to-female transsexuals by bullying them. ‘The ‘girls’ cry; the gays get aggressive.’ ” They follow this up with the assertion that, based on information from their participant-informant at a gender clinic, “diagnosis in the post-Benjamin era remains a subtle negotiation process between patients and physicians, in which the patient’s troubles are defined, legitimated, and regulated as illness.”^[63]

Billings and Urban argue that the screening and interviewing processes for SRS still function as a form of patient socialization, where diagnosis and treatment are linked to the performance of normative gender. Patients are aware of this, and utilize, to the extent that they can, their prior knowledge of the diagnostic criteria to convince doctors of their suitability to the “treatment” they seek.^[64] For Billings and Urban, this is evidence of the evil of SRS—patients who are gender deviant are socialized by doctors to conform to gender norms.

I do not doubt that the existence of the transsexual narrative informs the self-understandings of many people, as it is part of an overall construction of normative gender that naturalizes dichotomous gender categories and labels transgression of such categories as illness. It likely leads some gender variant people to see their gender deviance through a depoliticized and privatized lens, as an individual illness rather than a commentary on the inhabitability of dichotomous gender. It also likely leads some people who understand themselves as not-transsexual to think that their adherence to gender norms is natural and healthy. Everyone is implicated in this narrative, not only trans people. However, I think that the image of SRS-seekers as solely victims of false consciousness is severely incomplete. A review of literature written by trans people, particularly the works less often cited by non-trans writers,^[65] suggests a self-conscious strategy of deployment of the transsexual narrative by people who do not believe in the gender fictions produced by such a narrative, and who seek to occupy ambiguous gender positions in resistance to norms of gender rigidity.

After attending only three discussion group meetings with other trans people, I am struck by the naiveté with which I approached the search for counseling to get my surgery-authorizing letters. No one at these groups seems to see therapy as the place where they voice their doubts about their transitions, where they wrestle with the political implications of their changes, where they speak about fears of losing membership in various communities or in their families. No one trusts the doctors as the place to work things out. When I mention the places I’ve gone for help, places that are supposed to support queer and trans people, everyone nods knowingly, having heard countless stories like mine about these very places before. Some have suggestions of therapists who are better, but none cost less than \$50/hr. Mostly, though, people suggest different ways to get around the requirements. I get names of surgeons who do not always ask for the letters. Someone suggests that since I won’t be on hormones, I can go in and pretend I’m a woman with a history of breast cancer in my family and that I want a double mastectomy to prevent

it. I have these great, sad, conversations with these people who know all about what it means to lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want. I understand, now, that the place that is safe to talk about this is in here, with other people who understand the slipperiness of gender and the politics of transition, and who believe me without question when I say what I think I am and how that needs to look.

VI. TRANSSEXUALS AS THE “EXEMPLARY ADHERENTS” TO GENDER NORMS

Garber writes about how trans people are more “invested in [the gender binary]” than everyone else.^[66]

The transsexual body is not an absolute insignia of anything. Yet it makes the referent (“man” or “woman”) seem knowable. Paradoxically, it is to transsexuals and transvestites that we need to look if we want to understand what gender categories mean for persons who are neither transvestite nor transsexual. They are emphatically not interested in “unisex” or “androgyny” as erotic styles, but rather in gender-marked and gender-coded identity structures. Those who problematize the binary are those who have a great deal invested in it.

Prior to this point in the chapter, Garber refers to the biographies of famous transsexuals Renee Richards, Jan Morris, and, to some degree, Christine Jorgensen.^[67] While Garber does stop to question why all the best-known transsexuals are MTFs and not FTMs, she does not question why the narratives of the transsexuals she uses as evidence are well-known, nor whether the “truths” about how transsexuals understand themselves and their gender identities that she collects from these biographies are at all strategically deployed. She asserts that trans people are more invested in dichotomous gender categories and are not interested in the in-between spaces of gender based on a few stories which 1) are likely the most popular stories of transsexualism among non-transsexuals because they affirm a transsexual narrative that reifies the naturalness of normative gender performance, and 2) may well have been strategically crafted by their narrators to achieve social acceptance/tolerance for transsexuals, which many people understand to be best sought through a model of innate transsexuality similar to the one deployed by Griggs. Her arrival at the conclusion that trans people are more invested in normative gender categories than non-trans people is facilitated by her failure to question the strategic value for trans people of adherence to gender normative notions of transsexuality. Absent from her analysis are the stories of trans people who work and live on the street, trans people of color, trans people who never strive to or never succeed in fitting into a vision of “successful” gender performance, with all of its racial and economic implications. Using a narrow set of famous examples, she comfortably arrives at an understanding of how trans people view gender that supports the way that non-trans people see trans people.

A similar move is made in Elsie Shore’s case study of a “former transsexual,” a birth-assigned male who sought SRS, was diagnosed with transsexuality, lived as a woman for a considerable period, and then decided days before surgery to return to male identity.^[68] The author describes that when she met “Mickey,” she had been “on female hormones for 21 months and . . . living exclusively in the female role for 14 months. Of medium height and build, dressed and made up in a realistic and nonflamboyant manner, Mickey presented as a convincing female. She [was] shy, lonely, and wanting to be loved and cared for.”^[69]

Shore attributes Mickey’s change of heart about SRS and continuing life as a woman to his realization that his prior adherence to strict beliefs about what men needed to act like was not true. She says that when Mickey joined a church and met men who were “warm and caring without losing masculinity” he found out that “one is not required to be female to be kind and loving.”^[70] Additionally, Mickey fell in love with a woman in his new religion, and “felt a desire to protect and to possess her and

conceptualized these feelings as those that a man experiences when in love with a woman.^[71] Shore recognizes, also, that an influence on his decision might have been that the possibility of his feelings for this woman being understood as homosexual may have frightened him.

As Shore sorts through what Mickey's decision to return to the male role means, she rules out possibility of an original misdiagnosis of transsexuality. She believes the diagnosis was correct because the history Mickey presented to the gender clinic that admitted him was "consistent with the generally accepted picture of transsexual development."^[72] Secondly, she believes that his success at living for two and a half years as a female attests to the fact that he was a "true transsexual," because "an individual with shallower cross-sexual identification will not" succeed at lasting a year in the new role.^[73] Shore believes that Mickey was, indeed, a "true transsexual," but that his condition was in large part a result of the fact that he was a very nonaggressive person and had a highly stereotyped definition of "man" which led him to believe that he must be a woman. Shore cites other experts in transsexuality who have found that transsexuals have rigid notions of what masculinity is, and "confuse dependency feelings and lack of aggressiveness in social interactions with femininity and sexual behavior."^[74] She concludes that therapeutic intervention directed at loosening rigid gender-role stereotyping might be a way to treat transsexuality without SRS.

Some contradictory presumptions underlie Shore's analysis. First, similar to Griggs, Shore sees the avoidance of SRS as a goal of treatment, and wants to keep SRS as a last resort option. Second, Shore accepts the diagnostic criteria and definition of transsexuality. She accepts that there is something about transsexuality that requires treatment of the individual transsexual to bring him into a male or female role. These presumptions allow Shore to arrive at the conclusion that what requires treatment in transsexuals is their over-adherence to gender norms or stereotypes. Ironically, it is just this adherence that the diagnosis and treatment criteria require in order for people seeking SRS to achieve their goals. Shore's failure to critique the diagnostic criteria of transsexuality before coming to her conclusions creates a situation where SRS would be harder to get than ever: if the patient adopted the norm-based narrative of gender required by the diagnostic criteria, she might still be refused treatment for precisely that.

Garber and Shore both assert that transsexuals are more deeply invested in gender norms than non-transsexuals without recognizing that the medical definition of "transsexuality" requires the performance of such an investment. Transsexuals are in a double bind—it is pathological not to adhere to gender norms, just as it is to adhere to them. The creation of the image of transsexuals as exemplary adherents to gender stereotypes requires an understanding of transsexuality that both fully accepts the medical definition of transsexual and ignores the multiple non-norm-adhering narratives that trans people produce outside of medical contexts.

VII. CONCLUSION

Personal narrative is always strategically employed. It is always mediated through cultural understandings, through ideology. It is always a function of selective memory and narration. Have I learned that I should lie to obtain surgery, as others have before me? Does that lesson require an acceptance that I cannot successfully advocate on behalf of a different approach to my desire for transformation?

An examination of how medicine governs gender variant bodies through the regulation of body alteration by means of the invention of the illness of transsexuality brings up the question of whether illness is the appropriate interpretive model for gender variance. The benefits of such an understanding for trans people are noteworthy.^[75] As long as SRS remains a treatment for an illness, the possibility Medicaid coverage for it remains viable.^[76] Similarly, courts examining the question of what qualifies a transsexual to have legal membership in the new gender category have relied heavily on the medical model of transsexuality when they have decided favorably for transsexuals.^[77] A model premised on

a disability- or disease-based understanding of deviant behavior is believed by many to be the best strategy for achieving tolerance by norm-adherent people for those not adhering to norms. Such arguments are present in the realm of illicit drug use and in the quest for biological origins of homosexuality just as they are in the portrayal of transsexuality as an illness or disability.

However, it is vital that the costs of such an approach also be considered. First, the medical approach to gender variance, and the creation of transsexuality, has resulted in a governance of trans bodies that restricts our ability to make gender transitions which do not yield membership in a normative gender role. The self-determination of trans people in crafting our gender expression is compromised by the rigidity of the diagnostic and treatment criteria. At the same time, this criteria and the version of transsexuality that it posits produce and reify a fiction of normal, healthy gender that works as a regulatory measure for the gender expression of all people. To adopt the medical understanding of transsexuality is to agree that SRS is the unfortunate treatment of an unfortunate condition, to accept that gender norm adherence is fortunate and healthy, and to undermine the threat to a dichotomous gender system which trans experience can pose. The reification of the violence of compulsory gender norm adherence, and the submission of trans bodies to a norm-producing medical discipline, is too high a price for a small hope of conditional tolerance.

NOTES

- [1] RIKI ANNE WILCHINS, READ MY LIPS: SEXUAL SUBVERSION AND THE END OF GENDER 63 (1997).
- [2] BERNICE L. HAUSMAN, CHANGING SEX: TRANSSEXUALISM, TECHNOLOGY, AND THE IDEA OF GENDER 1 (1995).
- [3] *Id.*
- [4] *Id.* at 2.
- [5] I use this term in the broad sense, not just to signify the genital surgery which is often the legal criteria for achieving legal gender change. Specifically, I want to examine the types of surgery that are currently associated with “transsexualism” and therefore subject the person seeking them to the requirements of the Harry Benjamin standards of care. However, I also want to suggest a critical approach to the labeling of certain surgeries, such as mastectomy for people assigned “female” at birth or breast enlargement for people assigned “male” at birth, as surgery that changes gender expression or performance while other surgeries such as breast enlargement for people assigned “female” at birth or pectoral implants for people assigned “male” at birth are understood as innocuous “cosmetic” surgery.
- [6] ALAN HUNT & GARY WICKHAM, FOUCAULT AND LAW: TOWARDS A SOCIOLOGY OF LAW AS GOVERNANCE 28 (1994).
- [7] Wilchins, *supra* note 1, at 22.
- [8] I was able to pay \$10–20 weekly. I was qualified for services (stories of which are included in this paper) at the Children’s Hospital because I was 21–22 throughout the year.
- [9] My position on these questions has changed since I originally wrote this piece. I now go by “Dean” and “he.” However, my aim is to capture the set of desires I had in the year in which I was seeking services in L.A. and finding myself outside of medical professionals’ understandings of what it meant to be “trans.” It was my failure to provide a gendered picture that they could recognize as cohesive and consistent that disabled them from providing me the services I sought.
- [10] Hausman, *supra* note 2, at 3 (emphasis in original).
- [11] Dwight B. Billings and Thomas Urban, *The Socio-Medical Construction of Transsexualism: An Interpretation and Critique*, 29 SOCIAL PROBLEMS 266, 276 (1982).
- [12] As mentioned above, Billings and Urban understand SRS as “mutilation.” They appear entirely opposed to SRS of any kind. In their understanding, persons who get sex change surgery are just sexual deviants whose possibility for a political response to their situation is being squelched because they are being sold a quick fix answer to their discomfort in gender or sex norms.

Among the transsexual patients we interviewed were ministers who embraced the label “transsexual” to avoid being labeled “homosexual”; sexual deviants driven by criminal laws against cross-dressing, or by rejecting parents and spouses, to the shelter of the “therapeutic state”; and enterprising male prostitutes cashing in on the profitable market for transsexual prostitutes which thrives in some large cities.

Id. at 276. Billings and Urban paint a picture of those seeking or receiving sex reassignment surgery as apolitical, needing to be educated rather than medically treated (mutilated) so that they can start a gender revolution. The revolution they imagine, however, has no place for body alteration to change gender presentation, and such activity can only represent for them, disempowering “commodification,” “reification,” and the reinforcement of traditional gender roles. While I agree with their assertion that the operation of medical authority in the diagnostic and treatment processes for transsexuality often does work to privatize and depoliticize the politics of gender conformity and deviance, I reject their narrow understanding of the potential political meanings of SRS, their ignorance of the politicized acts and identities of trans people, and the paternalistic and disrespectful approach to trans people they take throughout the paper,

- exemplified in moments when they refer to trans people like Christine Jorgenson using pronouns appropriate to their birth-assigned gender. *Id.* at 267.
- [13] *Id.* at 266.
- [14] *Id.*
- [15] Forms of illness are always more than biological disease; they are also metaphors, bearing existential, moral, and social meanings. According to Taussig, “the signs and symptoms of disease, as much as the technologies of healing, are not ‘things-in-themselves,’ are *not only* biological and physical, but are *also* signs of social relations disguised natural things, concealing their roots in human reciprocity. Billings & Urban, *supra* note 10, at 276 (emphasis in original).
- [16] MICHEL FOUCAULT, THE HISTORY OF SEXUALITY, VOL. 1: AN INTRODUCTION, 3–13 (1978).
- [17] *Id.* at 18.
- [18] *Id.* at 53–54.
- [19] *Id.* at 43. “The nineteenth-century homosexual became a personage, a past, a case history, and a childhood . . . the homosexual was now a species.” *Id.*
- [20] “Law is neither the truth of power nor its alibi. It is an instrument of power which is at once complex and partial. The form of law with its effects of prohibition needs to be resituated among a number of other, non-judicial mechanisms.” MICHEL FOUCAULT, POWER/KNOWLEDGE: SELECTED INTERVIEWS AND OTHER WRITINGS 1972–1977, 141 (ed. Colin Gordon, 1980).
- [21] Hunt & Wickham, *supra* note 6, at 49.
- [22] Michel Foucault, *The Subject and Power*, in MICHEL FOUCAULT: BEYOND STRUCTURALISM AND HERMENEUTICS 208, 221 (Herbert Dreyfus & Paul Rabinow eds. 1982).
- [23] Hunt & Wickham, *supra* note 6, at 27.
- [24] See, *infra*, section V, for a discussion of the strategic use of the transsexual narrative to gain access to SRS.
- [25] The symptoms of GID described in the Diagnostic and Statistical Manual (DSM-IV) primarily focus on two elements: the failure to conform to gender stereotypes (particularly in children) or the desire for gender-related body alteration—SRS and hormone therapy (particularly in adults). See *infra*, section II, for a discussion of the construction of the transsexual childhood. Such a focus on gender conformity supports the conclusions of the Billings and Urban that the doctor-patient relationship in the transsexual situation is one in which the doctor is producing adherence to gender norms, and pathologizing gender non-conformity. However, the question arises as to whether the problem lies in the search for gender-related body alteration (“mutilation,” as they would call it), or in the process by which permission for such self-engineering is obtained.
- [26] Hausman acknowledges the resistant content possible in body alteration projects, and the ways that transsexual diagnosis/treatment serves to contain that threat. “[T]he commonsense understanding of transsexualism as a ‘disorder of gender identity’ is a cover up for the potentially more threatening idea that transsexuals are subjects who choose to engineer themselves.” Hausman, *supra* note 2, at 9.
- [27] One doctor described the requirement: “Patients are expected to live in the new gender role . . . for 1 to 2 years in order to experience life in the new role and develop appropriate role behaviors.” Elsie R. Shore, *The Former Transsexual: A Case Study*, 13 ARCHIVES OF SEXUAL BEHAVIOR 277 (1984).
- [28] Feinberg writes about the search for origins of gender nonconformity as well, and answers this question: Who cares! As long as my right to explore the full measure of my own potential is being trampled by discriminatory laws, as long as I am being socially and economically marginalized, as long as I am being scapegoated for the crimes committed by this economic system, my right to exist needs no explanation or justification of any kind. LESLIE FEINBERG, TRANS LIBERATION: BEYOND PINK OR BLUE 32 (1998).
- [29] Rachel Pollack, *The Varieties of Transsexual Experience*, 7 Transsexual News Telegraph 18, 20 (1997).
- [30] CLAUDINE GRIGGS, S/HE: CHANGING SEX AND CHANGING CLOTHES 32 (1998). See section V, *infra*, for more discussion on strategic use of the transsexual narrative.
- [31] AMERICAN PSYCHOLOGICAL ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL, 4th Edition 532 (1994).
- [32] *Id.* at 533.
- [33] *Id.* at 536. The difference is, apparently, that GID gender trouble “represents a profound disturbance of the individual’s sense of identity with regard to maleness or femaleness.” Personally, I never knew a tomboy or sissy who might not qualify as profoundly disturbed about their gender, especially in the eyes of their parents and teachers. The differential diagnosis of these kids from kids with GID seems like an afterthought in the writing—a quick way to try and make it not appear that all gender nonconformity is being pathologized by the generalized diagnosis which relies on an impossible norm—a child with no cross gender play habits or transgressive gender explorations. Since almost no child will state “I’m profoundly disturbed about my gender,” this determination will always be left for parents, doctors, and teachers—the surveillance system kicks in.
- [34] Foucault, *supra* note 15, at 21.
- [35] Foucault uses the example of sexual discourse in the secondary schools of the 18th century. While the general impression may be that the sexuality of children was hardly spoken of at these institutions, in reality an elaborate discourse about the danger of the sexuality of the schoolboy dominated. Every aspect of education was designed to contain the imagined danger. As Foucault describes, “the discourse of the institution—the one it employed to address itself” was consumed with concern, speculation, and attempted regulation of schoolboy sexuality. *Id.* at 28.
- [36] Hunt & Wickham, *supra* note 6, at 27.
- [37] APA, *supra* note 30, at 537.

- [38] I use the gender neutral pronouns “sie” (pronounced “see”) and “hir” (pronounced “here”) to promote the recognition of such pronouns, which resist the need to categorize all subjects neatly into male and female categories, at the suggestion of Leslie Feinberg. In this essay, I use these pronouns when discussing a hypothetical person, but when I am referring to people who have articulated a self-identification in a particular gender, I respect that choice by using pronouns which reflect it. Feinberg, *supra* note 24, at 1.
- [39] Griggs, *supra* note 29, at 10–13.
- [40] *Id.* at ix. Hausman posits a similarly helpless and afflicted view of transsexuals. “Ostensibly, the demand for sex change represents the desperation of the transsexual condition: after all, who but a suffering individual would voluntarily request such severe physical transformation?” Hausman, *supra* note 2, at 110. This presumption is a fundamental part of the medical approach to transsexualism. The therapists I’ve seen have wanted to hear that I hate my breasts, that the desire for surgery comes from desperation. What would it mean to suggest that such desire for surgery is a joyful affirmation of gender self-determination—that a SRS candidate would not wish to get comfortable in a stable gender category, but instead be delighted to be transforming—to choose it over residing safely in “man” or “woman”?
- Griggs writes that there is no “perceptual middle ground between male and female” and that “transsexuals cannot fade gently” between genders. Griggs, *supra* note 29, at 1. To this I would respond with a proverb that Feinberg quotes: “The person who says it cannot be done should not interrupt the person doing it.” Feinberg, *supra* note 27, at 61.
- [41] MARJORIE GARBER, VESTED INTERESTS: CROSS-DRESSING AND CULTURAL ANXIETY 102 (1992).
- [42] Feinberg, *supra* note 27, at 19.
- [43] Neil Gotanda, *A Critique of “Our Constitution is Colorblind,”* in *Critical Race Theory: The Key Writings That Formed the Movement* 257 (Kimberle Crenshaw, et al. eds. 1995). “[U]nder the American system of racial classification, claiming a white racial identity is a declaration of racial purity and an implicit assertion of racial domination.” *Id.* at 259.
- [44] Shaefer and Wheeler, chroniclers of Harry Benjamin’s work, describe a “successful” transsexual:
- With Benjamin’s encouragement and the inspiration of Jorgensen’s story, Janet took a more scientific and intelligent path toward fulfilling her dream. As with Inez, despite her generally masculine appearance and the late age at which she completed her surgery (in her late 50s), Janet’s is a genuine success story. Freed from her lifelong gender struggle, her brilliant talent emerged. Janet and a business partner developed an invention sufficiently valuable to be sold eventually for millions of dollars.
- Except for her closest and most intimate friends, no one in Janet’s life knew that this loved and wonderful woman was not a genetic female. Although she died at 72 of lung cancer, Janet lived her last 25 years in great wealth and contentment.
- Leah Cahan Schaefer & Connie Christine Wheeler, *Harry Benjamin’s First Ten Cases (1938–1953): A Clinical Historical Note*, 24 *Archives of Sexual Behavior* 73 (1995) (individual pagination not available). The story illustrates the mediation of proper gender performance through capitalist values. I would assume that a patient who went on to have a career in sex work or food service would not be considered equally “successful.” A similar trend was present in the story that begins section II, *supra*, where I describe the ways in which the therapeutic approach to my desire for body alteration necessitates a privileging of sexual or gender difference above all else, and an erasure of other aspects of my positionality. Such an occurrence falls in line with Foucault’s analysis that the sexual self has become the true self—to confess your sex is to confess your self.
- [45] Griggs, *supra* note 29, at 1.
- [46] *Id.* at 17.
- [47] *Id.* at 21–22.
- [48] *Id.* at 22.
- [49] Judith Halberstam, *Transgender Butch: Butch/FTM Border Wars and the Masculine Continuum*, 4 *GLQ* 287 (1998).
- [50] *Id.* at 292.
- [51] *Id.* at 298. “[M]any of the tips focus almost obsessively on the care that must be taken not to look like a butch lesbian.” *Id.*
- [52] Wilchins, *supra* note 1, at 121.
- [53] In some ways, some of these goals are similar to those of people who seek other kinds of cosmetic surgery. Perhaps the most notable difference between some instances of SRS and, say, breast enhancement, pectoral implants, or laser vaginal reconstruction is the ferociousness with which medical practitioners guard technologies which aid in enhancement of the femininity of birth-assigned men and the masculinity of birth-assigned women, and the easy pleasure with which they perform procedures to enhance the femininity of birth-assigned women and the masculinity of birth-assigned men. See Peter M. Warren, *A Cap and Gown—and New Breasts. Trends: In Time for High School Graduation, More Teens Are Getting Implants. Surgery on the Young Stirs Controversy.*, L.A. TIMES, May 21, 1999, at E1.
- [54] Garber, *supra* note 40, at 103 (emphasis in original).
- [55] *Id.* at 103.
- [56] Feinberg, *supra* note 27, at 63.
- [57] Billings and Urban, *supra* note 10, at 273.
- [58] *Id.*
- [59] *Id.*
- [60] *Id.* Doctors shared experiences of having patients later reveal, after the completion of surgery, that they had “tailor[ed] their views of themselves and their personal histories to prevailing ‘scientific’ fashions.” *Id.* The director of Johns Hopkins University’s gender clinic stated his concern, in 1973, about the possibility that many people “not qualified” for SRS were receiving such treatment through deception. “[T]he label ‘transsexual’ has come to cover such a ‘multitude of sins.’ Meyer acknowledged that among the patients who had requested and sometimes received surgery . . . were

- sadists, homosexuals, schizoids, masochists, homosexual prostitutes, and psychotic depressives.” *Id.* Doctors around the country shared a fear that they were losing control of the maintenance of the “transsexual” category as numerous deviants who did not perfectly conform to the formula cracked the code and received surgery through deception.
- [61] Such a strategy is present in Agnes’s story as well. *Infra*, notes 2–4 and accompanying text. The sexual orientation of Agnes’s boyfriend, Bill, was a location of great speculation and concern for the doctors treating Agnes. Their observations focused on whether Bill was homosexual or heterosexual, and whether Agnes and Bill had engaged in anal intercourse. “[T]he doctors . . . were constantly on the alert for signs of incipient homosexuality in their patient. Agnes’s apparent heterosexuality was an essential component of her convincing self-representation as a woman.” Hausman, *supra* note 2, at 6. The doctors were not willing to produce a woman who would have anal sex, or a homosexual boyfriend. Agnes’s ability to be the most norm-abiding heterosexual intersexed person possible was essential to her achievement of SRS.
- [62] *Id.* at 275, quoting Dr. Donald R. Laub & Dr. Norman M. Fisk, *A Rehabilitation Program for Gender Dysphoria Syndrome by Surgical Sex Change*, 53 PLASTIC AND RECONSTRUCTION SURGERY 388, 401.
- [63] *Id.* at 275.
- [64] Of course, for some patients, the narrative doctors seek is the narrative they believe about themselves, and lying is not necessary for gaining access to SRS. However, for numerous others, tailoring stories and producing evidence of the expected symptoms of transsexuality is fundamental to achieving body alteration.
- [65] See section VI for a discussion some theorists’ use of the biographies of famous transsexuals as evidence of transsexual adherence to gender stereotypes.
- [66] Garber, *supra* note 40, at 110.
- [67] Marjorie Garber, *Spare Parts: The Surgical Construction of Gender*, in Garber, *supra* note 40, at 93–117.
- [68] Shore, *supra* note 26, at 277.
- [69] *Id.* In this passage, Mickey’s “realness” is linked to her “nonflamboyant” appearance. Just as FTM’s are legitimated through a differentiation from butchness, MTFs are legitimated through a differentiation from drag queens and fags. Mickey’s success at female identity is tied, in this description, to occupation of a stereotypical female identity that is separable from the “fake” femininity of female impersonators. A similar basis for Agnes’s “realness” was used by her doctors.
- “The most remarkable thing about the patient’s appearance when she was first seen . . . was that it was not possible for any of the observers . . . to identify her as anything but a young woman. . . . Her hair, which was long, fine, and pulled back from her face across her ears, was touched a blonde-brown from its normal brown. . . . Her eyebrows were subtly plucked.” She was dressed in a manner indistinguishable from that of any other typical girl of her age in this culture. There was nothing garish, outstanding, or abnormally exhibitionistic in her attire, nor was there any hint of poor taste or that the patient was ill at ease in her clothes (as is seen so frequently in transvestites and in women with disturbances of sexual identification).
- Hausman, *supra* note 2, at 5.
- [70] *Id.* at 281.
- [71] *Id.*
- [72] *Id.* at 282.
- [73] *Id.*
- [74] *Id.* at 283.
- [75] Many trans people believe that a viable path to legal protection against discrimination on the basis of gender identity is through disability statutes. This possibility appeared somewhat truncated when the Americans with Disabilities Act (ADA) was passed including an explicit ban on coverage for transsexuals. See, 42 U.S.C.A. § 12100 et seq. (2000). However, recent state developments suggest that hope remains for anti-discrimination protection through disability statutes. California trans activists recently celebrated after Governor Davis signed A.B. 2222. The bill provides that the California law may provide greater protection than the ADA. The bill extends protection to transsexuals and people with GID, which means that transgendered people who may be perceived to suffer from may be protected from discrimination in employment and housing on the basis of that perception. Additionally, the new law requires employers to enter into good faith negotiations with transgender employees who claim their transsexuality as a disability regarding “reasonable accommodations” for their disability.
- [76] Courts throughout the United States have arrived at different conclusions as to whether Medicaid coverage should include SRS. For a detailed account of the decisions and their reasoning, see Eric B. Gordon, *Transsexual Healing: Funding of Sex Reassignment Surgery*, 20 ARCHIVES OF SEXUAL BEHAVIOR 61 (1991).
- [77] See *Richards v. U.S. Tennis Ass’n*, 400 N.Y.S.2d 267 (1977); *R. v. Cogley*, [1989] V.R. 799; *M.T. v. J.T.*, 355 A.2d 204 (1975). However, it is important to note that “unpopular” conditions often considered disabilities associated with social deviance, including transsexuality, drug addiction, homosexuality, and voyeurism were intentionally excluded from coverage under the Americans with Disabilities Act. 42 U.S.C. §§ 12101, 12213 (1991). See Adrienne Hiegel, *Sexual Exclusions: The Americans with Disabilities Act As a Moral Code*, 94 COLUM. L. REV. 1451 (1994). This suggests that the disability model may not be reliable for achieving improved legal status for trans people, because it does not exclude the possibility that lawmakers can establish “deserving” and “undeserving” classes of disabled people.