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“Not Just a Guy in a Dress”:

Transsexual Identity, Embodiment, and Genital Reassignment Surgery

in the United States

A dissertation submitted in partial satisfaction of the
requirements for the degree of Doctor of Philosophy
in Anthropology

by

Muriel Vernon

2012

ABSTRACT OF THE DISSERTATION

“Not Just a Guy in a Dress”

Transsexual Identity, Embodiment, and Genital Reassignment Surgery
in the United States

by

Muriel Vernon

Doctor of Philosophy in Anthropology

University of California, Los Angeles, 2012

Professor Linda Garro, Chair

Genital Reassignment Surgery (GRS) is commonly recognized as the surgical alteration of genitalia to align transsexuals' bodies with their chosen gender identities in order to alleviate the persistent discomfort of Gender Identity Disorder (GID). Clinical and psychological evaluations of the outcomes of GRS have focused primarily on the individual benefits of the surgery and on the aesthetic or functional aspects of newly created genitalia. Left out of medical and social science research is attention to the patient's hopes for social gains and benefits following GRS. Critically assessing the current biomedical model of transsexualism and its treatment, this study considers not only the different meanings GRS holds for patients (contrasting life-world concerns with biomedical concerns), but also explores what GRS is expected to contribute to the everyday experiences of transsexuals. Through participant

observation and person-centered interviews, I examine what patients expect to gain from GRS socially, what kinds of hopes they have invested in the surgery, how they intend to integrate their past and present gendered histories, and whether they feel that undergoing GRS will significantly improve their social status. This study thus offers a patient-centered perspective on the meaning of surgical intervention for a socially stigmatized condition. I find that while GRS can provide individual benefits for transsexuals through eliminating body dysphoric feelings through the surgical alignment of the mind with the body, the surgery does not, and cannot, eliminate their social history of transsexual embodiment. The socially liminal positions that many transsexuals experience prior to surgery are thus likely to remain unchanged as the main barrier to social acceptance or social equality lies primarily in the history of gendered embodiment and not in the bio-medical assumption of mind-body disjuncture.

The dissertation of Muriel Vernon is approved.

Sondra Hale

Doug Hollan

Geoffrey Raymond

Linda Garro, Committee Chair

University of California, Los Angeles

2012

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VITA

EDUCATION:

- 2007 M.A., Spring 2007, Anthropology, University of California, Santa Barbara (UCSB).
- 2005 B.A., Summa Cum Laude, Anthropology;
Minor Degree in Lesbian, Gay, Bisexual, and Transgender Studies, University of California, Los Angeles (UCLA)

EMPLOYMENT/TEACHING:

- 2012 Instructor of Record. The Anthropology of Gender Variance: From Third Gender to Transgender, Spring Quarter
Instructor of Record. LGBTS 187 Special Topics: Transgender History and Culture, Winter Quarter
- 2011 Teaching Fellow/Head TA. Culture and Society
Instructor of Record: Dr. Jason Throop, Fall 2011
Instructor of Record. The Cultural Construction of Gender and Sexuality: Cross Cultural Perspectives of Homosexuality, Summer Session
Teaching Fellow. Medical Anthropology.
Instructor of Record: Dr. Linda Garro, Spring Quarter.
Teaching Fellow. Current Issues in Psychological Anthropology
Instructor of Record: Dr. Alan Fiske, Winter Quarter
- 2009 Teaching Associate. History of Psychological Anthropology
Instructor of Record: Dr. Jason Throop, Fall Quarter
Teaching Associate. Introduction to Biological Anthropology
Instructor of Record: Dr. Joseph Manson, Spring Quarter
Teaching Associate. Culture and Society.
Instructor of Record: Dr. Sharon Bays, Winter Quarter
- 2008 Consultant on NIH funded HIV Prevention Project, conducted by the University of Minnesota. Supervisors: Walter Bockting, Ph.D, and Jaime Feldman, Ph.D. (publication in process)
Teaching Assistant. Introduction to LGBT Studies
Instructor of Record: Dr. James Schultz, Fall Quarter
- 2007 Teaching Assistant. Introduction to Cultural Anthropology.
Instructor of Record: Dr. Dwight Hines. Spring Quarter.
- 2006 Teaching Assistant. Introduction to Cultural Anthropology.
Instructor of Record: Dr. Dwight Hines. Fall Quarter.

AWARDS:

- 2011 CUTF Fellowship 2011-12
Teaching Assistantship (UCLA Winter-Spring 2011)
- 2009 Student Research Travel Grant (UCLA)

- Teaching Assistantship (UCLA Winter-Fall 2009)
- 2008 Departmental Scholarship (UCLA)
- Teaching Assistantship (UCLA Fall 2008)
- 2007 Departmental Scholarship (UCLA)
- Teaching Assistantship (UCSB Spring 2007)
- One Quarter fees Fellowship (UCSB Winter 2007)
- 2006 Teaching Assistantship (UCSB Fall 2006)

PRESENTATIONS:

- 2011 Society for Psychological Anthropology Bi-Annual Meeting
- Paper presented
- “To be seen as a woman: The Interaction of Intersubjective Memory, Cognition, and Transgender Embodiment”
- Thinking Gender 2011 Annual Conference
- Paper presented
- “Losing Sons and Gaining Daughters: Renegotiating Kinship through Male-to-Female Gender Transition”
- 2009 Society for Psychological Anthropology Bi-annual Meeting
- Paper presented
- “Natural Born Transsexuals: Challenging Cultural Ideologies of Becoming One Self”
- 2008 American Anthropological Association Annual Meeting
- Paper presented
- “Women Trapped in Transsexual Bodies: Sexual Reassignment Surgery, Social Stigma, and the Limits of Biomedicine”

Introduction

Manhood as Illness: How to Recover from Life as a Man

One afternoon in the Morning After House, I sat on a crooked chair next to Lana who was more or less comfortably lounging on her bed, still sore from having had genital reassignment surgery (GRS) only a week prior. With my digital recorder positioned on the nightstand and my notebook on my lap, I was working my way through interview number 4 questions, as I had done twice that day already with other patients recovering from the same surgery in the rooms above and adjacent to this one. As we sipped on cold drinks, I asked Lana whether she felt that the surgery resolved or cured her gender identity disorder (GID), looking for a complex elaboration to my intentionally simplistic but pivotal question to my research. But Lana did not need much time to reflect. “Completely”, she said, “I’ve only had the surgery for 7 days but that’s exactly what it does”. And then she added “Now what I’m gonna have to recover from are the symptoms of 55 years of having had a penis, the 55 years of having been a...fulfilled the role of having been a male”. Lana’s framing of having to come to terms with her social history as a man in terms of “symptoms” she had to “recover from” made me realize that the complexity I was looking for in her answer actually laid in the complexity of the question: What kind of symptom is having a penis? And how does one recover from the illness of manhood?

Lana’s candid choice to use a medicalized framework to express her thoughts on the therapeutic effects of GRS provides a simple but clear insight into the ill fit between the medicalized model of gender identity disorder and the real life experience of a transsexual woman as it instantly separates body from mind, individual from society, and medicine from culture. Lana’s sense of having been “cured” physically, yet pondering her social recovery

furthermore separates notions of individual cure from those of social healing. But how can a person recover from an illness, which, throughout the therapeutic process, changes a person so profoundly that they never return to “pre-illness” state of “health” in a Parsonian sense, and yet, can feel “cured”? And how can a person recover from an illness which calls into question every component of the medical “problem - diagnosis - treatment - cure” model while simultaneously being undoubtedly constituted and regulated by its very discourse and practice?

The disjuncture between these two complementary perspectives of transsexualism — a social problem with persistent cultural barriers to social acceptance vs. a medical problem with highly therapeutic potential for the individual — illuminates the complexity of what it means to occupy a gender-nonconforming or gender-variant status. It furthermore broadens the central question which many academic scholars, transsexual activists, and as of recent, mental health professionals have pondered before: is transsexualism essentially a social or medical problem? How do social and medical perspectives on transsexualism inform each other in the context of a transsexual person’s life? And if they are indeed mutually constitutive, are medical interventions in social problems, and particularly socially stigmatizing conditions like transsexualism, effective? Based on the assumption that these are valid questions to ask about the socio-cultural aspects and effects of medicine, I ask what is the *social capital* transsexual women gain from individual biomedical body modifications such as GRS?

This dissertation explores how transsexualism as a socio-cultural problem is mediated and affected by biomedical intervention, focusing primarily on GRS. I want to suggest that without understanding the relationship between social causes of illness and intrinsic distress, medical solutions focusing on intervention at the individual level are socially ineffective. While the most common misconception about why transsexuals suffer societal non-acceptance and

rejection is based on the essentialist body-mind disjuncture, a cultural analysis of societal demarcation between *cisgender*¹ (non-transgender) and transgender individuals reveals that it is not the individual body-mind disjuncture that is most problematic, but rather it is the historicity and intersubjectivity of such embodiment which constitutes lifelong troubles for transsexuals. This primacy given to individuals as social beings draws into focus that all identities and bodies are essentially *relational* and cannot be decontextualized medically or theorized intellectually as isolated entities. Based on this notion, I aim to critique the essentialist assumption of individual body-mind disjuncture as the singular focus of medical health authorities who have reframed transsexualism as the psycho-medical problem now known as Gender Identity Disorder (GID). As I will try to show in this work, the much theoretically acknowledged but less ethnographically explored problem of cultural non-acceptance of trans identities is based on the shared social histories transsexuals have achieved in the past which greatly hinder acceptance of their “true” gender. I propose that these two perspectives to societal rejection of trans identities (essentialist/constructivist) work in tandem to constitute the cognitive rationale for the prevailing social stigmatization of transsexuals: because if transsexuals undergo GRS, and the essentialist rationale (i.e. women do not have penises) no longer makes sense, a constructivist rationale (i.e. transsexual women have not been raised as women), takes its place. This particular perspective on societal rejection of transsexuals cannot sufficiently be explained by concepts of *transphobia* which literally denotes an irrational fear of transsexual subjects (Shelly 2008), or *cissexism* which assigns primacy to “real” or natal men and women over transsexual men and women regardless of surgical status (Serano 2007). While transphobia and cissexism are important

¹ The Latin prefix “cis” indicates to/near this side, and is taken here to reference alignment of sex and gender identity. Throughout this work, cisgender and cissexual are used interchangeably.

concepts in understanding why many transsexuals struggle with social equality and integration, this third perspective, which I will call “social history disjuncture” for lack of better term, is what I will explore throughout this work. In essence then, I propose that transsexualism is a social problem of changing one’s social status which invariably affect one’s social relations. This stands in contrast to transsexualism as primarily a personal problem of changing one’s individual body which invariably affects one’s psyche.

Why the focus on GRS? Although some would argue this, it is my assumption that GRS, as part of transsexual’s gender transition process, is its most significant, irreversible, and most consequential aspect. Focusing on GRS also assumes that the other parts of transition (counseling, hormone replacement therapy [HRT], and the Real Life Test [RLT]) must have already occurred in a transsexual person’s life before they can undergo GRS as outlined by the *Harry Benjamin Standards Of Care* (2001). Although much more attention from the medical establishment, the media, and the general public focuses on the transsexual “phenomenon” in general than on GRS in particular, it remains one of the most controversial medical treatments in history, and its powerful cultural meaning continues to hold the American public captive. And although transsexual women undergoing GRS are the central focus of this work, of course, other aspects of transsexual women, mainly their social lives and social relations past and present, are necessary for analysis because they emphasize an important aspect in medical anthropology in that individual experiences of illness are never solitary, isolated, or divorced from their social environments. All illness experience is somehow connected to, shaped, and informed by human sociality. Because our daily lives are invariably social existences, illness cannot be perceived, diagnosed, treated, or cured in just the individual person. Thus, a critical question which

exemplifies both the notion of individualization and medicalization is this: are transsexuals subjected to social suffering from illness or are they subjected to illness from social suffering?

As alluded to above, a critical distinction I make in this work is to differentiate between the clinical description of GID and the cultural experience of transsexualism. While GID is much more narrowly defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) by 4 basic diagnostic criteria², transsexualism subsumes a holistic cultural experience of cross-gender identification and focuses on the everyday existence outside of socially normative and prescriptive conventions of gender. Contrasting clinical descriptors of GID with the cultural reality of transsexualism evinces that GID cannot describe in clinical terms or as clinical conditions the subjective experience of suffering from the social stigma associated with transsexualism: that is, the social isolation, marginalization, exclusion, and interpersonal distance based on a distinctive individual marker of difference. Based on this assumption, I ask how or why would GRS affect the social suffering associated with transsexualism? What do people expect to gain from GRS individually as well as socially? Why would GRS as the ultimate medical solution for GID contribute anything to the cultural solution for transsexualism? What is its role in “healing” the social suffering associated with transsexualism? And is the psychological stress endured from living with GID intrinsic to the condition, or socially induced and incurred?

It is important to note that this dissertation is not about the “successes” or “outcomes” of the surgery which ignores the patient’s subjective desires and reasons for undergoing it, or assumes a homogeneous patient desire at best. While follow-up studies claim that GRS has an increasingly high “success” rate, one has to wonder what this means; does it mean that GRS

² Mainly a strong and persistent cross-gender identification and discomfort with one’s natal, biological sex

patients are “happier” because they no longer have a penis or does it mean that they no longer suffer from GID? Does it mean that their psychological wellbeing has improved because they no longer feel body dysphoric or does it mean their psychological well-being has improved because they now experience less stigma? Is “success” simply constituted by a low rate of “regrets”³? I suggest that surgical “successes” may not automatically confer social successes and the rationales for why or when this would or wouldn’t be, is the subject of many patient narratives to follow. Most importantly, however, is the task of understanding what the individual GRS patient hopes or expects to gain from genital reassignment in the social contexts of their life - without this critical piece of information, follow-up stories only tell, what I have begun to call “half the story”.

Thus, an important question about GRS that I ask is not “does it work?” but to analyze, considering the social stigma associated with transsexualism, what kind of social capital it bestows on those who undergo it. What kind of medical promissory note is realized here? And what is the meaning of this process beyond its therapeutic event? The critical point to consider is whether we ought to look at medical intervention in bodily transformations as ends themselves or whether we should look at them as means to an end. If GRS were merely a medical end to itself, then yes, “function” and “aesthetic” of newly created genitalia as sexual organs are of primary importance. And if GRS was solely intended to alleviate the discomfort with genital body parts then the entire process could be reframed as alleviating an individual physical problem for which pre-surgical psychiatric evaluation would hardly be necessary or justifiable.

But genitalia are so much more than body parts: they are core parts of our identity and not just fleshy apparatuses of the body machinery. The possibility of rejecting or embracing such

³ See Olssen and Moeller (2006) for a in-depth, person-centered example of regret

parts of the body and the self can have profound effects on whole lives. Vaginas and penises indeed “do” things: they permit or prevent the assumptions of kinship roles, they bestow or prohibit legal rights from marriage to custody of children, they enable or prevent intimate, sexual, or romantic relationships, they permit or prevent access to gender-segregated spaces, and so generally, they permit or prohibit participation in cultural contexts which constitute and give meaning to our everyday lives. To dismiss genital embodiment as irrelevant to gender as both a social construct and an individual identity, as some transgender activists have claimed, is fatal to analyses of whether genitalia matter in “what makes a woman a woman” or “what makes a man a man” because clearly, at least to the 50 transsexual women who participated in this project, and the many more who undergo GRS in the U.S. and abroad every year, it matters a great deal - and why, how, and when genitalia matters to them is the central subject of my work. As GRS surgeon and transsexual woman Marci Bowers remarked, “genitals tell us who we are every day”. But the question of what they tell others about who we are is perhaps not so easily answered.

Psycho-Medical Models of Gender Identity Disorder

Gender Identity Disorder (GID) and Genital Reassignment Surgery (GRS) (also often called Sex Reassignment Surgery or SRS) have traditionally and predominantly been explained and explored from a psycho-medical perspective (see Steiner 1985, Stoller 1985, 1975, Green and Money 1969, Benjamin 1966 for the seminal literature on transsexualism, and Ettner et al. 2007 for more contemporary perspectives). These approaches classify transsexualism as mental or psycho-sexual disorder (APA: DSM-IV-TR 2000) commonly described as a condition in which individuals experience a strong and persistent discomfort (dysphoria) with their anatomically

given bodies and socially assigned gender roles, and desire to become or live as the opposite gender. These individuals seek out medical interventions such as hormones and surgeries to achieve the goal of physical transformation to match their psychological identities as closely as possible (Istar-Lev 2004). The basic, prevailing medical rationale for GRS can be summed as follows: “If the mind can not be changed to fit the body, then perhaps we should consider changing the body to fit the mind” (Hoopes 1966 in Green and Money 1969:288; see also Benjamin 1966; Meyerowitz 2001).

The psycho-medical model of GID and its diagnosis, treatment, and cure is a recent development embedded in medical technological and theoretical advances in endocrinology, psychotherapy, and reconstructive or plastic surgery. Early ideas about gender identity disorder have conceptualized the condition of gender and sex incongruity as men or women “trapped in the wrong body”; this metaphor, evident in medical, scholarly, and autobiographical transsexual literature, still reverberates in today’s narratives about transsexuality (Prosser 1998; Hausman 1995). Because earlier efforts to “cure” gender dysphoria through psychotherapy had failed consistently, Harry Benjamin, an endocrinologist who treated the first transsexual patients in the U.S., argued that changing the body to fit the mind rather than attempting the opposite was the best way to alleviate transsexual’s discomfort with their bodies (Benjamin 1966; Rubin 2003; Meyerowitz 2002). Benjamin was an avid supporter of GRS as the best solution to gender dysphoria and his work remains influential in modern medical treatment of transsexuals as specified in the *Harry Benjamin Standards of Care* (HBSOC 2001). Although the HBSOC has undergone numerous revisions, its basic framework still informs the major stages of treatment for transsexuals: psychotherapeutic evaluation, hormone replacement therapy and genital reassignment surgery (Meyerowitz 2002). However, the medical labeling of the condition as

pathological remains controversial as some transsexuals themselves oppose being labeled mentally ill. Many transgender activists and trans-positive⁴ mental health specialists argue that living in a chosen gender is a personal preference or desire, not a sexual or psychological disorder (Feinberg 1996; Bornstein 1995). Nonetheless, in order to receive medical treatment and/or complete the process of gender transition, transsexuals must submit to the prescribed outlines of treatment; thus, in order to become men and women, transsexuals must first become medical patients. But since gender identity disorder is framed as a problem relating to pathological aspects of one's subjective sense of gender, it is first and foremost important to establish how gender is conceptualized and constructed through cultural discourse which has informed, and continues to inform medical assumptions about gender.

Socio-Cultural Perspectives on Gender and Trans-Gender Identities

Generating ideas about gender is a distinctly socio-cultural practice that has been studied by anthropologists in sites throughout the world (Nanda 2000) and has been theorized as ontologically distinguishable from sex and sexuality (Money and Ehrhardt 1972; Stoller 1975). One of the most theoretically relevant theories of gender in the U.S. has emerged from the framework of ethnomethodology, originally introduced by sociologist Harold Garfinkel⁵ (1967). This perspective has led scholars to conceptualize gender as not something someone “has” or “is” but rather something someone “does”, denoting its instability, fragmentation, and subjectivity (Wickes and Emmison 2007, Speer and Green 2006; Speer 2005; Hird 2002, Preves

⁴ Therapists who do not adhere to the current model of GID as a mental pathology

⁵ Garfinkel's early and often cited account of a transsexual woman he called “Agnes” reveals concerns about gender identity and gender presentation remarkably similar to those of my own participants. This similarity indicates that such concerns remain stable and relevant to the phenomenon and experience of transsexualism.

2000; Zimmerman 1998; Widdicombe 1998; Lorber 1994; Zimmerman 1992; Rogers 1992; Butler 1990; West and Zimmerman 1987; Kessler and McKenna 1978). “Doing gender” is an ongoing, intersubjective accomplishment in everyday interactions that requires consistent identity work by all participants involved (Speer 2005; Hird 2002; West and Zimmerman 1987). The significance of doing gender, emphasizing its constructedness, is exemplified in the context of transsexualism and more specifically, in the context of genital reassignment surgery (Speer 2005; Hausman 1995; Shapiro 1991; Garber 1989; Kessler and McKenna 1978).

Cultural anthropologists interested in the cultural construction of gender and transgender identities have mostly focused on theoretical developments of transgender identities (Valentine 2007) and less on transgenderism as a lived experience (Namaste 2000). Anthropologist Stephen Eyre notes that “Male-to-female transgenderism is a highly theorized but under-researched topic which is in need of ethnographic representation and analysis” (Eyre et al. 2004, see also Morris 1995). The post-structural model of gender as shaped by discursive practices, also sometimes referred to as “the turn to performativity,” is quite useful as a theoretical construct in theorizing the relationship between gender, sexuality and language. But unfortunately, gender as a social and linguistic construct often overshadows its physical or material realities. Eyre sums up the problem of over-theorizing without attention to ethnographically grounded research on transgenderism:

A number of critics have argued that recent scholarly trends distance theoretical discourses of gender from the study of transgender life (Halberstam 1998; Prieur 1998; Newton 1996; Pettitway 1996). Other scholars argue that abstract theory cannot be substituted for accounts of embodied experiences (Rubin 1998; Wilchins 1997). Transgender and Transsexual scholar Ki Namaste (2000) argues that current gender theory, including widely cited works by Butler and Garber, do not produce knowledge of transgendered experiences (Eyre 2004:148)

While most theories on transsexualism are inevitably linked to the social construction of gender as the leading idea on explaining, justifying, and legalizing transsexuals' change of gender, this idea is not uncritically accepted by scholars focused on the meaning of transsexual embodiment. One of major aims of this study is thus to problematize the theory of gender as a social construct by being ethnographically engaged with the corporeality of gender, which GRS, by focusing on reconstructing genitalia, makes highly visible. As gender cannot be decontextualized away from bodies with which gendered experiences are lived out, theories of its social construction may explain how notions of masculinity and femininity are subject to historical and cultural changes, but they do not explain why male and female corporeality remains an ahistorical and universal experience unless radically challenged by transsexualism.

Of course, transsexualism as a form of gender non-conformity is not unique to the U.S. Cultural anthropologists who have studied gender roles and gender diversity in other cultures through conducting in-depth ethnography have concluded that gender variant individuals can tell us a lot about their societies' sex/gender system (Nanda 2000). In examining the ways in which societies deal with gender variance or gender non-conformity, anthropologists have learned how societies explain, respond to, situate, and incorporate individuals who transgress the boundaries of sex and gender in everyday life (for example, Schmidt 2010, Reddy 2005; Manalansan 2003; Rubin 2003; Besnier 2002,1993; Chao 2001; Kulick 1998; Murray and Roscoe 1998; Johnson 1997; Herdt 1993; Grimeaux 1993; Janssen 1992; Mageo 1992; Nanda 1990; Callendar and Kochem 1986, 1983; Williams 1986; Blackwood 1984; Whitehead 1981; Wikan 1977; Levy 1971; Devereux 1937). There have also been a few ethnographic contributions by sociologists, most notably Annick Prieur (1998) and Billings and Urban (1982). Although the body of literature on gender variance within and outside of anthropology seems extensive, only a small

percentage of all writings on gender variance and transsexualism have been based on fieldwork and ethnography. Furthermore, despite anthropological interest in both gender variance and medicalization of gender non-conformity, very little ethnographic work has been done on transsexualism in the U.S.

The ethnographic record on gender variance holds a significant value for social scientists interested in the cultural construction of gender but it has also been vehemently critiqued for its romanticization of non-western gender variant people's lives (Towle and Morgan 2002). A good number of anthropologists cited above suggest that other cultures are more accepting of gender-variant people because they base a person's gender not on natal or biological sex, but rather on gender roles, occupations, and social positionality within their respective cultures. This process is often referred to as institutionalization of "third" genders or of alternative gender roles. I find this notion highly problematic for three reasons: first, the analytical focus is on the social construction of *gender* when it should really be on the social construction of *acceptance*. Individuals are generally accepted as gender non-conforming individuals particular to their culture and their trajectory of transition is not from man to woman, but from man (or boy) to Two Spirit, Travesti, Hijra, or Fa'fafine. For example, as Schmidt (2010) remarked about the latter, "being a fa'fafine does not signify the transition from man to woman" as it does not change the person's kinship or gender status as a man (50).

Second, no known society or culture equates transgender individuals as equal to or no different from natal males and females. All cultures in which transgender people live or have lived differentiate between trans and cisgender individuals. And all cultures have an implicit understanding of the biological difference between males and females, even if it is not emphasized as a main barrier to assuming different gender roles or sexual practices. Finally, I

speculate that non-western or non-industrial cultures incorporate transgender individuals socially because they cannot afford *not* to, or at least this seems to be the case in small-scale societies where mutual support based on kin or social networks is, or was, important and the specialized economic contribution of the individual to the household is, or was, highly valued. The social inclusion of gender variant individuals often rests on maintaining the division of gender by way of divisions of labor - in cases where work tasks are exclusive to each gender, it is usually one's occupational role, which determines one's gender (see Whitehead 1981 for an extended discussion). Acceptance in those cultures may simply mean not excluding gender variant individuals from most social activities; but acceptance does not automatically eradicate discernible differences between cisgender and transgender. Thus, while the anthropological record of cross-cultural gender variation has challenged the ethnocentrism of the western sex/gender model, it has obscured an anthropological understanding of acceptance as also being subject to cross-cultural variation.

Anthropological Perspectives on American Transsexualism

With the exception of David Valentine's 2007 *Imagining Transgender: An Ethnography of a Category* and Anne Bolin's 1988 *In Search of Eve: Transsexual Rites of Passage*, no full-length ethnography explicitly addressing transgenderism and gender transition in the U.S. has been published⁶. Valentine's work, as the more theoretically oriented of the two, investigates the problematic knowledge production of transgender as a category, identity, and community in that he explores the diverging views of individuals who are commonly subsumed under the term

⁶ I am purposefully excluding anthropologist Esther Newton's 1972 ethnography on female impersonators because at the time, drag performance was mostly associated with gay male subculture

transgender but who do not necessarily self-identify as such. Valentine shows that ideas about what constitutes the transgender subject have emerged from academic, white, middle class contexts, which obscure and erase the complexity of identity for poor people of color and other subjects marginalized by class, race, and cultural dominance. Valentine's research subjects reveal that categories such as transgender can both harm and benefit individuals within identity politics and beyond community organization.

While Bolin's central research question, how genetic males are "transformed into psychic, social, and somatic women in a culture that regards gender as genetic and hence non-negotiable" (Bolin 1988: 4), is similar to my own investigative framework, this study focuses primarily on the surgical aspects of gender transition and its multiple meanings. Moreover, my approach differs from hers on two important points. First, Bolin's relatively small sample (N=17) was mostly composed of transsexuals who were at one point or other tied to the Berdache Society, a Native American based support group for individuals in gender transition. But while some transsexuals seek out the help of such groups, and while some emerge out of a gay or lesbian background or community, many do not (Bolin acknowledges this on page 36). My own participant sample was composed of individuals who have contacted the participating surgeon for appointments, and it is fair to assume that this sample will constitute a wider socio-economic, ethnic, geographic, and age-diversified demographic.

Secondly, Bolin's concept of gender transition is based on Van Gennep's rite of passage model explaining "how people cope with change in their lives" (6). Bolin's basic research question of how transsexuals, in spite of their biological anatomy and personal history, become women, was contextualized according to the rite of passage model's three phases: separation, transition, and incorporation (7). Bolin made an excellent case for using the model, alongside

symbolic interaction, to analyze transitional rituals in secularized societies. Bolin argued that transsexual gender transition broke down into three phases, the first of which denotes separation, “a series of events in which transsexuals symbolically and actually are removed from the world as males”. The second phase denotes transition, in which “transsexuals are instructed in, and learn their new role as women, and prepare to enter society as legitimate claimants to their new status”. The third phase denotes incorporation, “which is characterized by the surgical conversion where the neo-vagina is created from male genitalia”. Transsexuals “are then more completely integrated into society as women, fulfilling the cultural requirement that women are people with vaginas, and thereby gaining access to the most intimate sectors of women’s life” (7).

The Persistent Problem of Social Stigma for Transsexuals

For Bolin, the conclusion of the third phase constitutes the end of occupying the stigmatizing status of being a transsexual. Referring to Goffman’s work on stigma⁷, she writes “Goffman’s concepts are particularly valuable in understanding the transsexuals’ rite of passage not only as a transition of gender, but as a *journey out of stigma* (1963)” (Bolin 1988:8, emphasis mine). She underlines this point further by adding that transsexual’s passage is “one into normalcy, where after the surgery, they can disappear into their culture as natural women” and that once transition concludes “transsexuals can assume the status of those born female” (9). Goffman’s discussion of stigma, initially taken from its original meaning referring to “bodily signs designed to expose something unusual and bad about the moral status of the signifier” (Goffman 1963:1), and expanded to frame his concept to the notion of “the disgrace [of stigma] itself” (2), explores the

⁷ See Chapter 1 for an extended discussion on definitions and concepts of stigma.

social relationships in which a person holding a stigmatized identity is “reduced in our minds from a whole and usual person to a tainted, discounted one” (3). Furthermore, he argues that stigma, “an attribute that is deeply discrediting”(3), constitutes a shared knowledge between stigmatizer and stigmatized as both parties hold the same beliefs about identity (7). The discreditable status transsexuals occupy, meaning that their mind/body disjuncture or given gender identity is “discoverable” and thus makes their chosen gender identity discreditable, exemplifies Goffman’s notion of a stigma representing a “spoiled identity”.

Herein lies the analytical complexity transsexualism and GRS produce for notions of social stigma: if the stigma associated with transsexualism denotes the fact that there is a disjuncture between one’s body and mind, constituting a discreditable status, then the surgical alignment between body and mind would, as Bolin suggests, conclude the occupation of such a stigmatizing status, and thus allow for a journey out of stigma. But while Bolin presumes that what is ultimately stigmatizing is gender ambiguity or the mismatch between body and mind, I would argue that social stigma applies to both, the disjuncture between a transsexual person’s body and mind, as well as the disjuncture between their past and present.

The notion that a transsexual person’s pre- or postoperative status may be irrelevant to instances of social stigmatization is reframed by transsexual writer and activist Julia Serano as *Cissexism*: “the idea that transsexual’s identified genders are inferior to or less authentic than those of cissexuals (i.e. people who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned)” (Serano, 2007: 12). Relabeling non-transsexual identities as cissexual identities is meant to call attention to the “unmarkedness” or taken-for-grantedness of a gender identity which matches a sexed body identity. Serano’s cissexuality model describes a specific form of social stigma directed against transgender

persons and transsexuals including pre- and post-operative individuals (however, in this context it is most relevant when applied to post-operative transsexuals). She first notes a categorical distinction between transphobia and cissexism: transphobia denotes “an irrational fear of, aversion to, or discrimination against people whose gendered identities, appearances, or behaviors deviate from societal norms” (2007:12, see also Shelley 2008 for an extended discussion) This is an important distinction because cissexism suggests that post-operative transsexual bodies are not threatening to the gender-sex-match binary because they disrupt the binary, but rather because they can approximate it so closely that they put into question the “naturalness” of anyone’s body or gender. It is thus the “normalization” of bodies, or the surgical possibilities of such, which is more threatening than “abnormal” bodies which do not match a person’s gender presentation. She then notes that the function of cissexism is to create an artificial hierarchy through the demarcation of transsexual persons’ gender as “fake”, and cissexual gender as “natural” (13). So while GRS theoretically enables genital “normality” to offset stigmatization based on sex/gender incongruence, the very instance of surgical modification defies the “naturalness” of genitalia because “natural” bodies are commonly understood as unaltered since birth.

Perspectives on GRS as a Cure for Transsexualism

Serano’s position on GRS as a “cure” for transsexualism is very clear. “Not only is sex reassignment surgery just about the most stigmatized medical procedure that exists in our society” she writes, “but transsexuals themselves are rarely accepted culturally and legally as legitimate women” (154). Serano’s notion has been reiterated by other transgendered individuals (Denny 1991), and explicated by few psychiatrists (Walters and Ross 1986, Blanchard 1985),

and psychoanalysts (Chiland 2005) who have expressed that GRS does not necessarily cure or dissolve transsexualism. Heath reiterates the old psychiatric “stealth” model of gender transition by noting that “An assumption, especially among the medical establishment, is that transsexed people will want to have GRS, pass as men or women, and thereafter live their lives by being as indistinguishable as possible from natal people of their affirmed sex” (2006:171). However, this surgical logic seems too simplistic considering that the primary effect of the surgery may simply be alleviating the body dysphoria transsexuals’ experience. The main question about GRS remains, as Blanchard asked over 20 years ago: “does gender reorientation alleviate the emotional distress of gender dysphoria?” (1985:365).

“The nature of the transsexual’s stigma” writes Kando, is that even if transsexuals can pass, they “do not once and for all become women after their conversion” (1972:475). A change in sex characteristics does not automatically confer any kind of change in social status or treatment to the person, mainly because genitalia remain mostly hidden from public view. Transgender activist Dallas Denny remarks “Sex reassignment is not a ‘cure’ in the traditional sense, for in no other ‘illness’ is the body altered to match to mind. Reassignment is an unusual and only marginally socially acceptable procedure which can provide tremendous relief to an individual who is gender conflicted – but it is not guaranteed to do so.” (1991:8). Denny also notes that GRS is “very disruptive to human relationships” (13) and some people may never accept the transsexual person in their chosen gender.

Other mental health specialists working with transsexuals have come to similar conclusions regarding the social benefits of GRS. In terms of long-term success of GRS, Walters and Ross note that “reassignment has not necessarily brought [transsexuals] the improvement in life they had expected” (1986:145) and although mental health improved generally, “social

adjustments only improved marginally” (146). Many post-surgical surveys and assessments show overall positive results although social and psychological improvements are often not clearly differentiated if addressed at all (I will discuss follow-up studies in more detail in the next chapter). Psychoanalyst Colette Chiland adds “In contrast to the patient’s overall satisfaction, social integration remains a problem for those for whom this was already the case before their operation...” (2005:33). Throughout her many years of working with transsexuals, she noticed that:

Social integration varies from person to person. Many complain of loneliness. They find it hard to talk truthfully about themselves and their background, and this makes it difficult for them to have close friendships...If they intended to live as members of the opposite sex, they have reached their goal. If their aim was to be men or women in the fullest sense of these terms, they cannot but be disenchanted or even terribly disappointed (34)

Chiland also picks up on the necessity for a shared reality of gender between transsexuals and non-transsexuals. “If other people do not enter into their belief system,” she remarks, “this represents a threat to their very being” (45). Even for the analyst and the transsexual patient, this shared reality of gender can be difficult to establish. From her clinical perspective, she notes “Simply for the patient to say that he or she is a woman or a man and for us to go along with that does not make the problem go away: the transsexual is not a woman who was born female nor a man who was born male, and will come up against problems that no-one has the power to prevent” (75). Her sentiments on sex reassignment surgery reflects those of some surgeons in that “Although the condition cannot be cured, the patient’s distress can be relieved to some extent” and that “Physicians who propose hormonal and surgical sex reassignment do so out of compassion” (76). Finally, Chiland’s conclusion reiterates that even if surgical intervention

could change every aspect of a person's biological sex "it would not erase the life experience the patient had up until then" (76).

"If transition is the bridge" mused Samos, "GRS is the burning of the bridge that tells everyone concerned that the transition is complete and settled with finality" (2009:199). However, others have concluded that transition is far from over once GRS or any final physical aspects of transition are complete – for some, transition and its social and psychological consequences never end. Serano's and other's standpoint on societal perceptions of gender are reminiscent of Bolin's remark that most people view gender as an ascribed, not achieved status which can not be changed. Here Serano makes a powerful observation on the hypocrisy cissexuals exhibit when it comes to transcending social class barriers: "cissexuals in our society tend to look disparagingly upon societies and cultures that still rely on class or caste systems...so while most Western cissexuals frown upon birth privilege as a means to determine these other forms of social class, they hypocritically embrace it when it comes to gender" (2007:168). The important implication here is that cissexist individuals rely on an essentialist notion of gender to justify the "fake/natural" hierarchy; however, some cissexuals are quick to turn to social constructionist theories when transsexuals approximate the physical aspects of gendered embodiment too closely. This turn is exemplified by the argument that in order to be a woman, one must have been raised as one, which naturalizes gendered socialization and enculturation (Garber 1997). Although Serano acknowledges the notion that we all "do gender", cissexual gender imitation is taken for granted, while transsexual gender imitation is overemphasized (2007:171; see also Wilchins 1997).

While Serano is an observant analyst in critically evaluating the individual and social benefits of GRS, no single piece of literature has illustrated the cumulative effects of GRS as

bluntly as transsexual writer Claudine Griggs' personal account of undergoing GRS in Trinidad, Colorado (2004). Griggs provides the following summary of what GRS can and cannot achieve:

Transsexualism is not 'cured' after reassignment surgery: genetic sex is not altered; gender role adjustment is not automatically improved; the attributed gender will not be enhanced – if a person has difficulty 'passing', that problem will persist; life history is not rearranged, and one does not get to be a little girl by having a vagina constructed in adult life; there is no fertility; and family rejection is not necessarily eliminated or reduced. A foreshadowed 'normalcy' after SRS may carry disturbing results, and perhaps even entice some individuals to undergo surgery. Many believe that it will do more than it can (91).

Griggs is by far not the only transsexual person who harbors the sentiment that surgery does not eliminate one's transsexualism. "I wanted genital reconstruction to make me 'not transsexual'. That did not happen," notes Griggs (25). "While I find this idea appealing," she adds, "it seems dangerous to assume that when a transsexual has surgery he or she becomes not transsexual or even 'less' transsexual" (39). Most remarkable about Griggs' account is her realization that despite her physically successful gender transition, she felt that she had transitioned from feeling like a "woman trapped in a man's body" to feeling like a "woman trapped in a transsexual body" (210) because even if GRS can erase the physical reminders of one's given body, it can not erase a person's gendered history. In a follow-up letter to her surgeon, Griggs writes, "Unfortunately, there is no cure for transsexualism, and I accept the surgery as a great improvement but still regret that I will never be a natural female – this is a pain no surgeon can ever remove" (197). Griggs' words describe the distinctive emotional sentiment of wistfulness which, as I argue (and will expand upon later), escapes clinical descriptions of GID, but which I found to be deeply embedded in many of my own participants' narratives about living with GID.

Griggs' initially hopeful journey to Trinidad, Colorado to undergo GRS turned out to be no journey out of stigma after all; although Griggs acknowledges the positive individual gains of

achieving mind/body congruency, she comes to the sobering realization that socially, very little has changed in how she is perceived by others: “In some sense I feel trapped in a female body in the same sense I once felt trapped in a male body. Something like being a woman, a person, trapped in a transsexual body” (210). Griggs’s experience exemplifies that transsexuals are products of a cissexual world, in which sex reassignment surgery has become a medical commodity covertly advertising gender identities for sale, but which unfortunately do not equate their individual worth in social currency. Here, bio-medical rationales producing and clinically validating gendered identities present a socio-medical paradox by making transition from one gender into another at once subjectively possible, but intersubjectively impossible. The problematic bio-medical model of transsexualism thus reiterates that powerful medical intervention in creating subjectivity remain encapsulated in a cultural matrix which projects infinite ways of medical becoming, while at the same time revealing distinct limitations in societal acknowledgements of such endeavors.

Griggs’ experience thus illustrates Serano and many of my participants’ sentiments that GRS does not unproblematically facilitate a “journey out of stigma” as social knowledge about a person’s past history remains fixed in an unspoken cissexist consciousness. It is this cissexist consciousness which primarily enables social stigma to emerge and manifest itself in the lives of transsexuals pre- and post-operatively, and the effect it has on shared social histories is what I advance in more depth throughout this study. Of course, Griggs is not the only one who has contextualized this notion in what is essentially already a medical anthropology approach. “Because transsexualism is viewed as a personal problem rather than a sociocultural problem” observes MacKenzie “‘cures’ become the responsibility of the individual rather than the culture” (1994:70). Similarly, Judith Butler argues that centralizing suffering in the individual

“domesticates the distress caused by social norms” which is subsequently “recast as an internal problem” (2006:295). Thus, despite the transformative potential of modern plastic surgery and the prevailing cultural ideology, which celebrates individual self-realization in a “before-and-after” society, GRS can not offer transsexuals a “journey out of stigma” because all bodies are, as Nancy Scheper Hughes reminds us, social bodies upon which cultural meanings are inscribed collectively.

Not Just a Guy In a Dress: GRS as Identity Distinction

As I will show throughout this work, transsexual identities and bodies can be read, and transsexual women can be “seen” in a myriad of ways; however, exploring the meaning of the surgery for participants shows that surgery enables a distinct authentication from which selfhood is projected. Halberstam (1998) has argued that from an objective perspective, identities are not “discovered” by a positivist approach, which essentially claims that they have always existed, but rather, identities emerge from distinctly historical and cultural contexts as identifications *against* others. Similarly, from a subjective perspective, identities are not simply felt or experienced in isolation, but are often discovered to form against those of others already in existence. Whereas transsexual men oftentimes identify against butch lesbians, many transsexual women tend to identify against transgender identified people, mainly cross-dressers, but also other transgender or gender queer identified individuals. And although there are ongoing debates about the “border zones” (see Rubin 2003) between gendered and sexual identifications, and the various pathways in which identities solidify or transform, self-identification against others is prioritized by the individual, but not always legitimized by their respective communities, cultures, or societies.

Body modification such as surgical interventions to create or accentuate distinctly physical markers of gender identity are often centralized in categorical debates of when or whether individuals “count” as transsexual. Because GRS or the pressing desire for it, as some argue, is the primary identifier of transsexuals, transsexuals are also often described as suffering the most “extreme” form of clinical distress associated with GID. However, I found that the motivation for surgery is not solely based on relieving the individual distress about the mind-body mismatch; GRS can be said to be socially motivated as well in that mind-body congruence holds social importance beyond individual relief.

In connecting the body to self-identification, I show in this work that the transsexual identity distinction which is claimed by and through GRS re-emphasizes transsexualism as a social experience where embodiment becomes central to identity claims as men or women for transsexuals: as they are highly aware that they share performative aspects of gender with cross-dressers and other transgender identified individuals, transsexual women focus on permanent embodiment, or changes to embodiment, as their central marker of identity against others. GRS thus enables not only an identification against being a man, but against being “just a guy in a dress”. The implication of this idea therefore suggests that the desire for surgery is not solely about the individual relief from being a woman with a penis, but rather the social relief from being seen as a man “pretending” to be a woman.

Kessler and McKenna (1978) have shown that sexing bodies never occurs from a gender neutral position but is intrinsically *phallogentric* (i.e. based on the absence or presence of a penis even if other parts of the body indicate at least some ambiguity). Similarly, I would argue that gendering individuals also does not occur from a gender-neutral position and is thus *androcentric* (i.e., based on absence or presence of masculine markers even if other features or

behaviors indicate some ambiguity). The persistent androcentrism in gendering individuals is not inconsequential: women in pants are unlikely to cause the same social sanctions as men in dresses. Because women are more often allowed to avail themselves to cultural markers of masculinity, female cross-dressers are hardly acknowledged as such while male cross-dressers can be diagnosed as suffering from a recognized pathology (i.e. transvestic fetishism, as classified in the DSM). The “cultural anxiety” modern societies feel about cross-dressers, as Garber (1997) has suggested, similarly reveals that cross-dressers pose a much more significant threat to the socio-sexual conventions of deviance than women who cross-dress do. It is this social reading of male bodies and masculine genders as transgressive of social boundaries of deviance which transsexuals not only identify against subjectively, but seek to disengage ontologically by undergoing GRS.

Terminology

Throughout this dissertation, several terms are used, sometimes interchangeably, which require explanation. First, Gender Identity Disorder (GID) is the official nomenclature of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Gender Dysphoria (GD) describes the negative feelings associated with thoughts about one’s given/natal/assigned sex and gender. GID and GD are often used interchangeably, however, I prefer to differentiate GD as a symptom of GID because it is this term which denotes clinical distress. In other words, if someone had no problem whatsoever with identifying or expressing themselves opposite of their assigned gender, this person would still have GID but there would be nothing to be dysphoric about.

The terms ‘transgender’ and ‘transsexual’ have also been used interchangeably throughout the literature although they constitute a constant point of debate in and outside of

academic circles. David Valentine (2007) has devoted a full ethnography to the discussion of what or who is transgender, transsexual, both, or neither. As an all-inclusive so-called umbrella term, transgender describes and includes any and all gender variance or diverse expression or ambiguity, whereas transsexual describes an “extreme” or polar form of unambiguously wanting to live and be seen as the opposite gender and the desire for permanent body modification to approximate the opposite sex. Throughout most of this dissertation, I have preferred the term transsexual to describe categorically, but have used the simpler pre-fix “trans” to describe very general issues pertaining to transgender or transsexual culture, or “trans women” to differentiate between male and female transsexuals. I also commonly use “Male to Female” (MtF) and “Female to Male” (FtM). Nonetheless, whenever topics were more generally relatable to the broader category of transgender, I have purposefully used the term to be more inclusive, especially when I talk about children who may or may not yet have an unambiguous or persistent cross-gender identification.

Although much of the literature describes and abbreviates the surgical modification of genitalia as Sex Reassignment Surgery (SRS), I have adopted Marci Bowers’ preferred term Genital Reassignment Surgery (GRS) because I feel that it describes the surgical process best. GRS is also sometimes used to denote Gender Reassignment Surgery, however, this term feels entirely wrong as the individual presenting for surgery has already submitted to his or her own personal subjective change of gender identity, role, expression, etc. The surgical process is solely focused on the anatomical rearrangement of genital tissue, which has little to do with our current understanding of gender. Therefore, gender is not, and cannot really be surgically assigned or reassigned.

The most terminological difficulty in writing this ethnography however was my inconsistency of referring to my participants as patients or conversely, calling patients participants - it is important to note that both terms refer to the same people. Yet, the inconsistency also reveals the multiplicity of these identities - participants become patients and patients become participants. Significant however remains the fact that ethnographic writing can be awkward in maintaining researcher/subject boundaries as I often did not know what to call participants or whether to think about them as patients or not. Even the most neutral descriptors of “trans women” hardly covers all ground; some participants or patients identified as “just woman”, others proudly adopted “trans” as an adjective. And for a few, even this distinction was changed throughout the process of GRS.

Within and beyond transgender studies, terminology indeed remains a point of contestation between transgender individuals, activists, scholars, medical professionals, journalists, and academics. The central issue lies not only with labeling or naming transgender individuals or identifications, but with the power differential between researcher and subject, which shapes what sort of discourses are produced about trans people by non-trans writers or researchers. Many transgender individuals take issue with how they are represented in contemporary literature and some have provided helpful suggestions and guidelines for non-trans scholars writing about transgender or transsexual subjects (Hale 2004). I have tried to take into consideration, as much as possible, these and other linguistic concerns in my writing, but I would be remiss not issue a disclaimer here; there is no perfect or always-correct way of writing or speaking about ethnographic subjects, and furthermore, as new research reveals new insights about people’s identities, more often than not, terminology changes in the process.

Summary and Aims of Study

This ethnography explores the therapeutic potential and the multiple medical and social meanings of genital reassignment surgery (GRS) from an anthropological perspective. GRS is commonly recognized as the surgical alteration of genitalia to align transsexuals' bodies with their chosen gender identities in order to alleviate the persistent discomfort of Gender Identity Disorder (GID). While outcomes of GRS are clinically evaluated through psychological or post-surgical assessments, focusing mostly on the individual benefits of the surgery and on the aesthetic or functional aspects of newly created genitalia, patient-centered hopes and expectations of social gains and benefits through GRS have not been assessed in medical or social science research. Although many studies have addressed the objective rehabilitative qualities of GRS through post-surgical surveys, none have ethnographically documented the patient's personal meanings invested in the surgical process of sexual reassignment pre-surgery.

This ethnography is therefore divided into three main parts: the first part describes the theoretical background, the research methods, and the field setting. The second part describes the surgical experience, the post-surgical recovery processes, as well as the shared experiences of healing involving family members. The third part draws mostly on interview material collected to illustrate patient perspectives on GID, GRS, and the integration of gendered past and present lives. In sum, the specific merits of this study lie in its emphasis on showing not only the different meanings GRS holds for patients (contrasting life-world concerns with bio-medical concerns) but also evaluating what GRS is expected to contribute to the everyday experiences of transsexuals living with GID. The latter issue is of particular interest as it serves as a way to critically assess the current biomedical model of transsexualism and its treatment. While the biomedical focus of the surgical process is on individual benefits and physical outcomes, a life-

world focus of the surgical effects takes into consideration the social benefits and social outcomes patients expect to gain from the process of genital reassignment.

Although psychologists have unanimously acknowledged that transsexuals suffer from significant psychological distress, it is unclear whether their suffering is primarily caused by experiencing gender dysphoria, or by social stigma which many transsexuals experience on an ongoing basis. My primary aim in exploring this disjuncture was thus to elicit transsexual patient narratives through person-centered interviews which address what patients expect to gain from GRS, what kinds of hopes they have invested in the surgery, how individuals intend to integrate their past and present gendered histories, and whether they feel that undergoing GRS will significantly improve their social status. While GRS can provide individual benefits for transsexuals through eliminating body-dysphoric feelings by surgically bringing the body into alignment with the mind, it does not eliminate their physical or social history of transsexual embodiment, which can keep transsexuals in socially liminal positions. The findings of this study attempt to bridge the gap between clinical concepts of GRS as therapeutic approaches to GID and illuminating its broader social meanings beyond its clinical context. Seeking to document a distinctly “experience near” perspective on patients undergoing the surgical process, this study aims to shed new light on the illness experience of gender dysphoric patients and the meaning of surgical intervention in cases of socially stigmatizing disorders. More generally, this study also provides gender and sexuality scholars with new cultural perspectives on the role of body modification on social identity construction, self and social perceptions of gender, and socially stigmatizing effects on sexual or gendered minorities.

Chapter 1: Transsexualism from a Medical Anthropology Perspective

Theory and Background

Taking a Cultural Approach to Illness

In this chapter, I try to situate my work within the theoretical context of medical anthropology. I chose this approach because the main shortcoming of both psycho-medical as well as the social science literature on transsexualism and GRS is that the former is too focused on surgical outcomes, function, and aesthetics of reconstructed genitalia, while the latter is often too focused on transsexual identities, not embodiment. No study to date has focused on collecting ethnographic data and personal narratives on how the surgical process is experienced, what patients expect from and invest in the surgery, and how they intend to navigate their social environment after the surgical process of gender transition has concluded. Indeed, transsexualism and genital reassignment are exemplary of many tenets within cultural studies of medicine from the social construction of illness to the medicalization of social problems. However, transsexualism and genital reassignment are conspicuously absent in medical anthropological literature, although ethnographic studies of transsexualism and surgical intervention could offer medical anthropologists an excellent opportunity to observe the experiences of a contemporary illness and how its particularities, which reach far beyond medicine, unfold in a clinical setting.

Contrasting studies of lived experiences of illness with bio-medical models of illness constitutes an integral part in most medical anthropological ethnographies (see for example Rapp 1999; Hahn 1995; Martin 1994; Young and Garro 1981). These differential approaches speak strongly to the schism between patients and medical authorities where the former tend to view GRS as, for example, a “journey of becoming whole” while the latter view GRS as “fixing” a discrete, physical part of the body (see for example Biber in Bullough and Bullough 1997, also

see ethnographic studies on intersex surgery such as Karkazis 2008). This potential conflict of interests, rooted in the oppositional framework of biomedicine vs. life-world concerns (Gill and Maynard 2006), is central in assessing what GRS is hoped to actually accomplish. Investigating the different meanings GID and GRS hold for patients and medical practitioners is thus an important ethnographic task in analyzing the oppositional therapeutic aims, interests, and goals which inform doctors' and patients' perspectives in this context.

The following theoretical approaches to transsexualism and GRS serve to problematize what is often understudied and under-theorized about transsexuals in the first place: their illness experience as social beings in society and most notably, the effects of surgical intervention on both their social, and individual problems. From a medical anthropological perspective, transsexualism and GRS represent contemporary problems with contemporary solutions but they can also reveal deeper insights and critiques about long-standing social and medical systems and their dialogical connection. My primary aim in using medical anthropology as the theoretical foundation however, has more to do with expanding existing psycho-medical perspectives on transsexualism by questioning not only the limitations of biomedical or surgical intervention, but also the limitations of the moral responsibility inherent in medicine. This responsibility, I argue, is too focused on restoring individual health rather than on social health which remains the responsibility of the patient, and not the health care provider or practitioner.

Cultural vs. Biomedical Models of Illness: Transsexualism as a Social Problem

Medical Anthropologists are fundamentally interested in the historical, cross-cultural, and continuously evolving dialogue between culture and medicine. A principal foundation of medical anthropology is the assumption that sickness and health are culturally constructed and that

meanings of sickness experiences change according to time and place. Many scholars, and medical anthropologists in particular, have utilized such a social constructivist perspective to analyze the history of illness and health, and medicine as a cultural system of knowledge and practice (Singer and Baer 2007; Mattingly and Garro 2000; Brown 1998; Loustanau and Sobo 1997; Sargent and Johnson 1996; Kleinman 1995; Hahn 1995; Lupton 1994; Becker 1994; Conrad 1992; Lock and Gordon 1988; Scheper-Hughes and Lock 1986; Gove 1982; Conrad and Schneider 1980). Lupton argues that “medical knowledge is regarded not as an incremental progression towards a more refined and better knowledge, but as a series of relative constructions which are dependent upon the socio-cultural settings in which they occur and are constantly negotiated” (1994:11). The constructionist perspective specifically highlights scholars’ engagement with the relationship between culture and mental illness. Gove notes that “It is a basic tenet of social sciences, and particularly of labeling theory, that culture plays a very active role in shaping the behaviors related to mental illness” (Gove 1982:8). Lorber expands:

In every society, the symptoms, pains, and weaknesses called illness are shaped by cultural and moral values, experienced through interaction with members of one’s immediate social circle and visits to health care professionals, and influenced by beliefs about health and illness. The result is a transformation of physiological symptoms into diagnoses or illness names, socially appropriate illness behavior, and heroic or stigmatized social statuses (1997:1)

Kleinman, referring to changing and differing explanatory models of mental illness and disease, adds that “culture shapes disease first by shaping our explanations of disease” (Kleinman 1977:4). The study of the social construction of illness, that is, how illness is understood in specific historical and cultural settings, is thus a useful framework for understanding how gender non-conformity has evolved into the pathological condition now classified as Gender Identity Disorder (GID).

Evaluating a medical problem whether on a macro-structural, or micro-individual level without considering the socio-cultural factors that inform the concepts and experiences of health and illness, is a major and broad critique of biomedicine, which has informed much of medical anthropologists' work over time. Since even the most basic ideas and processes in medicine such as pathology, diagnosis, treatment, and cure, are culturally informed, medical anthropologists generally advance research agendas, which consider multiple perspectives on human health or psychological problems. In this sense, every human health problem can be perceived and interpreted as both a problem and product of human culture rather than an independent and individual occurrence of pathology. Kleinman's invaluable insights from his own ethnographic work and that of others makes for an excellent theoretical starting point to look at the social causes of psychopathology which can hold its own against psychological perspectives on transsexualism. "A key axiom in medical anthropology" writes Kleinman (1980), "is the dichotomy between two aspects of sickness: disease and illness" in which illness "refers to the psychological experience and meaning of perceived disease ... illness is shaping of disease into behavior and experience. It is created by personal, social, and cultural reactions to disease" (72). More relevant here is Kleinman's notion that minor (non-psychotic) psychiatric disorders including "life problems and psychosocial crisis" could be examples of "illness in the absence of disease" (74). This idea of "illness without disease" describes the condition of transsexualism quite well as an example of "instances of social deviance that are labeled medical deviance..."(74). Kleinman has stated that suffering and distress are invariably social, collective, or intersubjective experiences, and not individual occurrences (1995). He asked, "What difference does it make - for theory, for research, for policy, and for social ethics - to change the border between a social and a health problem?" (16). Kleinman's "critical engagement with the

deep cultural processes that are at work within biomedicine” are undoubtedly useful for analyses of medicalized social problems. Good (1994) adds that “It is both the privilege and the obligation of medical anthropology to bring renewed attention to human experience, to suffering, to meaning and interpretation, to the role of narratives and historicity, as well as to the role of social formations and institutions, as we explore a central aspect of what it means to be human across cultures” (24). Good and Good’s earlier ‘meaning centered approach’ (1980) to illness connects illness meaning and experiences to culturally relevant metaphors such as transsexual idioms of “feeling trapped in the wrong body”. Similarly, Kleinman and Kleinman note that “ A medical anthropology unable or unwilling to examine how culture infolds into the body (and, reciprocally, how bodily processes outfold into social space) is not very likely to get far in conceptualization and empirical study of the sociopolitical roots of illness or the cultural sources of healing” (1991:710-11).

Another important aspect of medical anthropology and its ethnographic approach to illness is to illustrate how culture informs illness categorization. Re-invoking the constructionist perspective, some scholars argue that “illness categories are culturally agreed upon and that these categories changes over time and through cultural circumstances” (Brown 1998:8). Illness categorizations, as Kleinman and others have argued, emerge primarily when people assign medical labels to conditions which are ordered alongside a culturally informed normal/abnormal spectrum. Thus, culture defines normality with the consequence that what is acceptable and unacceptable, moral and immoral, varies from culture to culture, and from subculture to subculture. However, as Brown points out, illnesses have important symbolic dimensions where the cultural meaning assigned to an illness dominates medical as well as public opinion about it (1998:144). Thus, medical systems regulating anything from illness categorization to illness

behavior can be seen as reflecting social systems and social hierarchies, and this is particularly evident in the case of transsexualism. Furthermore, Brown remarks that “[e]thnography adds an ‘experience near’ dimension of people’s lives to medical social sciences” (8) which is why studying the illness experience related to transsexualism from an emic perspective — another important thematic point in medical anthropology — is critical in assessing GRS and its therapeutic benefits. Since illness (inner, subjective experience of alterations in health) and disease (observable, clinical manifestations of altered physical function) comprise the binary subcategories of sickness in medical anthropology, illness as “the human experience and perceptions of alterations in health as informed by their broader social and cultural meanings” (11) cannot be ignored. This distinction is particularly useful in the context of transsexualism because it is a phenomenon in which patients seek medical attention “in the absence of clinically identifiable symptoms (illness without disease)...”(11).

This dissertation presumes a theoretical position based on the medical anthropological tenets stated above; in essence, my analytical starting point is that transsexualism has for over 60 years now been considered a psycho-pathology of the individual through the central process by which many human problems become medical problems⁸. “Medicalization” writes Conrad “focuses the source of the problem in the individual rather than in the social environment; it calls for individual interventions rather than more collective or social solutions” (2007:8). One of Conrad’s main concerns with the widespread medicalization of society is its “transformation of many human differences into pathologies” (148) and he furthermore notes that “It has long been observed that the clinical gaze or the clinical medical model focuses on the individual rather than

⁸ See also Browner 1997 on how medical anthropology itself has experienced a tendency to become medicalized.

the social context” which Conrad calls “the individualization of social problems” (152).

Similarly, remarking on the increasing number of individuals diagnosed with mental illness, Szasz remarks “as so called mental health problems are not medical but human (that is, moral, social, and political) problems, we cannot solve them by therapeutic means...” (2007:8).

Kleinman (1988) has also commented on “the widespread process of medicalization in Western societies, whereby problems previously labeled and managed as moral, religious, or criminal are redefined as disorder and dealt with through therapeutic technology” (26).

But while medicalization is often understood as a unidirectional and oppressive force, Conrad notes that people can also become “active collaborators” in the medicalization of their problems (2007:9). This is most certainly true for transsexuals who have played a vital role in transforming their condition into a medical problem by seeking medical authorities’ support for illness legitimization, rather than merely seeking political support for social change. Nonetheless, two major consequences of medicalization and biomedical modeling of human problems emerge, as indicated above, which will constitute my theoretical baseline for this ethnography: the individualization of the social causes of illness, and the social aspects of suffering from illness.

The Social Causes of Illness: Stigma, Sociogenic Stress and Social Suffering

“One of the major goals of the medical profession, and of many physicians in practice, is to reduce suffering of individuals,” noted Conrad. “Yet”, he adds, “one can also ask the question, What are the limits to medicine’s role in reducing suffering” (2007:156) and “are there any forms of individual suffering that affect the body, mind, or behavior that are beyond potential inclusion in the medical realm?” (157). While GRS has originally been seen as an ameliorative treatment for transsexuals suffering from extreme dysphoria, this still rings true today. But, as I

argue throughout this work, what if the major social consequence of an illness, such as stigma, cannot be affected by its supposed treatment even if the individual improves? What if, as I suggest, the kind of individual suffering endured by people afflicted by an illness is actually secondary if inextricably tied to their social suffering? And what if most of the suffering endured is actually caused by social stigma and not the disorder or illness in and of itself?

Since Goffman's initial work, many anthropologists periodically engaged with concepts of stigma and social suffering have emphasized the intersubjective nature of stigma, the dependence of social context, and the situationality of social identities (Yang et al 2007, Lee et al. 2006, Kusow 2004, Ablon 2002, 1992, 1981, Kleinman, Das, and Lock 1997, Kleinman et al. 1995, Susman 1994, Edgerton 1993). Although Goffman's work on stigma (1963) is commonly the starting point for any and all analyses of stigma, his conception of stigma has been expanded and modified by a number of scholars across social science disciplines (Link and Phelan 2001, Crocker et al. 1998). "New" views on stigma emphasize "the importance of people's construals of their environment in shaping their emotions, behavior, intergroup attitudes, and intellectual performance" and "members of stigmatized groups are assumed to develop shared feelings, beliefs and expectations about their stigma and its potential effects" (Major 2006:196). These "collective representations" (Crocker et al. 1998) constitute an awareness and knowledge about socially devalued identities in culturally dominant paradigms. As Levin and Van Laar remark "Stigmatized individuals not only experience prejudice and discrimination directly, they are exposed to representations of their stigma in the dominant culture as well" (2006:5)

Some authors maintain a focus on stigma as a fixed "mark" of some sort (Jones et al. 1984), some differentiate mainly between societal deviance and situational deviance (Falk 2001), while others see stigma as a devalued social identity in specific social contexts (Crocker et al.

1998) or cultural contexts (Yang et al 2007). Others have taken a more critical stance towards Goffman's initially micro-interactional framework by adding macro-interactional, or structural frameworks to its definition (see Shuttleworth and Kasnitz 2004 for brief overview). Another development that has modified definitions of stigma is the change in focus from the stigmatizer to the stigmatized (Oyserman and Swim 2001, Sayce 1998, Kleinman 1995) which problematizes notions of discrimination and prejudice as uni-directionally applied to the individual by society in micro-interactional contexts.

As Link and Phelan remark "The stigma or mark is seen as something *in the person* rather than a designation or tag affixed to the person" (2001:366, italics in original). Kanuha adds that "there is nothing inherent in the constitution of individual persons that is 'stigmatizing' per se; rather the meaningfulness and subsequent creation of stigma is situated in historical, political, economic, and most importantly, social contexts" (1997:13). Thus, Link and Phelan suggest that stigma is conditional on "relationships between a set of interrelated concepts" which include the distinguishing and labeling of human differences, the dominant cultural beliefs which link labeled persons to undesirable characteristics and negative stereotypes, the placement of labeled individuals into "us and them" categories, and the resultant experiences of status loss and discrimination. In sum, the authors argue that stigma is contingent on unequal "access to social, economic, or political power that allows identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (2001:367).

One important modifier to which types of attributes or characteristics can be stigmatized is that "there is a *social selection* of human difference when it comes to identifying differences that will matter socially" (Link and Phelan 2001:367, italics mine). In other words, difference

alone does not necessarily stigmatize, and all instances of stigma are culturally and socially relative, rather than strictly binary. For instance, medicalization of social problems can provide a sharper contrast to certain conditions when compared to infrequent or singular occurrences of similar social transgressions. As Jones et al. note “Transforming societal definitions of a disorder from a moral transgression to a medical disorder can change public reactions to the afflicted person” (1984:104). Here, the social selection of difference becomes more clearly articulated when a medicalized identity becomes synonymous with a social identity that is devalued in a particular context (Crocker et al. 1998). Finally, institutionalization of social identities, in addition to social selection of human difference, reinforces labeling tendencies for deviant behaviors or personal attributes, often resulting in consolidating those into a “master status⁹” of the individual (Estroff 1989, Goffman 1963). Moreover, the interpretation of whether a negative reaction toward a stigmatized individual is undoubtedly motivated by stigma is not necessarily always evident. As Katz has noted, the discrepancy between a person’s true feelings and between culturally conditioned or expected feelings toward stigmatized individuals often results in the expression of *ambivalence* “rather than simply hostile or accepting” (Katz 1981:11).

Cultural contexts and localized interactional features thus play a key role specifically for anthropologists seeking to understand stigma as a distinctly psycho-cultural phenomenon between culturally competent interlocutors. Interesting here are especially “those features of the social matrix within which marking occurs that shape the reactions of the discrete individuals who are interacting” and this understanding of marked relationships requires “attention to the role of social-systems dynamics in the marking process” (Jones et al. 1984:80). This is an

⁹ A “master status” is especially stigmatizing when “membership in one, generally negative, category dominates all his or her interactions” (Jones et al. 1984:157).

important adjustment to Goffman's work as concepts of stigma are extracted from their micro-contextual bedding, and instead become more fluid or visceral for multi-layered analytical purposes. As Jones et al. confirm, "stigma is seen in both as an emergent property, as a product of definitional processes arising out of social interaction, and not as an attribute that people automatically have when they acquire a trait or quality that may be discrediting" (80).

Quinn notes that "a *concealed stigma* is defined as a stigmatized identity that is not immediately knowable in a social interaction, such as a history of mental illness or incarceration" (2006:84, italics mine). Notions of concealed stigma can give the impression that these are somehow easier to deal with than types of conspicuous stigma¹⁰. But Jones et al. note that "we must not conclude that if a mark can be successfully concealed by the marked person it will have no effect on interpersonal relationships" (1984:30). The constant emotional burden of keeping "a secret" can have severe psychological and interactional consequences. Quinn elaborates that "people with a concealed stigma must worry about discovery: Will others find out? Am I leaking any cues that would make them suspect to my status? Have they heard anything about me?" (2006:86). Individuals with concealable stigma are often placed in moral dilemmas about how, when, and to whom to disclose their stigmatizing condition. For instance, timing can be critical: "If individuals wait to disclose a stigma to a trusted person, he or she is seen as dishonest, and moreover the person is held responsible for the negative effects of the disclosure on the relationship". (86). "Moreover" Quinn continues, "some concealed stigmas reveal themselves" and "if stigma is revealed involuntarily, it also takes away the ability to choose to whom the identity is revealed" (87). Shared cultural knowledge about stigmatized identities form a large

¹⁰ Quinn is critical of other scholars' notion that costs of concealing stigmas are minimal. "the long term effects of maintaining a concealed identity" she notes, "are likely to be burdensome" (2006:87).

part of why someone might choose to keep his or her conditions or identities hidden from public appraisal. “Obviously, the reason people with a concealed stigma are concerned with keeping it concealed is due to the perceived and actual consequences of discovery” adds Quinn (89) because they know “exactly what close others think about their stigmatized identity” (90). This double threat of identity damage and dishonesty is deeply troubling to individuals who choose to conceal their status and it has profound effects on their psychological well-being and their self-esteem.

Although most concealable stigmas are permanent, some may be temporary or soluble. But the possibility for permanent removal of a once-stigmatizing status is debatable. Jones et al. argue that “in some instances, removal of the stigma does not gain the formerly marked person full social acceptance, if his history is known” and “Perhaps through some means that remains to be understood, all stigmas leave a permanent social blot and a psychic scar on those who formerly possess them” (1984:40). If information leading to revelations of stigmatizing aspects of the individual can be selectively avoided, it appears that one strategy for the stigmatized individual would be to simply avoid conversations, which may force disclosure or accidentally bring it about. However, closing off large domains of conversation is in itself suspicious behavior and may alert others. Although most people engage in a selective disclosure process in social interactions — some perhaps more consciously than others — individuals with concealable stigmas often create “double biographies” (206) rather than omitting information. This may be a suitable strategy for some individuals but the cost of constant auto-biographing is high in that a “second self” must be presented and remembered in certain interactional contexts with consistency. “There is also some danger with concealable stigma that the mark able will feel ‘inauthentic’” add Jones et al. (129). Finally, “If stigmatized individuals who hide their stigma

believe that they are not being true to themselves, the lack of authenticity may threaten personal self esteem and threaten the goal of being understood by others” (Swim and Thomas 2006:117).

Quinn remarks that “having a mental illness is considered a highly stigmatizing condition” (2006: 93). Many scholars have noted the enduring relationship between mental illness and social stigma and the impact of prejudice, discrimination, ostracism, and social exclusion on stigmatized individuals (Corrigan 2004, 2002, Corrigan et al. 2003, 2001, Corrigan and Penn 1999, Page 1995, Penn and Martin 1998, Link 1987, Link and Cullen 1986). Devalued social identities of the mentally ill which fall short of “socially defined ideal identities” (Overton and Medina 2008:144) are socially stigmatized based on both, having a diagnosis of mental illness, as well as actual or perceived abnormal behaviors. Overton and Medina further note that people with mental illness are often subject to structural stigma resulting in “lack of employment opportunities; limitations on finding adequate shelter; barriers to obtaining treatment services, including negative attitudes of mental health professionals; and the role of media in perpetuating the negative image of people with mental illness” (145).

“A central focus of theory and research about the stigmatization of mental illness” note Norman et al. “has been on the importance of negative stereotypical beliefs”. Their findings “support previous reports showing that beliefs concerning inappropriateness or disruptiveness of social behavior by those with mental illness and their potential dangerousness are the stereotype dimensions that show the greatest relationship to preferred social distance” (2008:155). Overton and Medinas’ structural barriers (macro-contexts) as well as Norman’s social distance (micro-contexts) remind us of the overarching conditional normativity which envelopes analyses of mental illness stigma. “Goffman’s seminal writings on stigma” add Norman et al. “emphasized the importance of a perceived social consensus or norms concerning behavioral responses to

stigmatized individuals and there have been several recent calls for more attention to the social normative context of stigmatization in general and stigmatization of mental illness in particular” (852). Stigmatized mental disorders are also highly dependent on situational contexts and “once a mental illness identity is revealed in a situation, that situation is likely to become threatening, in a sense that now a person must prove him or herself a competent, worthwhile human” (Quinn 2006: 94).

Symbolic interactionist perspectives hold that intersubjectivity is pivotal to self-understanding. For instance, “The self is derived from internalization of the way people’s social interaction partners view them” (Sinclair and Huntsinger 2006:235) and “The development of the self concept is a distinctly social process” in that “the construction of the self is in the affective reactions that are received from others” (Jones et.al 1984:111). When a person’s stigmatizing status is closely linked to a core aspect of the person’s identity (such as gender or race), it becomes all the more relevant in social interaction. “At its core,” write Crocker and Garcia “the experience of stigma is fundamentally a threat to the self” (2006: 289). But while stigmas pose a “threat to the self,” stigmatized identities can conversely pose threats to what Berger and Luckman have called “the social order” (1966). However, the imbalance of a perceived threat seems to be more heavily weighted towards threatening social environments “which are environments that can activate social identities and the relevant negative stereotypes about them” (Inzlicht and Good 2006:129) and which “can be thought of as settings where people come to suspect that they would be devalued, stigmatized, or discriminated against because of a particular social identity” (131). Thus, threats to the self seem to emerge more readily and across most types of stigma (i.e. gender, race, disability, etc.), than threats to the social order posed by stigmatized individuals.

Social stigma is invariably linked to self-stigma as negative attitudes about an individual's characteristics or behavior are internalized. Scambler's (1998) enacted and felt stigma distinction exemplifies this notion in that enacted stigma refers to instances of confrontational and consequential discrimination or othering, while felt stigma refers to fear or expectation of enacted stigma in association with devalued self-identity. A synthesis of both stigma principles often results in self-stigma or internalized stigma. Thus, when advancing an argument that social stigma is a co-causal factor in experiencing distress, it need not refer to actual experiences in the past or concurrent ones; stigma refers to all 3 ways it can be experienced - enacted, felt, and internalized. Moreover, when internalization of one's stigma is strongly related to one's core identity, the stigma "will become a defining attribute of the self" (Jones et al. 1984:112). This is especially evident in stigmatizing conditions turning into a "master status" of some sort wherein other aspects of the self are completely overshadowed by the stigma, and its bearer becomes *the homosexual* or *the schizophrenic*. Stigmatizing conditions are thereby transformed into cultural types or classifications with little room to develop an autonomous self outside of, or aside from the condition. "If an individual becomes stigmatized in a domain for which a self schema has been developed, the consequences for the overall self-concept are likely to be relatively dramatic" write Jones et al., and further "any stigma that directly threatens or undermines a self-schema is likely to have a pervasive impact on the self concept" (139).

"The human suffering of some illnesses may be in the form of discrimination, stigma, damaged self-concept, and social ostracism," writes Brown (1998:310), which speaks strongly to the case of transsexualism. Indeed, it has been argued that much of the psychological problems associated with Gender Identity Disorder (GID) are not etiologically related to the disorder itself

but rather to the consequential alienation, isolation, and marginalization from mainstream society which many transsexuals experience on an ongoing basis (see DSM debate to follow below for more details). Because transsexuals are often, to reiterate Goffman's concept of stigma, "devalued" or "shunned" socially, their stigmatizing condition becomes their "master status" and perpetuates their long-lasting suffering (Brown 1998:310). Moreover, social stress such as suffering from stigma, as Brown argues, "is a serious cause of illness" because it emphasizes the "interconnectedness of physical, psychological and social aspects of an individual" (Brown 1998:184). Transgender health specialists Bockting and Ehrbar confirm the notion that suffering from the disorder and suffering from its social repercussions are two different but related entities. "Gender dysphoria" they note, "can be alleviated with available treatment, whether or not this involves hormones or surgery. Social stigma and discrimination, an ongoing source of distress, will take longer to confront" (2005: 128).

Scheper-Hughes and Lock argue that "the societal and cultural response to disease create a second illness in addition to the original affliction, what we are calling the 'double': the layers of stigma, rejection, fear, and exclusion that attach to particularly dreaded diseases" (1986:137). They further note that "much sickness in modern society is *sociogenic*, caused by stresses and strains..." (1986:139). What I intend to show in the chapters that follow, is strongly oriented towards a sociogenesis of suffering, especially as the chronicity of GID is inextricably tied to social histories of patients which constitute the interface of living with it. The kind of "suffering from personal histories of profound social rejection" (35) that Scheper-Hughes, in her own work on mental illness (2001) has termed a double of "social dis-ease" (36), not only became apparent in my own work, but overshadowed any notion or reminder that I was working with a so-called psychiatric population for which the distress suffered was for a long time seen as intrinsic. Meyer

adds minority stress to that 'double' and notes that "minority stresses arise not only from negative events, but from the totality of the minority person's experience in dominant society" (1995:39) and Markowitz remarks that "labeling and stigma indirectly leads to sustained illness" (1989:335). For mental health specialists working with transsexuals, and especially those working with gender variant children, social stigma complicates a differential diagnosis of gender identity disorder "because it usually is not clear whether distress in the child is due to gender variance or secondary effects (e.g. due to ostracism or stigmatization)" (Hill et.al 2007:67). In other words, "it is questionable as to whether these youths are suffering because of their gender dysphoria or because of social stigma..." (71) Nonetheless, social stigmatization has received relatively little consideration in the treatment process in the past, as suffering from transsexual stigma, much like suffering from racial stigma, is considered an insufficient cause for classification as a legitimate disorder in the DSM (Bockting and Ehrbar 2005).

But what exactly constitutes suffering, individual or social in nature? Frank (1995), drawing on Cassell, writes, "suffering involves whole persons and thus 'requires a rejection of the historical dualism of mind and body'. The subject who suffers is, in Kleinman's phrase, a body-self". Further, "suffering take place when a 'state of severe distress...threaten[s] the intactness of person'"(169), "'suffering can occur in relation to any aspect of the person'" and that another condition of suffering is its "social nature" (170). The multiplicity of forms of suffering individuals or social groups experience can only be illuminated through closely examining subjective narratives which re-call, recount, and make intelligible those experiences especially while they are ongoing. And while such stories about suffering may appear conclusive or bracketed by time, they are also multifaceted and remain open to interpretation. "Stories of suffering have two sides" writes Frank, "one side, reflecting Cassell's emphases, expresses the

threat of disintegration” while the other side “seeks a new integration of body-self” (171). This integrative quest for body and self, rather than body and mind, I will show, constitutes the very domain in which the processes of genital reassignment surgery are rationalized and reflected on far beyond their medical realities.

Illness Narratives and Explanatory Models: The Patient Point of View

Collecting Illness narratives, or qualitative patient accounts of their interpretation, verbalization, articulation, or illustration of illness experiences is a common practice for medical anthropologists. “The illness narrative” notes Kleinman (1988) “is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narratives are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings ” (49). This underlines the importance of ethnographic approaches to medicalized social problems. Amongst other methods, Kleinman praises ethnography as a way to grasp “the complex inner language of hurt, desperation, and moral pain (and also triumph) of living an illness” (1988:28-29). In the context of chronic disorders, Kleinman notes that “the illness becomes embodied in a particular life trajectory, environed in a concrete life world” (31). The illness narratives in this dissertation, however, do not focus so much on individual experiences and thoughts about transsexualism or identity, but also incorporate and comment on the distinctly social aspects of living with it. In that sense, transsexual illness narratives are social illness narratives, even before “coming out” or transitioning because so much of the social stigma pertaining to transsexualism has been

internalized and has thus shaped the experience of being trans even before this became a clinical or social reality for GRS patients.

As I will show in the following chapters, how patients perceive their suffering and how clinical discourse frames it can differ significantly, although, as Conrad has suggested, patients are well aware of, and incorporate the clinical discourse into their own explanatory models (EMs) of illness. “Explanatory Models” explains Kleinman (1980) “are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” which can “cast personal and social meaning on the experience of sickness” (105) (see also Kleinman 1988:122). And although “Patients are often cautious to explain their own versions of what causes their suffering as they fear ridicule or embarrassment and do not feel taken seriously” in this case patients explanatory models are not only similar to, but have actually given shape to the first clinical notions of transsexualism in the first place. Further, Kleinman notes “Vagueness, multiplicity of meanings, frequent changes, and lack of sharp boundaries between ideas and experiences are characteristic of lay EMs” (107) which again illustrates the difficulty of describing a basic problem in social living and adjustment as clinical or medical. Nonetheless, transsexual patient accounts of what it is that ails them evince distinct similarities informed by much of the shared language between clinicians and patients which Kleinman reiterates by stating that “The metaphors used to articulate both patient and practitioner EMs disclose substantial cultural patterning” (107).

The classic explanatory model for transsexuals has been the metaphoric expression of feeling “trapped in the wrong body” which has been reiterated so often that it has been adopted into standard clinical discourse on GID. But today, some transgender identified people, and some of my own younger participants have begun to reject the metaphor because they do not feel this

describes their own experience with transsexual lives or bodies (see chapter 5). This rejection is also politically motivated as it focuses attention on the rigid maintenance of gender boundaries and categories which do not allow for men with vaginas or women with penises from which ideas about “wrong bodies” emanate in the first place. How then to solve, or to declare solved, a problem which is so complex that it has no known biomedical etiology and yet is socially experienced so harshly that medical explanations about its origins would contribute little to ease its discomfort? How can medicine cure an illness it cannot account for or comprehend in its full “symptomatology”?

Curing vs. Healing: Therapeutic Efficacy of Biomedical Approaches to Social Problems

“Curing” vs. “Healing” rationales in particular provide a key insight into what the process of reassignment means for GRS patients as it illuminates Frank’s notion that “The healing may not cure the body, but it does remedy the loss of body-self intactness that Cassell identifies with suffering.” (1995:183). Kleinman notes that healing refers to two different clinical tasks: the literal “curing of disease”, the “effective control of disordered biological and psychological processes”, and the “provision of personal and social meaning for the life problems created by sickness” which he refers to as “healing the illness” (1980:82). Kleinman adds that therapeutic procedures may also “heal social stress” (82). The semantic disjuncture between “curing” and “healing” is a very fine line medical health providers walk in regards to GID; since so few medical or psychological studies or accounts claim that transsexuals are explicitly “cured” after any kind of medical treatment, this question looms rather large on my analytical horizon. Kleinman reiterates my sentiment in that “...patient and practitioner evaluations of outcomes are often divergent” (305) because after each step of the transition process (coming out, therapy,

hormones, surgery), some kind of improvement has been noted in the literature. And while I am not questioning the merit of each step in improving how patients feel after submitting to it, I take words like “cure” to mean more than better than without treatment. “Illness and care” adds Kleinman, “are articulated in the idiom of the popular culture. That idiom draws on somatic, sociologic, cosmologic, moralistic, and naturalistic terminology” (308).

Thus, notions of cure and healing are not synonyms, and this is particularly true for illnesses such as GID. As Kleinman asked about healing “what role do cultural factors play in bringing about that efficacy?” (311). How can an individual said to be cured of her medical problem if her social problems which she incurred *because* of the illness, remain even if the “disorder” or “disease” subsides or is eliminated completely? Kleinman adds that “Problems in clinical care seem to arise when the practitioner is concerned only with ‘curing’ the disease, and the patient is searching for ‘healing ‘ the illness” (355). While a central symptom of GID, namely body dysphoria, appears to be cured through GRS, ‘healing’ from living with transsexualism, or as a transsexual person, means something quite different which biomedicine can not address because “By reducing healing to the language of biology, the human aspects (i.e. psychosocial and cultural significance) of healing are removed, leaving behind something that can be expressed in biomedical terms, but can hardly be called healing” (364).

What then should constitute a successful treatment in therapeutic terms for transsexual patients? Csordas and Kleinman have pointed out, treatment outcomes are “invariably linked to cultural context and the meaning attributed to therapeutic change” (1996:9). Further, they note that “the therapeutic process cannot be understood as bounded by the therapeutic event precisely because it is ultimately directed at life beyond the event” (Csordas and Kleinman 1996:19-20) and Monstrey et al. note that conditions for surgical intervention prescribe that surgery “*must*

have a therapeutic effect” (2007: 95, italics in original). As Kleinman notes in cases of “illness without disease”, therapeutic responses may follow “upon removal of the psychosocial stressor” and subsequent lessening of anxiety (366), and that therapeutic effects can frequently occur at the social level (371). This idea of healing at the social level seems much more fitting for transsexuals who experience increased acceptance, regardless of surgical status, over time. Indeed, I felt that what caused great distress, if not the greatest distress patients suffered, occurred at the social level in the first place: the loss of work collegiality, shared resources, family members, lovers, friends, and social group belonging constitutes an enormous social stressor before, after, and throughout transition. Social healing, or the restoration or revitalization of social lives and relationships, the reintegration into everyday affairs, as well as the sense that one is once again a social being seems entirely removed from biomedical agendas after any physical treatment process concludes. “Technological intervention may ameliorate or even cure the disease but not the illness” adds Kleinman (1988). But “to treat illness the healer must dare to meet the patient in a messy, confusing, always special context of lived experience” (206). This aspect is unfortunately lacking in most physician-patient interactive contexts as the physician’s responsibility for the patient ends as soon as treatment has concluded, with the exception of long-term follow-up studies which are voluntarily conducted and not always insightful into the patients’ ‘real’ life. But should a physician’s concern for the well-being of their patients really end when their treatment does? More importantly, should physicians only concern themselves with the corporeal state of the patient which allows far too many doctors to shrug off emotional suffering patients might experience? I align here strongly with Kleinman’s statement that “There is a moral core to healing in all societies that I take to be the central purpose of medicine” (253).

The difference between easing suffering and delivering a cure, as Emily Martin sees it, rests on a cure implying healing, “and healing would have to address not just people’s experience, crucial as that is. Healing would have to address the strong but not invincible barriers to our ability to flourish, as individuals and as part of collectivities” (2007:279). And what Arthur Frank (1995) terms “medicine’s single-minded telos of cure” is precisely what makes transsexualism difficult to fit into biomedical models and why, in particular, Parson’s “sick role” (1951) does not necessarily conclude with GRS as the ultimate or final treatment. “The temporarily broken-down body becomes ‘it’ to be cured. Thus the self is *dissociated* from the body” (85) and once “the body is broken down into discrete parts, any part can be fixed” (86). But Frank also acknowledges that illness is sometimes lived outside of medical purview and what he calls “living a life of overwhelming trouble and suffering” from which he concludes that “Society prefers medical diagnoses that admit treatment, not social diagnoses that require massive change in the premises of what that social body includes as parts of itself”(113). What ultimately constitutes a “cure” or “healing” of GID depends, again, and always on what exactly is addressed in such an attempt. But when the very definition and classification of the problem can be questioned, the distinction between the two becomes all the more salient.

The Problem of Distress in Biomedicine and the Life-World: The Current DSM Debate

The current debates surrounding the revision of GID in the forthcoming DSM-V (2012) held amongst varying members of the task force for the revision strongly support my argument that the psychological stress experienced in association with transsexualism is sociogenic (see also Winters’ 2008 book-length discussion). My position on what constitutes psychological stress and suffering in transsexuals reiterates that it is not solely or even primarily the intrinsic distress of

GID, but rather the social stigma transsexuals experience on an ongoing basis. While I am aligned with the notion that gender variance or non-conformity is not in and of itself a psychopathology, I propose that it is the social stigma, both internalized and experienced, which constitutes clinical impairment and distress. As Knudson et al. (2010) state:

The issue of distress is central to the debate on whether the diagnoses belong in the DSM. According to the DSM-IV-TR definition of a mental disorder, this distress needs to be inherent rather than due to social stigma because ‘neither deviant behavior nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in individual.’ (57)

This sentiment of the official DSM rationale for what constitutes distress has been already been questioned (Spitzer and Wakefield 1999) but stigma is commonly acknowledged as constituting the main source of extrinsic stress endured. Ehrbar (2010) writes:

One of the fundamental concerns is that the diagnosis solidifies and reinforces existing stigma against transpeople by implying that transpeople are inherently mentally disordered (e.g., Hill et al., 2005; Lev, 2005; Morrow and Messinger, 2006; Winters, 2005). The concern about stigmatization is heightened by current DSM GID diagnostic criteria (i.e., “belief that he or she was born the wrong sex”; APA, 2000, p. 581), which seem to imply that transgender people retain the diagnosis of GID even after successful transition and resolution of gender dysphoria. That is, this criterion implies the ongoing gender identity of transpeople constitutes a mental disorder regardless of whether or not they are experiencing any gender dysphoria, distress, or impairment. Hill et al. (2005), Lev (2005), and Winters (2005) also suggest that the distress and impairment transpeople face is not a result of their gender identity, but a result of social stigma that the distress in some ways “belongs” to the people interacting with the transperson rather than the transperson. Thus, they argue that the diagnosis violates the DSM’s own definition of a mental disorder. Specifically, “neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual” (APA, 2000, p. xxxi). Advocates for removal of GID argue that the diagnosis reflects exactly this conflict between trans-individuals and society’s rejection of their identity, and that trans-identity is not a “dysfunction in the individual” but simply a matter of diversity (e.g., Hill et al. 2005; Lev 2005; Morrow and Messinger 2006; Winters 2005). (62)

Ehrbar also notes that internalized stigma is widely acknowledged to add to the psychological burden of living with GID. However, like racism, or sexism, “discrimination and internalized stigma are conceptualized as social issues rather than mental disorders” (63).

As to the stigma of being diagnosed with a mental disorder, “Advocates for retention of a diagnosis recognize that in our society having a mental health diagnosis is stigmatizing” adds Ehrbar, but they “do not see this stigma, per se, as a reason not to have a diagnosis” (65).

Advocates for retention of a GID diagnosis agree that “if transgender clients only suffered from social stigma, it would be clearly inappropriate to have a diagnostic category based on gender identity” (Bockting and Ehrbar 2005:129). However, while social stigma is acknowledged by mental health care professionals as a legitimate source of distress, some insist on gender dysphoria as the primary stressor and impetus of diagnosis: “The distress inherent in gender dysphoria is real, and is not simply a manifestation of social pressure. This distress justifies a diagnostic category” (129). Ehrbar concludes:

Across work groups, members of the WPATH consensus process converged upon recommending that GID be revised to focus on gender dysphoria rather than gender identity. In this proposal the object of diagnosis is clarified as distress rather than difference. [] Using a gender dysphoria-based diagnosis rather than a gender identity-based diagnosis would allow for an appropriate diagnosis for those who experience gender dysphoria, without implying that all transgender, transsexual, or gender variant people need or qualify for a diagnosis. Nor would the diagnosis imply that trans-identities are pathological. [] Advocates for reform hope that a revised diagnosis focusing on gender dysphoria rather than gender identity or gender nonconformity will diminish stigma, while preserving a diagnostic category (only) for those who need it. This revision may help counter stigma as instead of identity (something fundamental to a person throughout the lifespan), the diagnosis would highlight gender dysphoria, which is not something inherent to all transpeople throughout their lives. (71)

Haraldsen et al. (77:2010) similarly remark that “While we do not see either the identities or gender expressions of transgender and gender variant people as inherently pathological, we recognize that the gender dysphoria often experienced by transgender and gender variant people

can cause significant distress and impairment in function.” And aligned with the medical anthropological tenets proposed earlier, Haraldsen et al. note that “The premise at the root of the disorder is not within the core identity of the individual but rather is the conflict among identity, anatomy, and social role” (77). Fraser et al. (2010) echo this sentiment by reiterating that “we propose changing the diagnosis to one based on distress, rather than the current diagnosis based on identity. A transgender identity or gender variant expression is not a pathology; rather, it is the distress that is the psychological problem” (83).

Bouman et al. (2010) reiterate the critical question “Is distress (Criterion D) inherent, a result of social stigma (minority stress), or both? What are the implications of the answer for the diagnosis?” and they note that it is important “to recognize both that much of the distress experienced by gender dysphoric individuals comes from social stigma rather than simply from the inherent condition of gender variance and that not all distress is meaningful for diagnostic purposes”. However, they “recognize that this distress is bidirectional between the individual and the individual’s social situation and not easily differentiated” (103). Still they note that “Social distress is not located in the individual, though it may affect the individual” (103) and that “transpeople may function well socially or occupationally, but still experience intrapsychic distress” (105). Corneil et al (2010) have commented on just one aspect of social stigma trans people face. “Marginalization of the transgender person” they write, “has been shown to increase their risk of suicide. Xavier, Hannold, Bradford, and Simmons, (2007) found that among 350 transgender study participants in Virginia, USA, nearly two-thirds (65%) of participants reported ever having thoughts of killing themselves, including 79% of female-to-male (FtM) and 58% of male-to-female (MtF) persons” (109-110).

In conclusion, the consensus statement of Knudsen et al. (2010) representing the WPATH task force reads as follows:

The consensus group did agree that gender variance is not in and of itself reflective of pathology and having a cross- or transgender identity is not a psychiatric disorder. Therefore, any gender-related disorder should represent distress—not identity—and the psychiatric consequences of this distress (116)

However, one last issue, which appears problematic, in my assessment is the notion of an “exit clause” or an “in remission” specifier for GID which denotes that individuals who have undergone successful treatment for GID no longer suffer from it, once the dysphoria has diminished (118). The proposed “exit clause” fits the biomedical model well; nonetheless, it does not address social problems, which linger after transition and/or treatment has concluded, successfully or not.

Outside of the DSM Task force, there are divided opinions on the benefit of receiving a diagnosis of GID compared to the costs of suffering the social stigma attached to it. Renowned gender scholar Judith Butler notes that “To be diagnosed with gender identity disorder (GID) is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all” (2004:76, see also Levi and Klein in Currah et al. 2006 on the stigma of transsexualism as a disability, and Ettner 1999:9, on transsexualism as excluded from the Americans with Disability Act). Others see the diagnosis as “a dubious benefit that only a few receive but for which the entire population of transgender people pays the price: the social stigma that results from this labeling of transgender as a mental illness though the existence and use of this diagnosis” (Samos 2009: xxvi). Even transsexuals have remarked how the diagnosis itself has added stigma to their condition. “I was cured of the

original ‘disease, ’” writes Christine Burns, “Now I was suffering from the residual stigma of it being dubbed a ‘disease’ in the first place” (2003:199).

The Problem with Follow-up Studies

Although studies on post-surgical adjustment generally claim a high success rate of GRS (Olsson and Moeller 2006; Green and Fleming 1990), many of these studies’ evaluative criteria have been criticized as being too objective, arbitrary, or biased (Lawrence 2003, Fleming et al. 1980). “There is...a growing consensus that subjective, criteria (i.e. patient’s self reported satisfaction or regret) may provide a more meaningful basis for evaluating GRS outcomes than the use of so-called objective criteria such as employment, choice of ‘appropriate’ sexual partners, or utilization of psychiatric services” (Lawrence 2003:2). Person-centered accounts of transsexuals’ experiences of not only post-surgical adjustment, but also the surgical process itself, have not been explored in detail, perhaps with the exception of Griggs (2004). This is a critical oversight because GRS is a key element in gender transition, which contributes significantly to gender identity management in transsexuals. Although GRS has been justified by psychologists, critiqued by feminists, executed by surgeons, and narrated by transsexuals autobiographically, no researcher has actually documented the process in situ, ethnographically. Contrasting the patient experience with the practitioner’s perspective simultaneously, Chrisman and Marezki, speaking to my point above, note that, “ethnographic exploration of the role of treatment institutions, and within each clinic, the specific role of health care staff, was considered even before Goffman’s classic 1961 publication as an important area for anthropological investigation ... ” (Chrisman and Marezki 1982:5).

The overall “success” of a person’s transition from one gender to the other, beginning with psychological evaluations and culminating in GRS, is assessed through post-surgical surveys and interviews with former patients. A meta-analysis and comparative overview of over 70 post-surgical assessments done by Pfaefflin and Junge (1991) show a relatively high rate of patient satisfaction overall. However, a closer look at these assessments reveals significant methodological flaws in almost every study examined, due to a lack of standardization of evaluative criteria¹¹. For instance, as Hill et al. note, “little is known [about post-surgical outcomes] because of a wide range of serious limits on this kind of study, including drop-out rates typically around 50%” (Hill et.al.2007:68). A significant number of studies only focus on patient satisfaction with aesthetic surgical results and the “functionality” of genitalia. Very few studies focus explicitly on life-world concerns such as improvement of social relationships and social acceptance of patients in their new gender role or identity, and the interpretation of social improvement rates after GRS is ambiguous at best.

For example, Stein et al. (1990) report no significant changes in parental support and friends, Pfaefflin and Junge (1990) report worsening of professional and social relations (1990), Lindemalm et al. (1986) report a high rate of unsuccessful post-surgical social adaptation, Simona-Politta (1983) reports that satisfaction with social relationships was unchanged for over half of the patient sample, Lohstein (1980) reports that only 65% of patients showed improvements in social areas, and one study by Hoening et al. (1971) concluded that the operation has not helped patients cope with their transsexual status. Rehman et al. (1999) found that some MtFs were disappointed because of “difficulties experienced postoperatively in

¹¹ See for example Meyer and Reter (1979) as being most heavily critiqued for methodological flaws

adjusting satisfactorily as women both in their relationships with men and in living their lives generally as women” (71) and that some believed that “having the surgery [would] wipe away the hostile anxiety that society exhibits towards them” (85). Roberto (1983) reiterates the reality of lasting social stigma and other problems remaining after surgery, Johnson and Hunt (1990) locate consistently poorer social adjustment within autogynephilic transsexuals, and Bodlund et al. (1996) notes that MtFs have poorer social integration due to lack of social support in general.

Because social issues associated with GID may not be resolved through surgery, some assessments emphasize that GRS is not a ‘cure’ for transsexualism (Cole et al. 1997). Snaith et al. (1993) cite “a continued sense of isolation” as the main cause for transsexuals’ unhappiness after surgery and they conclude that, “while gender reassignment will probably improve the distress of the incongruent self-perception of gender, it does not solve life’s problems” (682). Rauchfleisch et al. (1998) found comparable results in their study in which the social situations have “significantly worsened” for MfFs. Zimmerman et al. (2006) evaluated the overall life satisfaction of transsexuals post-surgery and found that although the subjective well being of the patient had improved, their social life had not. Most importantly, none of these studies explicitly claim that the patient’s gender identity disorder, or transsexual status, has been eliminated or resolved, and some question the validity of transsexuals’ self-assessments of social improvements (Smith et. al 2004). So while it can be summarized that GRS can confer personal gains in terms of mind-body alignment, these do not necessarily translate to societal acceptance of transsexuals as men and women.

Recent attitude studies about transsexuals from across the globe confirm this notion. For example, Landen et al (2000) found that Swedish attitudes toward GRS are generally quite positive but only 43% would support transsexuals in their new parenting role. Winter et al.

(2008) studied transphobic attitudes in Hong Kong and found that trans-unnaturalness (in reference to the fixity of biological sex) achieved the highest mean scores on Hill and Willoughby's transphobia scale. Polat et al. (2005) looked at Turkish families of transsexuals and found the social stigma and shame associated with having a transsexual in the family profoundly apparent. Antoszewski et al. (2007) assessed Polish college student's attitudes about transsexuals and found that less than two thirds supported GRS as well as hormonal treatments for patients. In the U.S. a handful of attitude studies about transsexuals have been conducted (Green et al.1966, Leitenberg and Lesley 1983, Harvey 2002) which, while not necessarily representative of the whole population, evince an increasing trend of acceptance of transsexuals. However, even if, for example, two thirds of the general population finds transsexualism acceptable, only one third would support the notion of health care coverage of GRS (Harvey 2002). Furthermore, the more closely individuals have to interact with transsexuals, for instance in the workplace, the less acceptance persists; Harvey (2002) found that attitudes towards coworkers or colleagues are at best "neutral", especially when males are concerned. What most of these and other studies have in common, despite being conducted within cultures quite different from each other, is a shared and persistent cultural stigma toward transsexuals rooted in the underlying cultural belief of both sex and gender as fixed properties of social organization. The most interesting aspect of attitude studies on transsexuals however, is their comparative value to follow-up studies; how, one could ask, is it possible that post-operative studies claim high levels of "success" when these evidently clash with low levels of social acceptance in attitude studies?

Stigma beyond Social Attitudes: The Structural Reality of Stigmatization

Many health professionals working with transsexuals have acknowledged the wide-reaching correlations of transsexual stigma to prejudice, discrimination, oppression, social isolation, and violence (Istar-Lev 2004; Leli and Drescher 2004; Mallon 1999; Ettner 1999; Israel and Tarver 1997). “Social stigmatization is pivotal in transgenders’ historical risk structures” note Bockting and Kirk (2001:25) which is why “aside from validating the diagnosis and assisting in finding appropriate resources for transition, the main work of the therapist is helping the gender variant patient cope with the past and present psychological consequences of social stigma” (Seil 2004:116). But the health care literature maintains an ambiguous position whether transsexuals suffer primarily from GID or from the social stigma attached it, or how much of their suffering is attributable to either (Rudacille 2005). Monstrey et al. reiterate this point by remarking that some people “question whether transsexualism is a medical condition or a social problem – that is, a reflection of narrow, socially constructed binaries” (2007:91). Still, social stigmatization receives relatively little consideration in the diagnostic and treatment process, as suffering from transsexual stigma is considered an insufficient cause for classification as a legitimate disorder in the DSM (Bockting and Ehrbar 2005).

“In contemporary societies, the predominant attitudes toward gender-variant individuals are ridicule, disdain, and outright contempt, with few exceptions” writes Ettner; “Shunned and ostracized, these individuals are the only group that it is still politically correct to openly mock.” (1999:9). Brown and Rounsley note that negative societal attitudes toward the decision to undergo gender transition including GRS often center on derangement (“you must be crazy”) or denial of authenticity (“you’ll never be real”) (1996: 214). Other research on societal attitudes toward transsexuals shows that these are more complicated than what Ettner and Brown and Rounsley suggest. For example, the findings of a Swedish survey on attitudes towards

transsexuals show that only 22% of survey participants considered transsexualism to be a treatable disease although since 1972, GRS has been covered under national health care in Sweden. Further, 60% would have a transsexual as a friend, but 84% would not want to have a transsexual partner (Heath 2006:13). Even if Sweden is one of the most accepting countries of transsexuals, this research reveals that only one of five people believe that transsexuals can be cured, only 3 out of 5 people would integrate transsexuals into their social lives, and less than one out of five people would engage in a love relationship with a transsexual. Perhaps the most important — and obvious — point is that *knowledge* about whether a person is transsexual or not matters in people’s social lives. It is this knowledge of transsexuals having a social and embodied past, a previous life in gender and body different from the one currently embodied, which is why stigma directed at transsexuals is so persistent. This is to say that even individuals who have never met a particular transsexual individual in person can engage in stigmatization based on knowledge of the person’s transsexual status if they have the institutional or structural power to do so.

The 2009 *National Transgender Discrimination Survey* which examined the current situation of 6,450 transgender people in the United States begins with this statement: “Transgender people are targets of discrimination in many areas of their lives; this marginalization exposes them to tremendous social and economic insecurity” (National Center for Transgender Equality and the National Gay and Lesbian Task Force). Similarly, a 2010 report on health and health care access by the same organizations opens with “Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people”. Although health care is generally denied to many people living in the U.S., transgender individuals are often denied care on the basis of identity. These and many similar

reports document clear evidence that transgender individuals occupy a socio-cultural minority status in the U.S. and experience severe social disadvantages individually and collectively on an ongoing basis (Lombardi et al. 2001).

Structural stigmatization directed against transsexuals has a long public record in U.S history. Transgender activist and historian Susan Stryker notes that from anti-cross-dressing laws issued in San Francisco in 1863 to the most recent Employment Non-Discrimination Act (ENDA) exclusion of gender expression or diversity, systematic exclusion or restricted access to economic, political, legal, medical, and social resources has been a struggle for transsexual individuals (Stryker 2008). Elsewhere in the world, structural stigmatization directed against sexual and gendered minorities has also been amply documented. Many anthropologists conducting research on third gender or gender-variant individuals have pointed out that “Although third gender people are generally revered, they often suffer similar levels of prejudice to that endured by transsexed and transgender people in Western Societies” (Heath 2006:9). Serena Nanda adds that “Idealization distorts the ethnographic record however, when it assumes, inaccurately, that sex/gender variation in non-Western or non-industrialized societies is always highly valued and that gender non-conformists are not marginalized, stigmatized, or discriminated against” (2000:4). Structural stigmatization of minority groups and its cultural consequences has been recognized as an important aspect of perpetual suffering by many anthropologists invested in studies of culture and illness (Reddy 2005).

A major structural barrier which transsexuals as a minority group share with ethnic or economically disadvantaged minorities is access to adequate housing and employment. “Housing and employment discrimination against transgender people are still legal in most places in the United States,” writes Stryker, “and this discrimination was even more common in the past than

it is now¹²,” (2006:66). Applicants for rental housing are often turned away by landlords based on their transsexual status; transsexuals are often left with no choice but to accept housing in poverty stricken, unsafe neighborhoods, which increases their vulnerability for interpersonal violence. Further, many transsexuals lose their jobs as a result of transition, are paid less than before transition, are financially exploited, are excluded from prestigious or high profile positions, have difficulty finding work, or experience limitations in job promotions. Conversely, gender transition is a prohibitively expensive endeavor. The cost for MtF transsexuals, including electrolysis, hormone replacement therapy, genital reassignment surgery, and any additional surgeries can total up to \$50,000-100,000. Since insurance companies often do not cover many gender-transition services, the financial burden of paying for high costs of gender transition on low-income jobs is often overwhelming transsexuals’ financial capacities.

Legally, transsexuals experience very high levels of stigmatization. Transgender rights activists have noted that although state laws differ, most transsexuals can not marry, consistently lose custody battles over children in divorce cases, have trouble changing their names and genders on legal documents, have almost no incarceration rights, are criminalized more often than non-transsexuals, and are generally not legally recognized as/in their chosen gender (Currah et al.2006). Blatant hostility to gender recognition and respect for individual’s gender as a choice often results in unfair criminal trials in which perpetrators of violence do not receive the same punishments as they would in crimes committed against non-transsexuals. Transsexuals have very little legal recourse to contest job dismissals or firings, discrimination based exclusions, or any other type of prejudice based legal actions taken against them. Although some of the above

¹² See also Stryker 2006:78 on transgender women being disproportionately affected by denials of employment and housing based on visual perception of a transgendered status when compared to transgender men.

aspects are slowly changing, legal obstacles based on transsexuals' stigmatized social status are often "a source of terrible disempowerment and loss;" (Currah et al. 2006: xix) and transsexual and transgender civil rights struggles are likely to continue for decades to come.

Politically, few transgender individuals and organizations have acquired significant legislative power to affect social, economic, or legal changes for transsexuals. Although gay and lesbian organizations are commonly thought to share an activist agenda with transgender individuals who have always been at least peripherally involved with such organizations, the emerging animosity between transsexual women and lesbian and/or feminist organizations in the 1970s added yet another exclusionary barrier to transgender pathways of political activism. In 1972, transsexual lesbian feminist organizer Beth Elliot "was ousted from the Daughters of Bilitis, not because of any accusations against her, but on the grounds that she wasn't 'really' a woman" (Stryker 2006:103), and in 1977 Sandy Stone was forced to resign from the women-only record label *Olivia Records* on the very same grounds (105). Shortly following these events, feminists nationwide began anti-transsexual campaigns fired up by overtly transphobic publications by feminist authors such as Mary Daly and her doctoral student Janice Raymond¹³ (Raymond later became notorious for producing the most anti-transsexual literary work ever written entitled *The Transsexual Empire: The Making of the She-Male*, 1979). Even some twenty years later, transsexual or transgender women are still excluded from cultural events such as the Michigan Womyn's Music Festival, evident in the expulsion of Nancy Jean Burkholder from the festival grounds (140). Although some transgender activists have long divorced themselves from

¹³ Raymond went as far as claiming that transsexual women infiltrating women-only spaces "rape" women not by force but by deception (See Stryker 2006:106 for an extended discussion).

sharing a political platform with gays and lesbians, transsexual politics are invariably subsumed in LGBT politics even if the “T” in LGBT is oftentimes ignored in political campaigns.

Another major area in which transsexuals experience extreme barriers to resource access based on structural stigma is health care. Health care services and treatments for transsexuals are oftentimes not covered by insurance companies as these are deemed “experimental,” “cosmetic” or “elective”. In addition, Hale (2007) has discussed the gatekeeping function of mental health care providers as an ethical conundrum at odds with accessing trans-related medical needs.

Further, many transsexual individuals experience additional discrimination based on their stigmatizing status even when their medical needs are not related to transsexualism. As Stryker notes:

Poor access to healthcare services due to poverty, stigma, and social isolation, as well as additional barriers created by the fear many transgender people have of disclosing their transgender status to healthcare providers (which could potentially re-expose them to social vulnerability they had worked hard to overcome) only served to compound the problem (2006:114).

Medical neglect of transsexual health care needs based on their stigmatized status is rapidly becoming apparent and many transsexuals have experienced maltreatment at the hands of medical providers. The most well known case of Robert Eads, a transsexual man who ironically died of ovarian cancer due to denial of services, sadly illustrates how quickly the Hippocratic oath “do no harm” can be perverted in the name of social normativity. Similarly, structural stigma has been directly linked to impeding important medical research on transsexual health including sexuality. For instance, up until recently, female-to-male transsexuals who identified as gay men were invisible in HIV prevention studies – homosexual transsexuals were thought not to

exist. When gay transgender activist Lou Sullivan contracted and eventually died of AIDS¹⁴, he considered writing “You told me I couldn’t live as a gay man, but now I am going to die like one” to the Stanford gender dysphoria program (Stryker 2006:120).

Transsexuals, being denied adequate housing, employment, legal rights, a political voice, and health care, are at a much higher risk for poverty and consequential health problems as a result of stigmatization than almost any other minority in the United States. Taken together, the consequences of the structural stigma transsexuals experience on an ongoing basis can marginalize transsexuals so severely from mainstream society that many transsexuals consider, attempt, and sadly often succeed in taking their own lives.

Summary: Medical vs. Cultural Perspectives on Transsexualism

Contrasting the medical perspective on GRS (changing physical aspects of sex) with the socio-cultural perspective on transsexualism (changing social aspects of gender) illuminates the problematic disjuncture between individual perceptions of self and societal perceptions of the individual. Maintaining a critical perspective on the social gains of GRS is key to investigating what the surgery ultimately accomplishes for transsexuals because GRS as a therapeutic, healing function should ideally reach beyond its clinical context, and beyond a bound, therapeutic event. In other words, GRS should not be seen as an end itself, but rather as means to an end, in this case, the desired integration of the individual as a man or woman into his or her culture or society. While theoretical biomedical rationales presume that GRS makes this possible, some post-surgical studies, and some socio-cultural perspectives such as those expressed by transsexual women themselves provide a substantial indication that this may not be the case.

¹⁴ Transsexuals suffer one of the highest HIV infection rates in the world (Stryker 2006).

Thus, without collecting ethnographic data on what kinds of social benefits transsexuals ultimately hope to gain from GRS, rationales on genital reassignment and its therapeutic effects on the individual's social life remain theoretical or hypothetical in nature, and cannot illuminate the condition of GID and its proposed solution in-depth. As I have tried to illustrate above, and will show throughout this work, considering transsexualism as a persistent social problem based on structural as well as interpersonal stigmatization requires the evaluation of its medical solution within and not outside of these particular socio-cultural contexts.

What I wanted to accomplish with this ethnography is thus to focus on the expected or desired social gains of GRS patients even though the surgical process of reassignment remains focused on individual gains. Through patients' perspectives on the pathologizing biomedical model of GID, its diagnostic processes, its treatment, and its anticipated cure or resolution, I hope to show that because transsexualism remains a profoundly social problem in nature, medical intervention must be evaluated against social, and not just individual gains obtained through the process. And although it could be argued that clearly GRS ethically follows the general goal of medicine to alleviate individual troubles with feeling trapped in the 'wrong' body, I ask what social troubles can be alleviated if individuals remain trapped in transsexual bodies?

Chapter 2: Research Methods, Data Analysis, and Patient Demographics

The Research Context

GRS as a Research Topic

After my initial visit to Trinidad with a friend who was undergoing GRS in 2005 during which I had a chance to meet Dr. Marci Bowers, Carol Cometto, and the hospital staff of Mount San Rafael, I decided to conduct my fieldwork here, seduced by the hyperbolic notion of the “Sex Change Capital of the World” (Brady 2006). My status as a patient’s support person as well as potential future researcher provided me with a unique opportunity to observe minute details in patient/staff interaction related to hospital routines, surgery preparations procedures, and recovery care. During my ten-day visit, I was also able to become familiar with the hospital setting, hospital staff and the surgeon in residence (Dr. Bowers), patient care, and everyday operations of Mount St. Rafael.

For a researcher interested in learning about genital reassignment, the most logical place is to go where this is actually practiced. I figured that logistically, living and doing research in Trinidad was highly conducive to accessing patients as they were going through the surgical process of genital reassignment. This temporal nature of connecting people to places was a bit unusual for ethnographic fieldwork, as normally, ethnographers are the ones who are the temporary visitors while the people they study occupy the field site more or less permanently. But in Trinidad, I was the one who saw all of my participants come and go within a timespan of about 7 to 10 days.

Furthermore, I felt that my sample of 50 participants would be geographically representative of the entire country as people travel to Trinidad from all over the United States, rather than focusing on only one geographic area. And although the geographic distribution was

slightly tipped in favor of relatively close places (such as Colorado and Texas), some people came from places as far as Hawaii. Finally, I wanted to look at the clinical context of GRS and how this informed people's experience with undergoing such a highly emotional and personal procedure. I wanted to provide a complementary account to follow-up studies of GRS which focus only on outcomes without a direct, one-on-one comparison of what people invested and expected to get out of the surgery. I also wanted to take advantage of patients' heightened state of awareness of their bodily and psychological states as they processed the surgery. As many researchers have lamented before, people's memory becomes more selective over time and I did not want to work with secondary accounts of how patients experienced the surgery - I wanted to be there to see it for myself. Although I declined the offer to actually watch the surgery itself (as to not add any more stress on patients or surgery staff), I became absorbed in the visceral world of flesh, tissue, blood, tubes, catheters, and all things physiological, in the clinic and beyond.

Although I have stated elsewhere that it is impossible to decontextualize GRS away from other aspects of gender transition or being transgendered in general, I did want to foreground the surgery in this dissertation for several reasons. First, the surgery does represent an objective end point to transition; patients must have undergone HRT and the RLT before surgery is even permitted. Even though this may only be one of many body-modifying surgeries some transgender women undergo, such as breast augmentation, and facial feminization surgery (FFS), it is the one with the most socially significant status change implications. Second, GRS is the most significant part of transition in terms of permitting important legal document change such as birth certificate amendments or re-issues (depending on the state) and passport changes. Third, although it seems that increasingly, some transsexual women are choosing to have FFS before undergoing GRS, institutional regulations reflect that the latter is the more profound change as it

changes more than physical appearance (i.e. marital/parental rights, sexual relationships, employment options, bathroom use etc). Fourth, although comparative research was not part of my project, focusing on those transsexual women who do want to undergo the surgery as compared to transgender women who do not, researchers can gain some insight about intra-group variation within transgender populations. Although economic restraints are an obvious answer as to why only a relatively small number of the transgender people undergo GRS, I do not believe that it is necessarily the major one; I think having or not having the surgery has just as much to do with age and growing up in environments and times where transgender issues are part of popular discourse, such as in universities or sub-cultural youth contexts. In the modern age of “transgender” or gender-queer youth cultures, the desire for surgery is often overshadowed by the need to create a culturally intelligible identity outside of normative gender boundaries. Similarly, the explicit rejection of surgery is just as much part of creating said identity, albeit with stronger political foundations in anti-binary agendas. Fifth, compared to most other surgeries, GRS remains one of the most controversial and socially stigmatized medical procedures in practice, and despite the overwhelming support of medical practitioners involved in terms of its efficiency, safety, and legitimacy, it seems as if at the same time, the medical stronghold of GRS within the broader practice of medicine appears frail and contestable. Although more and more surgeons are specializing in GRS, no medical program today offers classes on learning the procedure, few hospitals allow doctors to practice GRS, and few employers include GRS in insurance coverage packages for their employees. Finally, and most importantly, for anthropologists interested in the singular, subjective, and idiosyncratic experience of the individual in culture, assessing individual meanings attributed to standardized

and institutionalized medical practices and processes provide an invaluable insight into personal experiences with social institutions and systems.

The 10 months I spent in Trinidad have certainly taught me a lot about GRS, GRS patients, the clinical context of changing one's genital sex, the relationship between alternative healing contexts and its therapeutic effect, and most importantly, the complexity of people's relationship with their gendered bodies. But ironically, my fieldwork year coincided with a significant change to the very thing which defines Trinidad to the rest of the world: Marci Bowers decided to relocate her practice to San Mateo on the West Coast for personal and professional reasons. Thus, her move constitutes the end of the "sex change capital of the world". In practice, this meant the closing of the Morning After House (MAH) which housed many of the GRS patients over the last 3 years and which became a definitive part of the Trinidad experience for patients. And although Bowers and her patients have been long gone now, the legacy of the sex change capital of the world lives on through people's stories and memories.

Participant Observation

My basic method of data collection was straight-forward participant observation focused on everyday researcher-patient interaction (Bernard 2000) and person-centered interviewing (see below). Participant observation complemented the interviews conducted because informal talk and casual behaviors usually provide data which may not be explicitly addressed in interview questions. Moreover, participant observation, particularly fieldworker's assumption of certain roles and positions which "afford extensive contact with members of the community in areas of interest to the research" provide good opportunities for setting up interviews (Briggs 1986:7). My extensive daily engagement with participants is described in the following chapter. Seeking

patient-oriented “experience near” concepts (Wikan 1991, Geertz 1974) of illness expression and being-in-the-world sensibility is furthermore made possible through this primary anthropological method.

I chose to conduct participant observation in Trinidad, around the event of the surgery, for the following reasons. First, as I noted above, obtaining secondary accounts of a subject’s experience is usually less desirable for anthropologists in that events may be recalled selectively, in less detail, and may be unconsciously interlaced with post-event reflections not apparent at the time. Second, bearing witness to the experience of GRS and patients’ subsequent recovery provided me with my own perspective against which the patients’ experience could be analyzed and interpreted. Third, being present and engaged in the daily local interactions, conversations, and interpersonal momentum between patients and their families, friends, the hospital staff, the Morning After House staff, the surgeon, the residents of Trinidad, and other patients, allowed me to absorb a totality of feelings, moods, and impressions, which I could not have obtained otherwise. Although I did not officially interview neither the patients’ families, spouses, or friends who accompanied them to Trinidad, nor the nursing or surgical staff, being present within the casual context of participant observation afforded me plenty of contact with these individuals who voluntarily and often spontaneously related their own thoughts and feelings to me which I found very useful. Fourth, experiencing and observing the hospital setting, the daily medical care practices, and the clinical life of the surgical and nursing staff provided the necessary clinical context in which to situate and gain a much closer understanding of patients’ experiences in the first place. Lastly, the visual, auditory, olfactory and tactile environments of field sites enhance and give meaning to the textual imaginary of ethnography.

However, some limitations to this particular ethnographic context apply. As with most ethnographic accounts, experiences, reactions, and feelings expressed are of an immediate nature and may become modified or transformed over time; what participants related or communicated about their experiences and thoughts at the time of research may be too momentous or temporal to make general claims. Nonetheless, the heightened states of bodily awareness experienced around the time of surgery and recovery are no less insightful to patients' meanings of genital reassignment than those that have solidified over time.

Person-Centered Interviews

I conducted one quantitative demographic survey focused on obtaining basic demographic patient information (age, occupation, ethnic background, level of education, marital status, residence, etc) with each patient to gain a general overview of the patient body (see analysis below). A series of five person-centered interviews were conducted with each patient, totaling about 235 hours of audio-recorded data (please see appendix II for interview protocols). Three interviews were conducted with the surgeon, totaling about five hours. A participant observation setting was made possible for me as I had access to patients in the hospital, and was able to live in the same guest house with patients recovering from the surgery most of the time (see next chapter). This advantageous setting enabled consistent and close contact with patients beyond interview meetings. Although I was able to finish all five interviews with most participants face-to-face, on occasion I had to finish an interview over the phone, email a question or two to a participant, or use SKYPE as a communication medium.

Person-centered interviews “refer to anthropological attempts to develop experience-near ways of describing and analyzing human behavior, subjective experience, and psychological

processes” by focusing on “the individual and how the individual’s psychology and subjective experiences both shapes, and is shaped by, social and cultural processes” (Hollan 2001: 48). Person-centered interviews were particularly well suited for this project as the participant is viewed as a respondent, rather than an informant, which permits the ethnographer to gain a deeper sense of which experiences are more or less salient, relevant, and important to the participant. Person-centered interviewing permits researchers to “explore how the actor perceives his or her world from the inside out” (51) rather than assuming these perceptions are pre-determined by abstract cultural concepts. Although personal narratives are the primary means by which ethnographers gain deeper understandings about the participants’ sense of being in the world, patient narratives do not necessarily mimic life experiences as they were lived, which suggests that narratives are themselves constructs built upon culturally available knowledge (see Mattingly and Garro below). However, “Most person-centered ethnographers are interested in examining the relationship between subjective experience and the larger, social, cultural, and political economic contexts from which it emerges, including the extent to which it is affected by the context of the interview setting itself” (Lutz 1992 in Hollan 2001:53). Thus, the clinical setting as such a context, allows researchers to capitalize on the contextual, or in this case institutional, setting to contrast respondents’ subjective and personal perspectives on illness with objective, institutional ones.

Other medical or psychological anthropologists have utilized person-centered interviewing which is not only methodologically, but also thematically suitable to projects which “critique aspects of both biomedical and social science theory” (Kleinman in Hollan 2001: 59), or which point out the asymmetrical focus of symbolic healing which “only rarely examine the ongoing experience of the patient or supplicant in a systematic way” (Csordas 1994:3 in Hollan

2001:61). More specifically, for this study, person-centered interviewing was also useful in exploring the relationship of self and society, stress, illness and healing, and the body. “One of the principal foci of private experience” write Levy and Hollan, “is the ways that people in various communities live in and through their bodies, their sense and evaluations of the functions and form of their own bodies and the bodies of others, and the relation of bodies to action, to a person’s value, to a person’s nature and constitution, to self and identity” (1998:344). Finally, person-centered ethnography “offers a powerful way of grounding social, psychological, and even biological theories of human behavior in the lived experiences of real people” (Hollan 2001: 62).

Narrative Analysis

My main method for data analysis was narrative analysis; I established coding templates to look for common patterns and generalizable similarities within qualitative narrative accounts. I also designed individual patient profiles ordering narratives according to interview set questions to better compare narratives on particular questions and themes. Although I have opted stylistically not to include or reproduce long transcriptions or threads of narratives, but rather string together several shorter comments by a larger number of people, I want to note that many participants provided me with extended, detailed, and rich narratives. The richness and depth of many narratives I gathered were deeply insightful of emotionality and reflection which, I feel, is always difficult to describe or reproduce in texts because text cannot reproduce or represent different tones or colors of experience beyond the ethnographer’s own description. At other times, narrative tones seemed quite matter-of-fact or had a slightly scripted quality especially when participants were asked about topics which they had discussed at length before, and

moreover, when medical discourse was central to both question and answer. Based on my experience, I would imagine that other ethnographers might agree that the methodological goal of collecting rich and free-flowing narratives is thus perhaps a tad more idealistic than realistic for cumulative participant samples as not everyone prefers or chooses long, open-ended narratives solely because ethnographers encourage these. Nonetheless, I felt that these narratives also communicated more than stories, sentiments, or recollections and I sometimes felt as if I had somehow become the catalyst for participants' self-reflection, irrelevant of narrative length or depth. As Ochs and Capps note, "We come to know ourselves as we use narrative to apprehend experiences and navigate relationships with others" (1996:21) and I most certainly found that to be true for at least some participants.

Narrative analysis has been used throughout medical and linguistic anthropology to gain a deeper sense of patient's illness experience (Garro 2003, Ochs and Capps 2001, Mattingly and Garro 2000, Mattingly 1998, Moerman 1988). "In American culture" write Garro and Mattingly "narratives reflect the struggle to come to terms with moral ideologies concerning normalcy in the face of disruptive experiences" (2000:29). Attaining or restoring a sense of "normalcy" is invariably tied to transsexuals' narratives about sexual reassignment which makes illness narrative analysis an excellent method of data analysis for this study. "While differing in complexity and circumstance" write Ochs and Capps, "narratives transform life journeys into sequences of events and evoke shifting perspectives on experience" (1996: 20). Further, collecting transsexual patient's narratives in an ethnographic clinical context was highly preferable to collecting this information long before or long after the surgery has taken place as it permits the ethnographer to obtain an "experience near" account of illness experiences. Another advantage of collecting narratives "bedside" is provided by the heightened state of body

awareness patients experience during hospital stays; since I conducted person-centered interviews which permit unbounded, reflexive answers, lengthy narratives were ideally suited for thematic coding.

“Stories” notes Jackson, “aid and abet our need to believe that we may discern and determine the meaning of our journey through life...” (2006:16), and Garro adds that “Narrative provides a window on the process involved in relating individual experience to pre-existing frameworks available within a cultural setting” (Garro 2000:72). These cultural settings are vitally important to transsexual patients in situating their life world experiences and expectations in ways that can be understood by others who do not share these experiences. Indeed, drawing on shared cultural knowledge about gender allows patients to express their thoughts and feelings about their past, present, and future lives by narrating themselves into socially gendered environments. As Jackson notes “Given the tendency of human beings to conflate their experience with their identity, the act of getting public recognition for one’s story implies recognition of oneself, a symbolic acceptance back into the body politic of a soul that has been ostracized from it” (Jackson 2006:61). The act of surgically inscribing the body with social meaning to gain recognition in/as one’s chosen gender is particularly relevant to exploring transsexuals’ “symbolic acceptance” as women or men in society.

Garro and Mattingly remark that “narrative becomes the vehicle for the problematic issue of representing experiences and events as seen from the perspective of particular actors and as elements of a cultural account that can tell us something about a social world, however local that world” (2000:24). These social worlds and the actors’ embedding of these in their own narratives, are specifically sought out in patient narratives collected for this project, as they can

tell researchers a great deal about how inner and outer world experiences are processed and consolidated to be meaningful.

Patient narratives are sense-making devices, particularly in instances when “in telling a story, we renew our faith that the world is within our grasp” (Jackson 2006:17). This sense of being part of the world, to move away from the gendered periphery and into the center, is possibly one of the strongest motivators for transsexuals undergoing GRS as its ideology is a promissory note of gender normalcy. Nonetheless, without narrating the meaning of GRS into one’s gendered life-world, the surgery itself, or even its effects, is voiceless, which reiterates that “storytelling is a coping strategy that involves making words stand in for the world, and then, by manipulating them, changing one’s experience of the world” (Jackson 2000:18).

Participant Recruitment

It is estimated that “approximately 800 to 1000 male-to-female surgeries are now performed by a handful of surgeons in the United States each year...” (Conway 2001, in Istar-Lev 2004: 38-39) although exact numbers of transsexuals living in the U.S. are impossible to obtain (see also Horton 2008 for prevalence rates on GRS). Fifty transsexual women (roughly 8% of the 800 to 1000 patients who undergo GRS surgery yearly) and one surgeon participated in the study. Currently, there are about 6 practicing surgeons in the U.S. who perform male-to-female sex reassignment surgery. There are several other surgeons who perform female-to-male or male-to-female “top surgery” (breast augmentation) and other common plastic surgeries such as Facial Feminization Surgery (FFS). Around 20,000 surgeries were done in the 1990s and more than 30,000 males have had GRS since the 1960s (Istar-Lev 2004). While female-to-male transsexuals are growing in numbers and could undoubtedly contribute important information to

this study, phalloplasty (the complementary surgery to vaginoplasty considered here) is still a relatively unsatisfactory (or unsuccessful) approach to genital reconstruction and many female-to-male transsexuals do not elect to have this surgery (Istar-Lev 2004). Therefore, female-to-male patients are far fewer in numbers than male-to-female patients in clinics which perform GRS. For this and other reasons, I only considered male-to-female transsexual patients for this study. Furthermore, I was solely concerned with genital reassignment surgery and not secondary surgeries such as tracheal shaves, facial reconstructive surgeries, or breast enlargements.

Patients have been recruited directly through the study's participating surgeon, by the surgeon's assistant on behalf of the principal investigator. The surgeon's assistant forwarded a letter drafted by me to patients who were scheduled to undergo surgery during the time of research. Patients were informed that they had received the recruitment letter solely because they were scheduled for surgery and that I had no access to personal information about them unless they responded to the letter. The recruitment strategy worked quite well - about 75% of the patient sample contacted me in person before arriving in Trinidad, giving us a chance to become acquainted over the phone or via email; the remaining participants were either told about me and my project by those who were already participating, or decided to participate after they met me at the Morning After House. Carol and Robin were of course also quite helpful in this matter when they pointed new patients in my direction with a gentle mention of "have you met our live-in anthropologist yet?". All in all, I was relieved to find that recruiting participants for my project was not as hard as I thought it was going to be, given the rather private nature of the surgery as well the often preferred privacy of transsexual identification.

Demography: GRS Patient Profiles

All patients were given a short demographic survey to obtain quantitative and qualitative data about the patient body at the time of research (i.e. age, ethnicity, marital status, income levels, education backgrounds, etc.). An obvious bias is of course that these patients all chose to have surgery by the same surgeon. Marci Bower's specialty in obstetric surgery and her experience and training background make her a prime competitor in the market of GRS and related surgical services; however, it is fair to say that the majority of her patients chose her based on their shared experience as transgender women. And although this is only Bower's patient sample, it may be safe to say that this is more or less a representative sample of GRS patients in the U.S. based mainly on ethnic and educational factors correlating with economic status enabling patients to afford the high cost of GRS in general. Other GRS surgeons in the U.S. charge roughly the same amount of money (\$20 - 25,000) for more or less the same surgical technique but this figure includes the hospital cost as well as the surgery cost; Horton (2008) estimates that the surgery for MtFs alone averaged about \$10,400. The preference for other surgeons, for instance Bowers' main competitor Toby Meltzer, may derive from his surgical specialty of plastic surgery as well as his reputation for excellent breast augmentation, which some patients choose to do at the same time as GRS. It could also be argued that geographic location may have played a role in choosing a surgeon although I felt that based on the wide geographic distribution of patient's home cities, travel distance yielded to the choice of surgeon based on experience, personal preference, and quality of work.

While there is no "typical" GRS patient to be portrayed, it was insightful to define some demographic commonalities about patients seeking to undergo GRS at the time of research.

Age:

under 20	20s	30s	40s	50s	60s
2%	26%	8%	22%	30%	12%

Reported Ethnicity:

Caucasian	Asian	African American	Latina	Other (Mixed)
82%	4%	4%	2%	8%

Level of Education:

High School	Some College	Bachelor's degree	M.A. or higher
16%	30%	26%	28%

Reported Individual Income Level:

75,000 or higher	50-75,000	25-50,000	25,000 or lower
22%	28%	16%	34%

Relationship Status¹⁵:

Single	Married	Divorced	Long term relationship	Widowed
44%	18%	20%	14%	2%

¹⁵ Divorce and LTR - (double count). It is safe to say that of single participants, slightly less than half are divorced

Geographic Location:

Urban	Suburban	Rural
48%	38%	14%

Self-identification¹⁶:

Transsexual	Transgender	Woman	Transsexual/Transgender Woman	Other (variations)
8%	4%	44%	42%	6%

Sexual Orientation (in chosen gender, not given gender):

Heterosexual	Homosexual	Bisexual	Other (undecided)
28%	24%	34%	14%

Other Surgeries:

Breast Augmentation	Orchiectomy	Tracheal Shave	Facial Feminization/Facelift	Rhinoplasty
8%	4%	12%	10%	2%

Children/Currently assuming a parental role:

Children	No Children
46% (1stepson)	54%

¹⁶ Double count on some identifiers

Approximately how many people within past and present social environment (work, family, spouses, lovers, friends, neighbors, casual acquaintances, etc.) know of transsexual/transgendered status?

Everyone	75%	50%	25% or less
38%	32%	16%	14%

Approximately how many people within social environment know of undergoing Genital Reassignment Surgery*?

Everyone	75%	50%	25% or less
24%	20%	20%	36%

*These numbers proceed from the previous information, so it could be that only 25% of people know one is a transsexual, and of those people, only a fraction may know about the surgery.

Demographic Summary

The average patient age at the time was 47, with the youngest being 18 and the oldest being 67.

Although 18 is the minimum age required for GRS, there is no exact upper age limit for surgery; a patient's general health conditions inform the surgeon's assessment as to whether GRS can be performed or not which is in the patient's own best interest. This is solely a medical decision, not whether it is socially feasible for the patient. Over 50% of the patient sample fell within the 40-50 years of age slot.

82% of my patient sample was Caucasian and over 50% had education levels of Bachelor's degree (26%) or higher (28%). Income levels were correspondingly high with 28% earning \$50,000-75,000 and 22% earning \$75,000-100,000 or more although 34% reported income levels not exceeding \$25,000. Although the employment background of the patient sample was quite diverse, the most common occupations were related to fields of information

technology, health care (administration and management), and higher education. The only patients who were unemployed at the time were either on disability, students, or retired. In terms of relationship status, 44% reported being single at the time, about half of which were divorced or separated from their partners. 48% were living in cities. 44% self-identified as “woman”, 42% identified as “transgender/transsexual woman”, and only 4% identified as “transgender”. Sexual orientation broke down about equally between heterosexual (28%), homosexual (24%) and bisexual (34%) with some patients being undecided. 46% had children with 22 patients being biological parents and one patient being a step-parent. 12% had undergone tracheal shaves prior to GRS and 20% had various other surgeries performed by Dr. Bowers prior to or concurrent with GRS (such as breast augmentation).

One of the most insightful aspects of this sample was patients’ disclosure status in terms of being “out” and sharing knowledge about undergoing GRS. As the breakdown shows, 38% reported being out to everybody, and 24% reported that everyone knew they were undergoing GRS. It is important to note that the 24% applies to those who know of a patient’s transsexual status in the first place; in other words, only a quarter of all individuals who have knowledge of a person’s transsexual status are aware of their surgical status. From interview data, it is apparent that some patients assume their family, friends, and coworkers assume they had already had the surgery. This supports the notion that GRS is not often directly talked about although the question of whether someone has had “the surgery” is often one of the first questions asked about or posed to a transsexual by others. In summary then, Bower’s average GRS patients are white, middle-aged, college-educated, of upper-middle class economic background, have white-collar jobs, and slightly less than half are parents.

Most relevant to investigating social aspects of GRS however, is the fact that despite undergoing a profoundly transformative change of social status including GRS, only slightly more than a third of the patient sample are “out” to others in their lives or intend to disclose their transsexual and surgical status to others in the future. The contrast of, on the one hand, occupying a position of ethnic, educational, and economic privilege, and on the other hand, occupying a highly marginalized status which prevents trans women from sharing their lives openly with others, shows how the stigma of transsexualism impacts social relationships. Although it has been argued that trans women often lose their previously enjoyed “male privilege” during or post-transition, this seems not to be the case for those who continue to thrive economically; however, this sample may constitute a small minority for whom this is not the case. Furthermore, this does not mean that these women do not experience discrimination and harassment on the job. Another interesting demographic finding was the amount of time passed between “living full time” and undergoing GRS. Living full time usually denotes living and functioning in the desired gender in all domains of life (social, work, family, et cetera):

Years Full Time as Woman	1	1.5	2	2.5	3	3.5	4	4.5	5	9	12	13	15	16	20
Number (of 50 Participants)	7	2	11	5	7	1	3	1	6	1	1	1	2	1	1

(mean = 5 years)

This finding shows the following: 43 participants (86%) had undergone GRS after living full time for five years or less. There was no significant correlation between age and having lived full time; some of the younger participants had been living full time longer than the older ones; for example, the person who had lived full time the longest was only 37 years old. However, given

that the average age of participants at the time was 47, there appears to be a correlation between living full time and pursuing GRS within 5 years; participants' advanced age could be interpreted as a greater motivator to pursue surgery than being relatively young. However, economic constraints would indicate that since most participants had to pay for the surgery themselves, the relationship between higher income levels and older age would explain why the older participants had more financial means available than younger ones, some of whom were still college students or only at the beginning of their careers.

Humanizing Research Subjects, Researching Human Subjectivity: Individuals as Patients

Within my first week in Trinidad, I met my first participants who couldn't have been more opposite: Betty, my oldest participant, and Gill, my second youngest. The 45 years between them were not the most striking difference I noticed; they were different in almost every way imaginable. Yet, they had come to Trinidad for the very same reason. As I tried to find commonalities, for example, in the meaning GRS held for them and the hopes and expectations they had invested in coming here, I realized quickly that even when they did express very similar thoughts on this issue, their particular life circumstances past and present would contextualize this meaning very differently. Betty was 67 year old, retired, divorced, parent of two daughters while Gill was 22, lived at home, and attended college. Each had vastly different interests and plans for the future, and had completely different life experiences. Every patient I met after meeting Betty and Gill only complicated my attempt to find any kind of pattern, rather than making it easier. In short, in the first week, I was reassured that there is no "typical" transsexual and there definitely is no typical GRS patient beyond what can be statistically averaged from a demographic survey above.

As I refer to patients by alias throughout this dissertation, it is helpful to introduce patients briefly per short profiles listed alphabetically in Appendix I. Demographic data and basic descriptors are of course no substitute for personal impressions but these could take up infinite amounts of space to describe. In addition, I hold a slight disdain for ethnographic ‘character assessments’ of informants or participants, not to mention personal judgments of these, because the author’s power to present research subjects as moral/immoral, rational/irrational, normal/abnormal etc. shapes the reader’s perception all the same. So while I have occasionally included a personal attribute such as shy, resilient, or vibrant, as I did above with Betty and Gill, I want to be cautious in suggesting that participants necessarily share this view of themselves. I furthermore refrain from dwelling on discrepancies between my own, supposedly “objective” impression of participants and their own, subjective presentation of themselves because it so easily puts participants’ credibility into question and secondly, it empowers my perspective over theirs. Moreover, since transgender research subjects have already had to grapple with much mis-representations in social or scientific research (see for example Dreger 2008), I feel it is best not to focus on what they say is “true” or not.

As the data in Appendix I shows, the majority of patients came with support persons who stayed with them the whole time, or had others either drop them off, pick them up, or visit for short amounts of time. Only 16 out of 50 patients made the trip completely by themselves. The data shows that at least Marci Bowers’ patients are often accompanied at least for some of the time they spent in Trinidad. A few patients were already familiar with the area, with Marci, and even with the hospital because they had either taken an “exploratory” trip if they lived nearby, or they had accompanied or visited transsexual friends who had undergone the surgery before them. Most however, only had knowledge about Trinidad and Marci’s office through the Internet.

However, unlike other surgery patients who plan their medical travels around the practicalities of the location or the hospital stay, the Trinidad experience provided far more for most patients than just a medical procedure as I will discuss in the next chapter. These journeys, if not for all, were pilgrimages of becoming complete selves, diminishing the gap between body and mind, rather than merely journeys from sickness to health.

Although it is most certainly my intention to humanize my research subjects throughout this work, I have opted for a collective representation whenever possible and to include as many short comments on diverse topics and questions rather than choose fewer but longer narratives for analysis. Including shorter thoughts also helps to avoid misrepresentation within the sample, and not just within the transgender population in general. Still, not every transsexual woman will recognize herself or feel represented accurately by those who participated in this study, and I make no claims that this sample is representative of all transsexual women currently residing in the U.S. Furthermore, while my focus was often on the problems experienced by trans women within their past and present everyday lives, I do not wish to situate them into “pathographic” (Hawkins 1999) contexts of struggle or suggest that participants portrayed their daily existences as overtly negative. Quite the contrary is true: many participants managed to find joy and contentment in their lives despite their transsexual circumstances. I found a strong sense of optimism and hope for life improvement against the odds, and the will not to submit to social oppression and self-deprecation struck me as quite pronounced in many — this resilience against the odds is perhaps the reason why cissexuals often praise transsexuals for “bravery” or “courage”.

It was this specific sense of self-empowerment against a dominant and oppressive social system which has always impressed me about transsexuals, and especially those who face other

sources of stigmatization such as disability, race, or class. In the strains of persistent dehumanization, or even just against the awareness of it, I found that many participants rehumanized themselves in the process of transitioning from one gender to the other: I noticed a profound sense of embodied humility as if participants had, in the process of their own transformation, reached a different level of consciousness about themselves. And although I wish to put singular voices and faces into these narratives of bodily transformation, it is the diversity and breadth of human subjectivity, which underlies the commonality of experience.

Chapter 3: The Ethnographic Setting

Trinidad, Mount San Rafael Hospital, and The Morning After House

Trinidad: The Sex Change Capital of the World

Any researcher interested in Transsexualism and Genital Reassignment Surgery would be hard pressed to ignore the pivotal role of a small mining town in the American Southwest called Trinidad, also known as “The Sex Change Capital of the World” (SCCOTW). Trinidad, with its population numbering roughly 10,000 residents, is inextricably connected to the history of sex reassignment surgeries performed in the United States. And although this connection of place and practice is part of common Southwest folklore far beyond Trinidad’s city limits, one would never know it walking down Main Street with its Victorian-style buildings and quaint small-business storefronts. This is the kind of place where everybody knows everybody else and everybody else’s business. Trinidad is a quiet community, though it has seen its fair share of trials and tribulations through harsh economic depressions due to the closing of the mines in the 1950s. Today, slightly less than half the population is Latino, unemployment rates are high, and there are as many liquor stores as churches in town. Once a thriving frontier settlement attracting immigrant labor pools as diverse as those of major urban cities, Trinidad’s many closed storefronts remind the visitor at once of its old days of glory as well as the backlash of the global economy of today.

Nonetheless, Trinidad and its inhabitants are beaming with pride and are ever-ready to tell tales about its historical significance as a once-vibrant stop-over on the famed Santa Fe Trail. Although not a single written document about Trinidad available at the history museum evinces any notion about its main attraction for out-of-towners, it would be wrong to portray its historical connection with sex change surgeries as the town’s “dirty little secret” — any local resident has a

story to tell about Trinidad's transsexual visitors passing through at some point or another. The story of Trinidad as the SCCOW is thus, and has always been, an oral history. Indeed, Trinidad has probably seen more journalists, TV reporters, and documentary filmmakers over the last 20 years than any other small town which is otherwise unremarkable. Media dissemination about what has been going on here for over 40 years has reached the rest of the country and made headlines beyond local news. Especially the death of Stanley Biber, the surgeon who began performing sex change surgeries in Trinidad the late 1960s, prompted an avalanche of eulogies which remarked not only on his life's achievements as an early advocate for transsexuals, but also the town's conscious support in his endeavors.

From the *New York Times* to the local *Pueblo Chieftain*, newspaper reports of Biber's passing in 2006 reached the American public one way or another; these stories reveal the news media's continued fascination with Trinidad. Reading through various reports of Biber's death, I was astonished how similar in tone and content these reports were. It is not necessary to conduct a serious media content analysis to realize that the most common themes in news media reports about Biber's death are hardly different from those written at the time he was alive. Most recount his medical training history, his benevolent attitude and involvement with transsexuals, his down-to-earth-ness, and his pivotal role in making Trinidad the "Sex Change Capital of the World". In fact, Trinidad, Transsexualism, and Biber form a holy trinity in the media — you can't mention one without the other(s). What is interesting, however, is the way in which an intrinsic opposition or conflict of interest between transsexuals and the local townspeople is assumed a priori to set up Trinidad as an extraordinary place of embracing tolerance and diversity. Implicit in language, the ordinariness of Trinidad being "just a small town" clashes with the extraordinary circumstance of being transsexual. Over and over, the jargon of the news

media expresses puzzlement as to why such extraordinariness would have a place in the ordinariness.

At the same time, however, after the reader is conditioned to accept this polar opposition between trans and non-trans, the focus turns to “normalizing” Trinidad, especially the locals’ attitudes toward Biber and his patients. It appears that Trinidadians follow an unspoken Christian “live and let live” idiom which easily reads as if nobody in Trinidad cares about whether one is transgendered or not. On the other hand, Trinidadians feel uneasy when their home town is referred to as the SCCOTW; in addition, some articles make a mention of the attempts of religious functionaries of the town to stop Biber (and later, Bowers) from practicing GRS, attempts which were not supported by the majority of townspeople. This mention then usually segways into the economic benefits which many claim are the “real” reason Trinidad “tolerates” the business of GRS in the first place (see also Bucar and Enke 2011). And while it is difficult to establish exact numbers of how much profit for local businesses is generated by transgender individuals and their families, one figure which involved parties generally agree upon is 2 million dollars a year, excluding the hospital profits (also estimated around 2 million). What exactly this breaks down to for hotels, motels, B&Bs, restaurants, cafes, gas stations, gift shops, and Walmart (the largest retailer in town) is difficult to estimate. Undeniably, local townspeople who own or work in businesses which cater to Trinidad’s transsexual visitors and their families and friends do profit; but there are far more who do not own or work in such places and who don’t profit. One would expect that this economic distinction would have divided the town a long ago as it would many others; however, I did not find this to be the case. I never had the notion that owners, managers, or workers in establishments frequented by transsexuals had a more positive attitude toward them than those who had no one-on-one contact.

In addition to differential individual economic profits it is indeed difficult to single out any factors which would make any Trinidadian more or less accepting of transsexuals than his or her neighbor. Many Trinidadians are self-identified Christians, but Christian values are often given as the basis of acceptance, not the basis for non-acceptance of transsexuals in Trinidad. The ethnic diversity in Trinidad being roughly 50% white and 50% Hispanic, or of mixed background, also provides no indication whether one half is more accepting than the other. Age levels and different education levels also offer no clue as to why some locals may be more or less accepting. The only shared social identifier which, at least in my opinion, might tilt the Trinidadian attitude slightly in favor of one over the others is gender. Although I have never personally witnessed any direct confrontation between townspeople and transsexuals, it seems that women are more open to talk with, and about transsexuals and GRS being performed in Trinidad. Conversely, the most negative attitudes seem to be expressed by men, yet there are few incidents which could empirically support this notion as people tend to be highly conscious of being labeled transphobic in Trinidad, which may not be unlike being hyperconscious of making racist remarks in a racially mixed community. Further, to be openly transphobic may or may not move a local resident to the social margins of Trinidad as the town prides itself on its collective representation as a friendly, welcoming community. To represent Trinidad to the rest of the world means to embody and exemplify this very notion. However, this does not mean that Trinidadians do not divulge how they really feel about transsexuals when talking about them away from the public eye or out-of-towners. Or, of course, to a researcher who happens to be interested in such things.

Still, while watching Jay Hodges and P.J. Raval's documentary *Trinidad* (2008), I was struck by the performative nature of the tolerant attitudes displayed by the townspeople they

interviewed for the movie. It appeared as if townspeople had a well rehearsed, or perhaps even standardized (at this point) and locally shared repertoire of answers to the film makers' questions because they have seen so many journalists and writers come though Trinidad asking people the very same questions over the years. Further, and in line with not wanting to stand out, the answers given seem to be focused on reinforcing the town's collective attitude while carefully avoiding one's own, personal opinions.

Although the film makers did not shy away from including a few negative attitudes expressed, most viewers would get the idea that Trinidad is collectively supportive and accepting of transsexuals. But on a closer look, when people were asked how they feel about transsexuals, the attitudes may appear positive, but the reasons underlying these seem ambiguous, perhaps in an unconscious sort of way¹⁷. This brings about the obvious question of what is meant by "acceptance" (by both the film makers and the townspeople). If acceptance simply means refraining from any action or behavior which would directly affect and emphasize the difference between trans people and non-trans people, then yes, Trinidad is, on the surface, an accepting community. If however, acceptance is here to mean that people make or see no difference whatsoever between them and transsexuals, then clearly this is not the case. It's almost as if "accepting as equal" or "accepting as no different from" seem to say the same, and yet, they don't. This is quite clear in the commentaries of those who comment on the visibility of transsexuals. Although townspeople often focus on the similarities, such as noting that transsexuals live normal lives, have concerns for families just like them, and should have a right to be whoever they are, there is a sense of boundary keeping which evokes Serano's implicit

¹⁷ See also Stuart (1991) on transsexuals harboring hostile attitudes toward the general public for not understanding their dilemma

cissexist ways of demarcating transsexuals from cissexuals. Although well-meaning perhaps, the local understanding of transsexualism is a keen sense of “othering” transsexuals whilst welcoming them into their midst at the same time. This fits well into the overall town mentality of “keeping one’s business to oneself”; this is after all how most small communities deal with other potential individual social marginalization factors such as unemployment, mental illness, criminal histories, or alcoholism which have their fair share in Trinidad. Finally, one has to remember that the filmmaker’s own marginal identities as gay men may have played a role in people being rather self-editing with their commentary if indeed they had known that Raval and Hodges were gay. Also, it would be interesting to know if the film makers’ agenda had been to portray transsexuals in a negative light whether people could have been motivated to agree with the filmmakers.

The Woman Behind The Surgeon: The Private Side of Marci Bowers

Marci Bowers was born Marc Bowers in 1958 in Chicago and went to medical school in Minnesota. She married during the last year of medical school and is still legally married to her spouse with whom she has 3 children (two of whom are college age girls). She has been an OBGYN surgeon since 1990. Marci went through the process of gender reassignment herself in 1996. In 2000, she was introduced to Stanley Biber who was looking for a surgeon to train and work alongside with in Trinidad. At the time there were no young surgeons in the field of GRS which would have made suitable candidates to be Biber’s successors. On Marci’s website, Biber’s choice to take her on as his successor reads as follows:

“Many have come here to Trinidad to learn the surgery...some didn't have the hands, some didn't have the confidence, and some didn't have the heart. Marci is the first to

have all three" Stanley Biber, MD (as stated in the TLC documentary "The Sex Change Capital of the World")¹⁸

Dr. Pierre Brassard in Montreal and Dr. Toby Meltzer in Arizona were already middle aged and well established in their careers. According to Marci, Biber was aiming for “new blood in the field” when they met and Marci was ready to take on a new subspecialty in the field of gynecology and obstetrics. Ironically, Biber, out of all people, had no “t-dar” and didn’t know that Marci herself was a transgender woman.

Marci moved to Trinidad in 2003 and begin training under Biber. When she first arrived in Trinidad she was charmed by the idyllic setting, the “cuteness” of the small-scale town, and historic significance of the area including the Santa Fe Trail. The warmth of the locals welcoming her into the community as Biber’s protégé settled her into Trinidad for good. Marci assessed her economic contribution to Trinidad’s small town economy as significant. Estimating that her practice earns the hospital about 2 million dollars per year in revenue, and that the town collectively earns up to 3 million dollars a year through GRS patients and their supporters who accompany them, Marci realized that she had some “economic clout on my hands”.

I had first met Marci in 2005 when I traveled to Trinidad to accompany a friend who was having surgery with her. I remember meeting Marci and both of us liking her instantly. It seemed the feeling was mutual and she invited us over for a home-cooked meal at her house, which she did on occasion for other guests. She had also invited her girlfriend and some of her staff members who were equally pleasant company. We spent a jolly evening at her house, eating, drinking, and shooting pool in her basement. I had never known any kind of surgeon privately and I was struck by her hospitality and the effort she had put into preparing a delicious home-

¹⁸ www.marcibowers.com/grs/history/html

cooked meal. I've had quite a few dinners at her house during my fieldwork time in Trinidad and she never fails to dazzle me with her talent for cooking up fine vegetarian cuisine — after a 10 hour day in the operating room.

Aside from the three official interviews I conducted with her, I was a frequent guest at her house in one of the nicer areas of Trinidad. We share a love for wine, vegetarian food, and good conversation. In addition, our paths crossed frequently at friends' houses and the occasional art exhibition in Trinidad's only "proper" gallery. I very much felt privileged, and sometimes guilty for going to her house for dinner, leaving behind her patients who certainly needed her more than I did at the time. However, because I was not a patient, and because she didn't have to be a doctor around me, we struck up a friendship, as much as this was possible for me keeping in mind that technically, she was the key person who made my research in Trinidad possible in the first place while also being one of my research subjects. Nonetheless, I have to say, some of the most enjoyable evenings (and one early morning, for an interview over breakfast) I have spent during my fieldwork were spent sitting at the kitchen counter of her house. She'd tell me stories about past patients who had come to Trinidad, stories about her own life, her thoughts on just about anything I'd ask her, and she was one of the easiest and most interesting interview partners I had ever had the pleasure of talking to. I suppose she had a lot of practice, given that the media was constantly asking for her participation on all things transgender.

So what kind of person is Marci Bowers, personally and professionally? Perhaps people who don't know her would expect to find the perceived Saint-ism of Medical Anthropologist and Physician Paul Farmer when they first meet Marci. Like Farmer, Marci has a reputation beyond her field of medicine to be a compassionate advocate for her patients. She speaks on their behalf and she uses her celebrity status well to further a positive understanding of transsexuals in

educational and entertainment contexts alike. But unlike Farmer, Marci's devotion to the cause is not quite so selfless; an astute business woman, she felt that since she had worked hard professionally to become a physician, and had struggled against the odds personally to become a woman, she felt entitled to reaping the rewards of financial wealth and professional prestige. In short, Marci unapologetically embraces the perks of being a successful surgeon, perhaps to the point of cliché; she owns a Porsche, 3 family-size houses in 3 different states, and indulges herself with short but frequent vacations to luxury resorts with finely trimmed golf courses.

Trinidad from Transgender Women's Perspectives

What made Trinidad a significant part of trans women's "journey to womanhood" was symbolic in nature; many trans women have remarked on how coming to Trinidad has affected their experience here. Unlike common notions that because Trinidad is the sex change capital of the world, many transsexuals must live in Trinidad, only a handful of transsexuals actually reside here, dispelling the myth. However, I was astonished to find that some women revisit Trinidad after having had surgery, as it symbolizes a place of transformation for them. In Trinidad (the movie), Dr. Laura Ellis, a short-time resident of Trinidad once called Trinidad the "spiritual center for transsexuals", implying some kind of holy pilgrimage transsexuals undertake to become their "true selves".

Indeed, Trinidad often appears as a place of personal significance in trans women's narratives. Claudine Griggs entitled her first book describing her own reassignment surgery "Journal of a Sex Change: Passage through Trinidad" and Trinidad has found its way into many online-journal entries about trans women's transitions. The town also figures prominently into support groups based on having had surgery by the same surgeon. The first, but now defunct

support group based on having been Biber's patient was called "The Biber Girls" while a later online group for Bowers' patients was called "Trinidad Support Group" when Bowers practiced in Trinidad, and the group's name has changed since she moved her practice to San Mateo. These online support groups, like many others, offer mostly practical advice to transwomen who are planning on undergoing surgery and who can draw on the experience of others who already had the surgery. These communal peer-supported forums offer not only practical information but also a wide variety of personal experiences with the transition, hormones, surgery, and post-surgical adjustment. Some comments have a general aim of sharing personal feelings with others while some are meant to supply technical, medical, legal, insurance-related, or general health-related information. Some online groups are more strictly moderated than others but most limit access to individuals who are transgendered.

Since I was graciously granted participatory access to the Trinidad Support Group (by its moderator), I was able to observe the ongoing exchange, some of which included commentaries from my own participants. It is in these commentaries that the symbolism of Trinidad is expressed as figuring significantly into people's positive, but also sometimes negative experience with being in Trinidad. For some trans women, at least since the time that I was privy to the exchanges within the group, coming to Trinidad was synonymous with the final step of transformation or transition. For those to whom Trinidad was not a significant part of their journeys, it was reduced to simply being an unremarkable small town which was inconvenient to access. Those who really did not like their experience in Trinidad often blamed it on the outdated hospital, lack of personal and medical attention by hospital staff, or dissatisfaction with Bower's office staff. However, for the majority, Trinidad became an intrinsic part of the positive experience of GRS. Many took in the fresh mountain air, explored the most popular sights, and

enjoyed the few outlets for relaxation and regeneration not unlike ordinary tourists who come through Trinidad.

Trinidad's few entertainment opportunities ensure that many trans women have a shared experience while there: "Rino's", the Italian restaurant on Main Street and also the only "fine dining" option in town, became the crowing highlight of sociality outside of the Morning After House as many trans women gather either alone, with friends and family, or newfound friends for celebratory meals either before or after surgery, or just before departing Trinidad for good. Eating at Rino's is thus just as much part of the rite of passage as any other activity in Trinidad, such as visiting the Trinidad sign located on top of Simpson's Rest for the obligatory photo-op. Although any stranger in any town may ask another whether they had visited the major sights or landmarks, for trans women coming through Trinidad, this seems to add to their shared experience, and moreover, having made it here after all.

The Morning After House

Shortly after I had arrived in Trinidad, I went to meet Carol Cometto, Bowers' former partner, at the Park Café, local dive bar, for a beer. We had met before, on my initial visit to Trinidad, and we had spent a delightful evening at Marci's house. We met again some years later at a transgender conference in Tucson, Arizona. Carol ran the Morning After House (MAH), a "half-way" recovery house in a residential neighborhood where Marci's patients would stay for a minimum of 3 days before leaving Trinidad to return home. Some even stayed a few days before going into the hospital for surgery. The idea behind setting up such a place were multiple: first, Mount San Rafael's hospital costs are prohibitively high so Marci decided some years ago that a privately run facility would keep the overall costs related to undergoing the surgery at a more

reasonable level. Secondly, Marci believed that patients would benefit more from recovering in a less clinical environment rather than spending 7 days in a hospital. Although some patients preferred the privacy of one of the many Bed and Breakfast operations in Trinidad, many chose to stay at the MAH. Finally, since the house had several apartments but some communal areas, the MAH was also highly conducive to facilitating social contact between Marci's patients; for most this significantly contributed to their positive experience, while for some, it did not. In a sense, placing her patients in the MAH also gave her a better chance to monitor ongoing recovery process and to utilize Carol's supervision available for guests' immediate needs.

Although catering solely to Marci's patients, Carol ran the MAH as her own business. Opening in 2008, the MAH was the second guest house in Trinidad which was established for the purpose of serving transgender women in their recovery process. The first guest house, similarly titled "Morning Glow" was initially run by two trans women, Sabrina Marcus and Laura Ellis, who had come to Trinidad years earlier for their own surgeries, fell in love with the charms of the town, and decided to stay and start a business together which ultimately failed. Much of their story is featured in *Trinidad* (2008).

After Marcus and Ellis had left town, Carol took on the new responsibility of taking care of patients post surgery by establishing a new recovery house. Marci and Carol would work in tandem, with Robin helping Carol with schedules of incoming and outgoing patients. Carol was in charge of running the everyday affairs of the house, mostly keeping the house meticulously clean and the cupboards generously stocked with convenience foods which were available to all guests as included in the rental price. But Carol's unofficial role as someone who looked after the patient's overall well-being went far beyond changing sheets and buying milk and bread; Carol's unique sense of humor and compassion for transgender women (and some trans men)

made her much more than a caretaker. It is difficult to describe Carol to someone who has never met her. Born and raised in Trinidad by her Italian immigrant parents, a raucous, out-and-proud lesbian with heart the size of Trinidad itself, Carol epitomizes the rough-edged working class character typical of a small town, yet her sweet and welcoming attitude to both friends and strangers makes her quite the global citizen. She is Trinidad's most notorious outlaw and watchful sheriff all in one — a woman of staunch principles with a penchant for breaking the rules and beaming with glee for getting away with it.

Carol's reputation as freewheeling spirit has indeed earned her a soft spot in the heart of Trinidadians; if you live in Trinidad, you know Carol Cometto. Walking down Main Street with Carol takes about twice as long as walking it on your own — locals stop to chat with Carol, trucks drive by and honk, and people emerge from stores, just for a quick hello. Carol doesn't think twice about interrupting the deputy sheriff during his lunch to drive up to Simpson's rest with the key to open the gate to the dirt road with the justification that her guests would like to visit the Trinidad sign. Her unmistakably loud and distinct voice penetrates through any busy restaurant soundscape, and her irresistible charm and instantly cordial demeanor reduces the most conservative people to chumminess in seconds. I have never seen anybody address a stranger in a more instantly familiarizing manner with a "how are you, love?" followed by a bear hug. To Carol, it doesn't matter whether you are the Mayor of Trinidad or Oprah Winfrey; to meet people Italian-style and give them some "amore" is clearly in her blood.

Carol's uncomplicated and personalizing approach to welcoming trans women into the MAH took many guests by (positive) surprise. Opposite of the sterility of the hospital, the warmth and homey feel of the MAH provided more than simply a place to recover from the surgery. As soon as new patients would arrive at the house, Carol would give everybody the

“grand tour”, proudly telling people that she had furnished and decorated each room in the house herself. Since patients moved in and out of the house depending on their surgery schedules, Carol decided to give each room a name to make better sense of her multi-colored scheduling flow chart. Scheduling patients’ coming and going became an art form in and of itself, and demanded customizing patients’ accommodation needs. Robin and Carol took great care to match patients and their family and friends’ rooming needs to the total of 10 beds available in the house. While for example couples or patients who brought male guests were housed in the private, self-contained apartment, patients who seemed generally social and or alone were housed in bedrooms in more communal areas of the house. Carol and Robin could not always accommodate everybody’s needs and wishes, but for the most part, they received few complaints. Interestingly, one of the rooms was named the “Sabrina” room, named after Sabrina Marcus who had started to build the first GRS patient recovery home. Other rooms were named after the style of decorations and artifacts which graced shelves and walls throughout the MAH.

After I began living in the MAH, I began to appreciate the therapeutic effect unorthodox recovery environments can have on physical and psychological healing processes. Although many patients had already met each other at the hospital, or had even been “roommates” sharing the same hospital room, the inviting and comfortable communal areas provided opportune moments for patients to meet and get to know each other. The option for patients to have their partners, spouses, family members, and friends stay with them throughout their recovery time at the MAH - whenever scheduling allowed for there being enough room in the house - provided a great sense of comfort to patients. The care-giving provided by familiar people in a private home not unlike their own lessened patients’ anxiety of recovering in an unfamiliar environment. Although the MAH was only a short drive away from the hospital, and 24 hour care was only a

phone call away, having a trusted person close by was enormously helpful to patients for the “little” needs or simply assisting newly released patients to move around the house more easily. The greatest advantage for patients who had come alone, was that they were never alone in the house, or at least not for long; moreover, most family members and friends who had accompanied other patients often offered up help to those who had no one.

Another advantage to patients recovering at the MAH was Marci’s infrequent visits to check up on them. Marci’s visits to the MAH often struck me as reminiscent of the “house calls” “country” doctors used to make in the past - they were distinctly casual, rather than clinical, and holistic, rather than problem-oriented with Marci focusing more on inquiring about the patient’s overall well-being. Patients often had the opportunity to invite Marci for dinner, invitations to which she obliged whenever her busy schedule allowed. I felt that patients were very appreciative of the visits, and it gave Marci an opportunity to monitor not only the physical but also the psychological and emotional healing process of her patients. What was most interesting for me to observe during these informal social visits was the way in which medical practice and doctor-patient communication unfolded in a non-clinical setting. I felt that Marci visiting patients collectively in a private home setting was extremely beneficial to patients in terms of not feeling rushed to narrate their recovery process. Often, several patients would talk over the dinner table with Marci about what would otherwise be considered a private illness experience. Here, however, was a group of people who had all undergone more or less the same surgical procedure and were roughly in the same stages of physical recovery. After everybody had finished eating, Marci would often take each individual patient into one of the private bedrooms and check on their stitches or assess swelling of tissue. I felt that examining patients in a non-clinical environment enabled a doctor-patient dialogue which is not only more productive but also

exemplary of precisely the kind of humane medicine modern medical students should learn to practice. The feeling of personal care, the willingness of the doctor to take time to socialize with patients (as well as their families and friends) is invaluable to holistic healing processes involving, rather than separating, the mind from the body. Although it may seem to other physicians that spending time outside of office-time allocated for clinical visits with patients was a gesture of “good will” on the physician, in actuality, I found that these collective and casual patient visits at the MAH were highly economizing in terms of time for Marci. Considering that she could speak to several patients at once about similar problems they were experiencing, such as light bleeding, swelling, difficulty urinating, etc., and considering that patients could get answers to similar questions over a round of tacos saved both patients and physician the time it takes to make a check-up appointment, drive to the office, wait in the waiting room, and go through the formal preparation for a quick exam. What this shows is that in modern medical encounters where time spent with each patient has been reduced to an absolute minimum, these casual and personalized approaches of medical care would easily be dismissed as un-economical for the physician but I found quite the opposite to be true.

Another way in which unorthodox healing environments can positively influence the therapeutic process is the material culture of the place of recovery. I noticed how patients began to engage with what the MAH represented in the symbolic context of “coming home” as so many trans women before them had experienced in the MAH. On the dining table most central to the communal area, there were photo albums with pictures of previous guests and a guest book with hundreds of written entries. I felt that for some patients, flipping through the books gave them a sense of reflective sharedness, especially for those who had made the journey to Trinidad alone. Since Carol made a point of taking pictures with every single guest who came through the MAH,

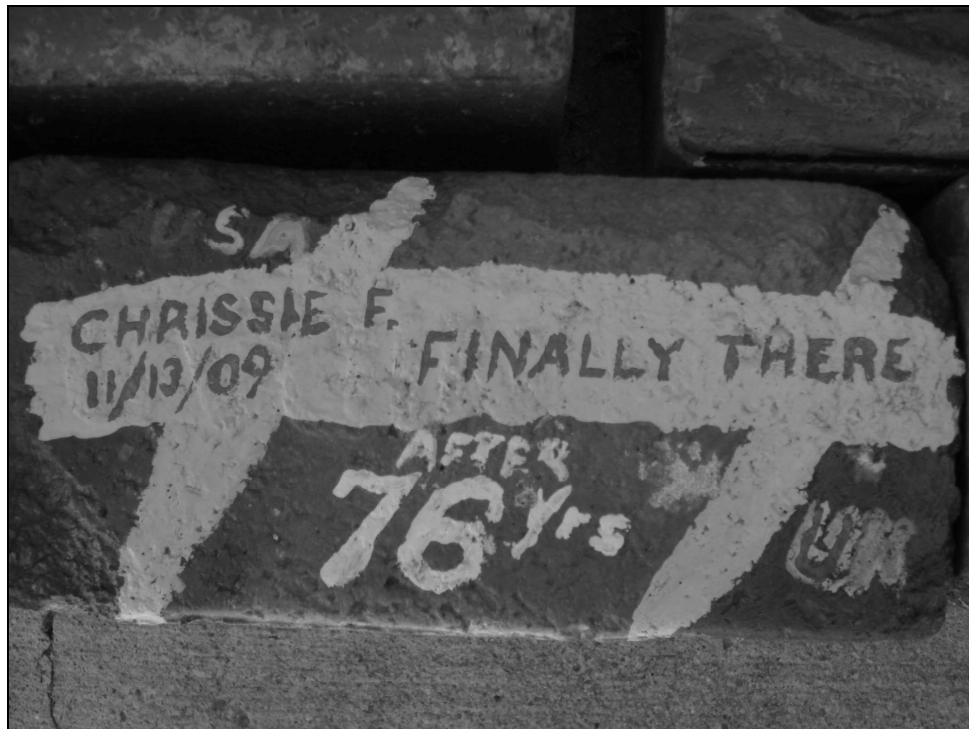
the photo album chronicled not only the history of the house, but it also poignantly reflected the diversity among all the trans women who came through Trinidad. The guestbook read as some kind of meta-diary, full of stories, reflections, and gratitude. I always hoped that the personal stories told in these documents would one day justify having a place in Trinidad's small town museum and become an official part of Trinidad's already colorful history.

Perhaps the most unique connection between GRS patients and Trinidad was Carol's idea to have patients paint on a brick with raised Trinidad lettering and add it to her growing collection in the side yard. These bricks originally graced some of the old cobblestone roads of the town and were emblematic of Trinidad's small town charm. Carol kept a stack of old bricks next to the patio and a bag with painting supplies next to the fridge in the kitchen. Outside the house, alongside of the MAH yard walls, she had designated a space where she laid the bricks out for everyone to marvel at. I don't remember how many she had amassed at the time, but her colorful collection inspired many guests to add their own; even though some took their on bricks home, it gave patients an opportunity to contribute their story to the story of Trinidad. Brick painting, on the stairs of the back porch became yet another opportunity for sociality at the Morning After house. In a sense, the primitive nature of the painted bricks reminded me of children's painting in school yards; on the other hand, I was struck by how much personal meaning could be conveyed with a few brush strokes on a piece of stone. While some bricks had only names and dates on it, some showed elaborate designs and decorative efforts embedding various words of gratitude. The one which always struck me the most was painted by an older patient, which read, "Finally There After 76 Years" (see below). The implicit meaning of the bricks shows that people invariably assign some sort of significance to places in which they

experience profound changes in their lives. But the Trinidad bricks in particular shows that when this significance is shared, its transformative meaning becomes all the more salient as a whole.

The guestbook, the photo album, and the painted Trinidad bricks remain some of Carol's most cherished possessions long after the MAH finally closed. In a sense, it had become part of her own life's journey.







My Daily Life At The Morning After House

When I first arrived in Trinidad to begin my fieldwork, I simply settled for the cheapest option in town. After enduring a couple of miserable months of living in a small bedroom at the Downtown Motel, Carol agreed for me to move into the MAH. Living in the makeshift basement apartment that Carol had put together for me provided me with a unique opportunity to be around my participants at all times. This highly advantageous set up enabled a perfect participant-observer context ideal for conducting ethnographic fieldwork. I woke up to the footsteps of the first person to come into the kitchen to make coffee or tea in the morning, and I knew when the last person had gone to bed by the dead quiet of the otherwise creaky floors located just above my bedroom. For Carol, having someone at the house at all times was reciprocally advantageous and I was glad to help her with household chores or to run errands. Since I made myself

available to patients who did not have transportation, I also frequently picked up patients from the hospital, drove them to the pharmacy, took them to Walmart, or picked up a few groceries for them here and there. As it is often the case when anthropologists become entangled with the daily activities of their field site, driving and accompanying patients around town gave me plenty of opportunity to engage in casual chats. Much of information gathered about participants' thoughts and feelings came about via frequent causal interaction, outside of the proper interview context. Furthermore, I felt that the more "accidental" micro-contacts occur between research and participant, the more relaxed and open participants become during actual interview sessions. Sometimes I would be folding laundry in the upstairs apartment while patients were relaxing on the couch, and we'd end up talking for a whole hour, forgetting all about the laundry until Carol would yell up the stairs "Muriel, the sheets!"

Scheduling interviews became increasingly easy as I was able to work flexibly around people's comings and goings. Interaction in the communal areas was always stimulating, especially when patients decided to cook together — and someone was almost always cooking. I much enjoyed the many dinners we had around the big dining room table especially because the social contexts at the MAH usually also involved family members and friends of patients who, even if they stayed in hotels or motels instead of the MAH, would join us for a meal. I have had many insightful conversations with parents, siblings, children, and friends of trans women who came to Trinidad over a meal at the MAH.

While most patients enjoyed the general sociality of the house, the highlight of social gatherings centered on what Carol termed "winewalling" — drinking wine with guests on the porch and lining up the empty bottles around the walls of the house. Sometimes, she would make guests sign the empty bottles so as to permanently mark their stay at the MAH in yet another

way. Carol's winewall parties were always semi-spontaneous events which sometimes lasted from early afternoon way into the night. Needless to say she had amassed quite a collection of wine bottles when I first got there, and I am proud to say that I have contributed significantly during my stay at the house. Winewalling was single-handedly the most conducive context to participant observation; most patients welcomed a glass of wine or two after the physically and emotionally draining days of recovering from the worst of the surgery. The jolly scene on the back porch on any weather-permitting day was nothing you wouldn't find in any other small town — perhaps with the exception of the ubiquitous inflatable “doughnuts” (medical plastic cushions with holes in the middle), discretely placed under still swollen and sensitive body parts without which sitting became quite a painful task.

But winewalling was more than just a perfect way to waste an afternoon; winewalling also functioned as a social bridge to introduce the house guests to the rest of Trinidad since oftentimes, Carol's friends would drop by to say hello. Since everybody in town knew about the guests at the MAH, the social interaction with various locals had a “normalizing” effect which was a new experience for a few trans women who otherwise lived terribly isolated lives because of their transgender status. Simply being introduced to someone with their new chosen name can be highly validating for those patients who had only been out for a short amount of time. In addition, I felt as if winewalling afternoons gave me an opportunity to share more about my own life with patients. Winewall afternoons became times when I could forget about being a researcher and just enjoy other people's company. Carol's uncanny sense of humor combined with her extremely short attention span resulted in a type of hilarity which was addictive; when she was in high spirits Carol was the most entertaining person in the world and you'd have to stick around for just one more glass to see what she'd say next. Carol made me laugh so hard

with her “Carolisms” that I began to write down her infrequent one-liners on little post-it notes and taped them onto the wall in her office. I hope that despite the turmoil of moving out, she kept our little collection.

Mount San Rafael: The Hospital as an Ethnographic Setting

Van der Geest and Finckler (2004) have discussed the hospital as part of the ethnographic setting and note that “Many anthropologists have come to realize that in a hospital, participant observation in the true sense of the term is an oxymoron” (1999). This most certainly speaks to the difficulty of situating oneself and a research agenda into a hospital context: one is neither patient, nor surgeon, nor staff, nor visitor. On the other hand, Van der Geest and Finckler observed that hospitals as ethnographic contexts are gaining in popularity as they reflect both globalized and localized social and cultural aspects of illness experience and behavior beyond the scope of biomedicine. The local context of Trinidad’s only hospital, Mount San Rafael (MSR) is of special interest here because it reflects Van der Geest and Finckler’s notion that hospitals “are domain where the core values and beliefs of a culture come into view” (1996). However, having been inextricably tied to Trinidad’s sex change history, it is remarkable that MSR has remained an unremarkable small-town Catholic hospital.

Built in 1889 as a 40-bed facility on donated land by a wealthy doctor, Mount San Rafael is now a two-story building with 70 beds¹⁹. Transsexual patients are regularly housed with other patients although they don’t share rooms. There are no visual demarcations anywhere inside the hospital to distinguish transsexual patients from non-transsexual ones, which is highly integrative to the hospital culture at MSR. In an almost comical sense, many patient rooms featuring

¹⁹ <http://www.msrlhc.org>

brightly colored balloons which can be bought in the small hospital gift store that read “It’s a girl”, making the visitor wonder whether the patient just had a baby or whether the patient had genital reassignment surgery. The hospital’s small lobby, with its floor-to-ceiling scenic mural, and its equally outmoded and bare-bones cafeteria constitute the only “social” spaces for staff, visitors, and patients; but for most of my visits, they seemed eerily deserted. Nonetheless, they also provided plenty of quiet spaces to which I could retreat occasionally, to write down a few fieldnotes while waiting for patients to shower or change.

MSR appears to be integral to many trans women’s experience of Trinidad. Quite a few trans women’s online blogs or journal writings include descriptions of MSR²⁰ in addition to Christine Griggs’ full length *Journal of a Sex Change: Passage Through Trinidad* (2004). These accounts describe anything from MSR’s location within the bucolic scenery of Southern Colorado to minute aspects of hospital life including interactions with nurses, staff, and surgeons. The descriptive details in these narratives reveal that people undergoing significantly transformative events seem to be in heightened states of awareness, especially concerning their immediate environments. Most intriguing to me, however, was the contrast between patients’ subjective experiences of an extraordinary and transformative event, and the everyday ordinariness and routinization of transsexual patient care at MSR.

A Day at the Doctor’s Office

Marci’s office was conveniently located across the street from MSR. Although I frequently went to the office to pick up patients or drop them off for appointments, I did not spend much time

²⁰ See for example <http://www.susans.org/reference/mysrs.html> and <http://heartcorps.com/melanie/diary/diary024.htm>

there. The small one-story building housed several separate offices and Marci and her staff, ironically perhaps, shared an office suite with Planned Parenthood. The office had 4 rooms, including an official exam room plus office spaces and a break room. Marci's staff at the time was composed of Ann who was the office manager, Janet who was in charge of billing, and Robin, Marci's assistant and patient liaison. Robin was the "go-to" person for patients and there was hardly anything she did not have an answer or solution to.

In a regular week, Marci would have 3 surgery days and 2 clinic days during which she met with patients for consultations, check ups, and catheter removal. Occasionally, she would also perform small medical procedures in the office such as orchiectomies or tracheal shaves. It is perhaps surprising to some people that something so extraordinary as a sex change operation actually only takes about 4 hours. The routine with which Marci performed sometimes up to 3 surgeries per day made the whole thing seem no different from other general surgeries. Something that some patients had spent years anticipating concluded quite anti-climactically from the perspective of surgeon and office staff.

The office was also the place that dealt with part of the paperwork, medical records, and general information. Since Marci was more of an independent contractor than permanently employed surgeon at the hospital, using hospital facilities and surgery staff, some paperwork and payment affairs needed to be processed at the hospital. Preliminary medical procedures such as drawing blood also took place in the hospital rather than the doctor's office. Finally, although the two places worked in tandem, it also seemed as if they were distinctly different entities in the process of GRS.

Doing Ethnography at MSR

Shortly after I arrived in Trinidad, I met Robin in the office and was introduced to the nursing staff at MSR. The HR lady made me my own photo ID that I had to wear every time I entered the hospital and when I was picking up or dropping off patients, during interviews, etc. On my first day, I was introduced to the nursing supervisor who welcomed me warmly, listened to my brief description of my research, and then gave me thick manuals to read about infection risks and emergency procedures at the hospital. Although I was not a staff member, I still had to familiarize myself with hospital policies and proper conduct around patients and staff. The manual was instructive and detailed, and after I had finished reading it, I realized that I never knew the hazard of unidentified contents of a puddle of liquid on the floor.

The benefits of having a hospital ID were that I could come and go as I pleased as long as I did not disturb the patients or staff. This allowed for great deal of flexibility as I could stay past the official visiting time if patients so desired. I actually liked spending time at the hospital at night; interviewing patients bedside became easier as we were not constantly interrupted by nurses bringing or picking up trays with medication, food, or other supplies, or coming in to discuss meal plans for the day, or changing sheets and fluffing pillows. Overall, the nurses were utterly accommodating to me on a whole and I in turn, tried to stay out of their way as much as possible. The nurses working on rotation behind the front desk would know that if I approached the desk, my usual question would be which room patient so-and-so was in. One nurse in particular, let's call her "Barbara" actually remembered me from when I came in 2005. I was surprised how few questions the nurses had about me or my work. From day one they treated me as if I was just another resident or frequent visitor. Nobody ever questioned what I was doing as the internal IRB had approved my being there and that was good enough for them. I also stayed clear of any interruption of their daily schedules so they did not have to accommodate me at all.

Although I preferred to interview patients at the MAH, sometimes time constraints or scheduling difficulties made hospital interviews a necessity. Also, I couldn't interview patients if they shared a room as was often the case, to protect their privacy. On the other hand, some patients seemed to enjoy my company as hospital life is decidedly quite boring when you have to stay in bed most of the day. Even if I did not have interviews scheduled, I would visit patients in the hospital if they welcomed the visits. I would run little errands for patients who came alone which I felt were kindly appreciated and I was glad that I could make myself useful — sometimes, just having someone bring you a cold lemonade can make pain and boredom just a little more bearable. When patients felt better, I often assisted them taking the first difficult steps out of bed; when they felt comfortable walking around the hospital halls, we circled the main corridors a few times. On occasional visits with patients who shared a room, we'd eat lunch together which provided yet more opportune moments for me to talk to patients; these casual conversations were insightful as the two people in front of me, or to each side of me, had just undergone the same surgery and were sharing a path of recovery. Sometimes, one would be dismayed about the other's quicker improvement, which felt a little bit like a competition of who could deal with pain better, or need less pain killers on the long road of recovery.

I also carefully negotiated interfering in infrequent quarrels between patients and nurses; while most patients thought that the nurses and surgery staff were treating them with the same respect and care as any other patients at MSR, some had petty complaints about having to wait hours to take an assisted shower, or not being given more pain medication when they asked for it. Most complaints centered on staff being overwhelmed and “forgetting” to bring medication, or fresh water, or an extra pillow. However, some patients were what nurses would reluctantly admit to be “high maintenance”, translate: whining too much. Having constant needs and worries

easily transforms a good, “compliant patient” into a bad, “problem patient”; what bothered some patients was that some nurses seemed to have dismissive attitudes and did not take their complaints seriously. For instance, nurses are instructed not to over-medicate patients with pain medication as to give the body a chance to process and deal with pain on its own. As I already noted, some patients indeed have much higher tolerance levels than others and some aligned themselves with the nurses attitude that too many pain killers are simply bad for you. Others experienced high levels of pain which understandably made them cranky and demanding all kinds of assistance with being just a little more comfortable.

Most often, patients voiced not complaints but worries to the nurses. Since Marci was unavailable during surgery or clinic days, patients were at the mercy of nurses when they felt something was wrong. Those who were labeled as “whiny” or “high maintenance” were quickly frustrated by the nurses explanations that everything was fine. From the nurses’ point of view, the high emotional anxiety about undergoing GRS made patients feel more on edge and over-worried; some nurses had years of experience dealing with common pains or bodily changes which are part of the healing process, such as light bleeding. And since many patients experienced light post-surgical bleeding, nurses often dismissed this as “normal”; however, the psychological aspect of bleeding, light, or not, was often left unaddressed as some nurses were not trained enough to elaborate as to exactly why bleeding occurs. Often, patients had requested to see Marci for minor healing issues which the nurses dismissed as a redundant request which did not necessitate summoning Marci.

From the patient point of view, it can feel incredibly frustrating to be tied to a bed, immobilized by pain, and people who are supposed to care for you don’t seem to take your complaints seriously. This is of course not unique to GRS patients. However, constituting a

clinical as well as social minority, it is easy to see how transsexual patients can feel relatively helpless in situations like these. Nonetheless, I felt that nurses treating GRS patients no different than they would others, had a great equalizing effect on patients' feelings of being in the hospital. Treating transsexuals as "just another patient" in a sense normalized the controversial aspects of the surgery and furthermore, added to the sense of tolerance and support which Trinidad prides itself in. I never witnessed a serious disagreement between nurses and patients at the hospital nor am I aware of someone filing an official complaint. However, some patients felt that they would have received better hospital care elsewhere as the hospital itself struck people as old, or outdated.

Clinical Intimacies with Celebrity Surgeons: The Doctor-Patient Relationship

The most common complaint voiced to me by patients was that Marci did not spend enough time checking up on them while they were in the hospital. Marci's response, while usually aligning with patients complaining about hospital staff, was aligned with the nurses; while she could understand the anxieties and worries about the bodily changes involved in the healing process, she insisted that based on her years of experience, the patients' worries were largely unfounded. And of course, like other surgeons, having to maximize time while operating or doing clinical consultations did not leave much time for post-surgical care, which was mainly the nurses' responsibility anyways. In a sense, it felt like tending to her busy surgery and office schedule to help those who had not had the surgery clearly was a priority she expected post-surgery patients and others to understand.

If there was one common patient complaint about the whole Trinidad experience, it was that in general, patients felt that Marci did not spend enough time with them, before the surgery

and especially after (although I found this an unfounded accusation in some cases, see the MAH chapter). Physicians or surgeons not spending enough time with patients is of course easily the most common complaint in modern medicine today. However, in this context, it is necessary to point out several factors which inform the dissatisfaction of GRS patients with insufficient attention provided by the surgeon. First, Marci's status as a national celebrity and transgender advocate who has been a very public media figure ever since she took over Biber's practice in Trinidad has undoubtedly contributed to her high demand as a surgeon, but it has also bestowed upon her a cult status within transgender communities. Second, since she is a transsexual woman herself, her own experience is believed to aid her understanding of what her patients experience physically as well as psychologically. Many patients are thus awe-struck, to varying degrees, when they meet her as potential patients.

High patient expectations are quickly lowered however, when they meet her on a busy day in the office and realize that this is just an everyday medical encounter and not a deeply bonding moment over a shared experience. And while patients understand quite well that the structured reality of daily medical practice constrains time spent with each patient, when they are cut short, they often take it personally. Patients realize that there is little time to recount their life histories in-depth, nor is this a time for sharing experiences when the surgeon's main concern is collecting patients' medical histories which is a standardized procedure and which leaves little time for personal elaborations. Third, her very personal and warm approach to individual potential patients, many of whom she meets at conferences and speaking engagements, endears her to patients long before they ever schedule an appointment. But it seems that patients forget that attending conferences and other public events is also part of Marci's marketing strategy — and quite a successful one indeed since her wait-list at the time of research was 14 months long.

Finally, because Marci had herself been a patient within the doctor-patient relationship, many patients believe that she should be particularly sensitive about patient concerns. But patients forget to take into consideration that Marci was also a doctor herself at the time, and that she had surgery by one of her colleagues who is now also her main competitor. This makes her experience with the entire medical process of gender reassignment quite unique, even if she might have had a surgical experience similar to her patients.

So while patient complaints about Marci not spending enough time with them is certainly explainable under the structural constraints of medical practice, GRS patients' personal expectations not being satisfied has less to do with the structural constraints but with culturally informed notions of belonging to the same community, a sense of kinship toward Marci, and expectations to find the public persona of an activist recreated in a face-to-face medical encounter.

Cultural Contexts of Medical Processes vs. Medical Contexts of Cultural Processes

While Trinidad and the Morning After House were perhaps unique cultural contexts in which transsexuals could experience medical transformations, the medico-structural constraints of daily routines at Mount San Rafael and the interactional limitations of the doctor-patient relationship remind us that regulated medical processes can be experienced vastly different in varying contexts. Although Trinidad significantly shaped most of my participants' experiences throughout the surgical and recovery process, it is difficult to say whether this is not also the case for trans women undergoing GRS elsewhere. I wondered whether perhaps trans women who went abroad for GRS would absorb a similarly localized framework of experience not unlike those who came to Trinidad. For example, Aizura (2010) suggests that trans women who travel

to Thailand for reassignment surgery tend to adopt a specific Thai aesthetic of expressing and experiencing local femininity because “the specifics of place mediate how medical travelers desire and identify with the cultural locations they interface with through medical travel” (425). And although trans women who came to Trinidad arguably remain within their familiar domestic conventions of femininity, this does not mean that these conventions are not also hyper-cognized within the local context. Most important to note here, however, is the idea that corporeality is not exempt from cultural modifiers such as geographical locations which are often credited with shaping local notions of gender, but which are rarely credited with transforming subjective experiences of gendered embodiment.

Trinidad as a significant locale in the history and current practice of genital reassignment surgery thus informs and transforms trans women’s corporeal experience in three distinct ways. First, coming to Trinidad for GRS transforms the experience of surgery from strictly *clinical* to *cultural*: the legacy of 40 years of transsexual “pilgrimage” to the “sex change capital of the world” involves by far more than a hospital stay and check-ups at the doctor’s office. Second, the Trinidad experience transforms the experience from *individual* to *social*: the majority of patients are often accompanied by family members or partners, and some come with friends who are either anticipating their own surgery or have been here before as patients themselves. Further, the sociality at the Morning After House, and frequent and encouraged interaction with the constant flux of other transsexuals coming through Trinidad makes the journey to one’s “true self” a shared one for many. Third, Trinidad also transforms the surgical experience from *private* to *public*: frankly speaking, if you don’t live in Trinidad the whole town assumes that you are here for GRS. And while GRS for most is an intensely private matter few openly discuss within their social or family environments, Trinidad permits, even if under the cloak of anonymity, a

relatively open dialogue (if desired) with strangers about GRS beyond the nursing or medical staff directly involved in the process — nobody in “t-town” would be remotely “shocked” to hear that someone had a sex change just up the road from their house.

However, while GRS can be a culturally, socially, and publicly shared experience shaped by various local contexts, its actual clinical or surgical execution is remarkably similar across the globe. In the next chapter, I focus on precisely this contrast of the singular, clinical, surgical reality of genital reassignment and patients’ subjective meanings invested in a process many have anticipated for decades. Whereas much of the Trinidad experience is indeed shared, from traveling, to housing, to recovery and receiving post-surgical care, the central event of the process — the actual surgery — temporarily extricates the individual, medical body from the social, cultural self so that the much desired unification of body and self can be made possible after all.

Chapter 4: The Corporeality of GRS - Surgery, Recovery, and Post-Surgical Care

Becoming Female-Bodied

V-day: From Male to Female in Less than 4 Hours

I would imagine that few GRS patients ever forget the day of their surgery. Indeed, as I have already noted in the last chapter, transsexual women who have written about undergoing GRS in autobiographies or online blogs often deliver very detailed narratives about their personal experiences, from drinking a gallon-sized jug of ironically labeled *Go Lytely* laxative bowl prep the night before, to the point of losing consciousness to anesthesia, to the very first waking moments after surgery (aside from Griggs' 2004, see for example Rose 2003, Richards 1983, Conn 1974). These and other similar accounts show that GRS provokes a heightened sensibility or awareness of not only one's physical surroundings, but one's own embodiment — this is of course not unusual for any surgery patient. But unlike other surgical experiences which generally do not change a physical state fundamentally connected to a core part of one's identity, GRS is unique in its highly symbolic, transformative meaning to patients' self-perception as not only being female *identified*, but being female *bodied*. The often reiterated notion of “rebirth” or “second birthday” underscores the deeply personal meaning the surgery holds for transsexual women, and many of my own participants in particular.

In contrast to the patient's symbolic reality of embracing female embodiment through surgical renaissance, the clinical reality of genital reassignment is distinctly unromantic, bloody, and bio-technical. Whereas many patients celebrate the day of surgery as one of the most significant events in their lives, for Marci and her surgical team, that day is simply an ordinary Tuesday in Trinidad. Moreover, what many patients have spent a lifetime anticipating concludes rather anti-climactically, within about 4 hours in the operating room. Also, this may be one of the

few conditions in which, paradoxically, patients experience intense emotional pain *about* but not actually *in* their genitalia before surgery, while afterwards they experience intense physical pain *in*, but no emotional pain *about* their genitalia. Even more evocative is the significance of the cultural and personal meaning patients invest in genitalia as sexual organs of pleasure, as signaling bodily sites of reproduction, and most importantly, as markers of assigning — or in their case — re-assigning gender. Yet, all of these personal cultural meanings vanish in the impersonal clinical thralls of cutting, clamping, draining, dabbing, prying open, and suturing shut blood-soaked flesh folds; it is as if the ultimate signifiers of gendered personhood undergo their own rite of passage from separation to liminality to reintegration. But watching the surgical transformation of genital tissue prompts this question: at what point of this transformation is a penis no longer a penis? While patients (fortunately) never experience the liminal state of their physical transformation as they sink into unconsciousness with penises and wake up with vaginas, surgeons do indeed move through witnessing such states of genital liminality close up.

The clinical visuals of surgically modifying male genitalia to approximate the shape and function of female genitalia instantaneously dispel the laymen's notion of sex changes being about getting one's penis "cut off". Indeed, the most commonly practiced surgical technique for genital reassignment is *vaginoplasty*, in which much of the penile and scrotal tissue is refashioned into a vaginal lining, a clitoris, and both labia majora and minora. The only tissue which is actually discarded are the testicles and the erectile tissue — everything else is, colloquially speaking, "recycled" and "rewired". Vaginoplasty, although deceptively simple in its description, is primarily a risky surgery because of the proximity to other organs which could be damaged in the process. However, aside from rupturing intestinal walls or main arteries or fistulas developing later on, most GRS surgeons would probably not consider the surgery as a

high risk when compared to others. Nonetheless, because the surgery is creating a body part which — for lack of a better term — does not “go” on the body it is being attached to, complications may be few and far between, but those which can occur are rather serious. Because vaginoplasty leaves intact much of the patient’s nerve sensitivity it is the preferred surgical method to earlier approaches which included attaching a part of the sigmoid colon; in cases where penile length is too short, this method may be used out of necessity. However, there are some frequent medical problems associated with this and few GRS surgeons use it as a primary method.

The different meaning of “V-day” for patients and surgeons reflects of course more than oppositional clinical vs. patient interpretations of the actual event of the surgery. Generally, patient narrations about the event of surgery can be quite clinical, and surgeons may choose to align themselves with patients’ jargon instead of drawing on the clinical neutrality of medical speak. But although most of my participants could explain the surgical process in medical terms with ease, the clinically objective language of male reproductive anatomy rarely found its way into descriptions participants used to talk about the process. As expected, both Marci and her patients talked about the surgical processes in patient-identity affirming ways. I noticed that when talk centered on male genitalia, both used non-possessives such as “the penis” or “the scrotum”; on the other hand, when talk centered on female genitalia, possessives “your/my vagina” or “your/my clitoris” indicated affirmative genital embodiment and an implicit acknowledgement of patients as female. This narrative alignment with the patients’ view of their bodies as female represents an important bond between patient and practitioner in this case because it communicates sensitivity to understanding patients beyond the medical issue at hand.

Further, validating and respecting transsexual women's identity as legitimately female significantly increases patients' trust in GRS surgeons in general, and in Marci in particular.

What I found most intriguing about the language around surgical processes between Marci and her patients, however, was the softening of the seriousness of the surgery through the use of humorous euphemisms for both genitalia as well as their intended future function. Marci, for one, often uses humor very effectively to lessen patient's anxiety about the surgery and post-surgical care. For example, as patients often ask about the minimum length of recovery time before being able to engage in sexual intercourse, Marci sometimes de-sexualizes these questions by reframing them as required time before patients could "take it out for a drive". Similarly, when patients talked casually about the surgery, they often used euphemisms for reassignment such as changing one's "plumbing" or "wiring", and having a different "tool kit" or different "equipment" afterwards. While it would be easy to read vestigial signs of irreversible male enculturation into these choices of words (on both the part of the surgeon and the patient), I felt that these were signs of coming to terms with one's embodied past, rather than unconscious signs of cultural regression to maleness. Lastly, I also felt that using such words reflected the bond between Marci and her patients as sharing a common history as male-bodied; this type of casual, humorous reframing of clinical issues reveals that perhaps the clinical is not always so easily distinguishable from the interpersonal relationship between doctor and patient. And if V-day was the medical moment in which transsexual women's bodily dysphoria was eliminated by no longer making them male, V-day was also the cultural moment from which onward, patients no longer felt like "just a guy in a dress".

Post surgery, GRS patients usually stayed 4 days in the hospital unless surgical complications or the patients' general health condition demanded extended supervision. The

second day post-operative, patients were encouraged to get out of bed and walk a few steps to improve circulation. Marci told me that Biber ordered strict bed rest for 7 days for all of his patients but she believed that moving around greatly aids the overall healing process. I was astonished how most patients managed to get around so quickly and I admired the will power, teeth clenched, and fists bunched, which patients mustered up to endure the pain of those very shaky first steps. I was also amazed, as was Marci, how most older patients seemed to be better able to deal with post-surgical pain than younger patients. It remains a medical mystery of why this is the case, as common sense indicates otherwise; while younger bodies are thought to heal faster, apparently youth doesn't seem to be correlated to pain tolerance, or at least not in this case. I can only speculate that perhaps because the older patients had experienced major surgeries before, their previous experience with working through pain may have somehow primed them or prepared them better to deal with surgical pain. This would indicate that the psychological effects of surgery seem more intense if this is the first surgery ever experienced, and that fear and anxiety could contribute to experiencing pain more intensely.

Daily Rounds With the Doctor: The Medical Gaze in Action

Although I didn't actually accompany Marci on her daily rounds, she often walked in on me interviewing or visiting with patients. I always offered to leave the room to give patients some privacy or alone time with Marci, but most often I was invited to stay for at least some of the visit. This gave me a rare opportunity to observe the physician-patient relationship up close, as well as to listen to bedside exchanges unfolding casually.

I never saw Marci wear surgical garb or the ordinary white lab coat; Marci always visited patients in casual, everyday clothing which greatly aided the casualness of the visit. Her visits

were mostly short and information-driven, however, Marci often took a few extra minutes to ask non-medical questions about patients' lives. She always had such a relaxed demeanor about her which was calming to the patient. Sometimes she would hug patients, hold their hand, rub their shoulders. Her literal bedside manner was always gentle, reassuring, yet professional. She never made the patient feel divorced from their bodies and I never heard her discursively segregate the person from the patient body in front of her. Marci always added a light sense of humor to her check ups and assuaged patient complaints about the staff with which she was sometimes at odds. I felt that she often took the patients' side, at least when she was visiting, and listened patiently to occasional complaints about the nurses, knowing full well that when the hospital staff was overwhelmed, under-staffed, or overworked, there was little she could do.

She sometimes invited me to stay to look at the surgical site as if I was a medical student, out loud assessing how well surgery was healing, giving recommendations for care directly to the patient. Whenever she physically examined patients and I would ask if I should leave the room, she'd give me that "what, are you scared to look at it?" glance and laugh. Some patients allowed me to stay during the exam and searched my face for clues of good and bad. Although at first it felt quite inappropriate and intrusive to look at people's most private part of their bodies, after a few weeks it stopped being something out of the ordinary. I had quickly become desensitized to looking at the surgical site, but I was also highly conscious of having to maintain an unfazed demeanor as to not upset patients. To my own surprise, I learned to adopt a clinically objective stance much like the staff. Marci would put on a pair of surgical gloves and remove pads and bandages, exposing what most definitely did not look much like a vagina at first; iodine-tinged, hairless, swollen, and bruised tissue folds don't really look like anything. However, to appreciate the surgical process of genital reassignment, refocusing the medical gaze

on what there is now versus what there had been before, one can only marvel at the profoundly real as well as symbolic transformation of the human body.

If this was Marci's first post-operative visit, patients sometimes used a little handheld mirror to follow Marci's explanations of what exactly we were all looking at. But the medical gaze was not the only mechanism through which a different "seeing" of the body became possible. The "medical narrative", as I would call it, often accompanied what physicians "see" or describe looking at. As Marci's fingers navigated the wound like laser pointers on a presentation slide, she would name the individual parts of patients' new female anatomy. "See, here's your labia majora, here's the labia minora, and here's your clitoral hood" she would say, as if explaining the parts of an automotive engine. Patients would follow along on the mirror, paying close attention as if to make sure to be able to identify the parts later, on their own. There was something quite elementary-school like about instructing the patient to care for "their" new vaginas, almost as if they had been entrusted to care for another being. Marci's use of possessive pronouns connecting body parts with their owners was perhaps unintentionally validating of patient's physical sense of gender; if it was intentional, it invariably seemed to say "welcome to the club".

In contrast to Marci's use of possessive pronouns to refer to patients' genitalia, nurses who had to actually touch the genital areas to clean dressings and change bandaging, never really used the word "vagina" or "your vagina". Most nurses would discuss the area "down there" although there is nothing un-clinical about the word vagina. I speculate that this is where the cultural context of MSR being a small catholic hospital figures in; some nurses had served under Biber, had been around transsexual patients for more than 20 years, and seemed to like the transsexual patients at MSR, they never got comfortable with the instantly inter-personalizing

aspects of communication revolving around genitalia. This may be explained by the idea that when two people talk about one person's genitalia, it colors the conversation with sexual undertones; this is perhaps where discursive segregation of body parts is most difficult because nurses occupy a precarious position as liaisons between patient and surgeon through which they tend to form more personal relationships with patients (Colucciello 1996).

Vaginas Without Histories: Neogenital Embodiment and Somatic Experience

Looking at a surgically constructed vagina is quite different than looking at people's "natural" genitalia — I can't quite explain this notion except that these vaginas had no "history"; they looked as if they were generic versions or fleshy copies of "the original". They also looked so raw and traumatized that it was almost surreal looking upwards from a patient's genital area into a perfectly rosy and smiling and healthy face at the other end of the body. I also felt that for the transsexual patients at Mount San Rafael, "private" parts had become rather "public" parts by the time they left the hospital — the clinical context of talking about, looking at, cleaning, and the constant negotiation of pain management of their genitalia involving the surgeon, the staff, visitors, partners, and of course the anthropologist, "de-privatized" something we naturalize as intrinsically private. Vaginas without "histories" look peculiar on bodies which clearly had histories of injury, disease, sun exposure past and present, body modification such as tattoos, or simply the physiological signs of age. Then again, they also completed the biocentric imagery of female embodiment which no longer placed patients' transsexual bodies into a cultural imagery of gender liminality.

By the time Marci had finished her physical exams, she usually concluded that "everything looked great", even if it defied the visual reality of traumatized, swollen, "angry"

tissue. Framing the medical evaluation of a surgical wound in aesthetic terms is of course another way of reducing patient anxieties, unless the surgeon is giving him or herself a compliment on artistic achievement, which is most definitely true for Marci who views surgery as an art form in and of itself. I couldn't help but agree with her that her creations were indeed "beautiful" because their potential to transform patients relationships with their bodies from hate to love was nothing short of that.

Comportments of Discomfort: Gendered Embodiment of Pain

How patients dealt with pain became an interesting aspect of witnessing the physical recovery of GRS. In a strange way, vaginal pain became gendered pain; there was something about the patients "comportments of discomfort" which resembled the pain women who had just given birth expressed physically. However, not all patients dealt with similar pain levels or similar pain experiences. Enduring pain on the path to womanhood sometimes produced great warriors who internalized the pain with pride, and other times it produced little girls who felt justified in externalizing every sting of discomfort because after all, women are allowed to show pain. Redistributing the body's weight so as to de-pressurize the genital area makes for awkward movements and is a tell-tale sign of someone who recently had surgery. But what made this observation particularly salient was the comparison with a few FtM patients who had come to Trinidad for metoidioplasty²¹ and/or testicular implants. Although all patients post surgery would move rather slowly and carefully, it seemed that FtMs would draw much more attention to their genital area by touching it in front of others, and most notably hold the ubiquitous package of

²¹ Metoidioplasty refers to a surgical technique in which the testosterone-enlarged clitoris is reshaped into a micropenis.

frozen peas casually right over it as if it were the most ordinary thing to do. This perhaps reflects as cultural consciousness which denotes that it is much more acceptable for men to grab their genitalia in public whereas women are never to draw physical attention to theirs. On the other hand, it could be argued that precisely such cultural knowledge is utilized to emphasize one's newly acquired genital status in social situations; perhaps FtMs indexing of gender by now having "something there" to index in the first place, and vice versa for MtFs, operates not quite as unconsciously as it seems to for cisgendered individuals.

Learning to Dilate: Lessons in Creating Sexual Selves

Shortly after the internal packing and catheter are removed from the neo-vagina, patients are instructed in how to dilate by a nurse. Dilation involves inserting plastic stints of various sizes into the neo-vagina to carefully stretch the new vaginal cavity and prevent vaginal closure. In post-surgical care, this becomes a daily necessity about three times a day but lessens in frequency after the vagina is fully healed. Dilation is also a practice which most transsexual woman need to adopt for life unless they have frequent heterosexual intercourse or use dildos for sexual pleasure to prevent neo-vaginal atrophy.

The daily practice and experience of dilation produces a wholly new sensation for patients physically, emotionally, and most importantly, symbolically. The symbolism about being able to insert something into one's genital body versus inserting something into someone else's is readily apparent; women's bodies are commonly envisioned as culturally receptive, rather than inserting entities. It is this aspect of GRS which brings about a new physical reality which elevates many trans women's consciousness about experiencing their bodies as genitally or sexually female. The negotiation of physical discomfort endured to ensure later sexual

pleasure — regardless of whether heterosexual intercourse is actually desired — makes for a peculiar circumstance in which patients literally become active creators in their own sexual capacities.

Dilation necessitates vaginal lubrication, dilator sterilization with antibacterial ointments, lying in a comfortable and physically enabling position, relaxing pelvic muscles, and navigating, inch by inch, the slow insertion of a hard, inflexible piece of plastic. Through dilation, patients develop a new sensory imaginary about vaginal depth, curvature, and unexplored terrains of their own physiology. But more importantly, patients also experience genital sensations, even if not yet sexual, which are now experienced as congruent with female embodiment. This body-self congruence, I felt, also furthers the permissiveness, acknowledgement, a welcomeness of genito-sexual sensitivity which had been a dysphoric, negative experience for most patients in the past.

However, nothing could be more non-sexual as dilation even if it essentially mimics the mechanics of heterosexual intercourse. The clinical reality of dilation extends beyond the nurse instructing and actually supervising the patient dilating for the first time. This highly personal context, watching a patient dilate, requires perhaps the most emotion work nurses working with GRS patients must accomplish. Far beyond changing bandages or cleaning surgical wounds, here, two strangers must engage in simulating an essentially sexual act without any sexual involvement, reference, or sexual response (individually or to the other person). This extremely personal interaction between patient and nurse certainly stretches the boundaries of clinically scripted doctor-patient encounters because sometimes patients ask nurses questions about female sexual activities which cannot exactly be answered in clinical terms. These questions are sometimes bridging the clinical with the personal because patients looked to nurses for answers

not because they are medically knowledgeable personnel, but because they are natal females with sexual experience.

Although several nurses were knowledgeable about how to instruct patients on dilation, this task usually fell to one of the nurses most experienced with working with Marci's patients post surgery. "Sybill" had a very matter-of-fact approach to dilation training while being able to assuage patient fears about rupturing freshly sutured tissue. Neo-vaginas are less flexible than natal ones and since they are fresh surgical wounds, inserting hard plastic objects into them seems antithetical to healing, many patients are initially worried about dilating. Since dilation requires paying close attention to letting the position and flexibility of the neo-vaginal canal direct the dilators, patients furthermore become hyper-aware of their new bodily dimensions. Thus, "Sybill's" job was not so much working with patients on technique, but also on guiding patients mentally in envisioning a new sense of their anatomy and controlling muscle contractions to permit insertion in the first place. The patients' own emotion work in this context required trusting her instruction against their intuitive hesitation to insert the dilators; yet these cooperative efforts of learning to care for one's new body seemed to unfold with remarkable ease.

After patients returned from their instructional visit in the doctor's office, they were left to their own devices. Dilation times were the quietest periods at the MAH as patients would retreat to the privacy of their rooms for 20 to 30 minutes. The daily ritual of dilation provided the first opportunity for patients to get to know their new anatomy intimately and privately. However, patients' fears of suture ruptures and bleeding often became a reality which sent quite a few patients into an instant panic despite Marci's and the nurses assurance that some light bleeding was normal during dilation. Although bleeding of any kind is of course always

unsettling, many patients worried a great deal about it. But ironically, some patients interpreted their vaginal bleeding as the ultimate signifier of being physically female. And Marci capitalized on the analogy of natal women's natural biological processes in her humorous assertion that bleeding was a "true" sign of womanhood. But her intent, as if to say "you want to be a woman but you can't deal with a little blood?", was also a cleverly convenient way to ward off unnecessary patient return visits to her office to double check on the sutures yet again.

"It's a Girl": Experiencing GRS as a Family

As I have suggested earlier, illness is never an isolated, singular, or individualistic experience and neither is healing or recovery. Most of the time, when people fall ill or struggle with disease, there are others whose proximity draws them into the illness experience through obligations of care-giving. Undergoing GRS is no different; although the symbolic meaning of GRS remains perhaps highly personal or idiosyncratic, and is perhaps only understood by others from clinical or compassionate aspects, going through the process together affects all parties involved. In this section, I want to explore what it means to care for a family member or spouse going through and recovering from GRS. Since most supporting persons fell into categories of either parents or spouses/partners, I will focus mainly on these two sets of individuals, beginning with parents, then moving on to pre-transition spouses, and ending with post-transition partners. A total of 10 participants in their early 20s came to Trinidad with parental (and some sibling) support. April and Mia were accompanied by both parents, Rhonda, Audrey, Elsa, and Joanne came to Trinidad accompanied by their mothers, Nadine came with her father, Sia and May were picked up by their fathers, and Gill came with her mother and her sister. I will use Gill's example to illustrate family dynamics of experiencing GRS as a family.

Gill was a soft spoken 22 year old college student who came to Trinidad with her mother “Alexis” and sister “Corinne”. I was instantly taken by the level of family cohesiveness and their unflinchingly dedicated support for Gill; it was as if they operated as a single unit through the entire process of the surgical experience — I called them “Team Transition”. Although throughout my fieldwork I met quite a few family members of patients who had come to Trinidad to support their loved ones, Team Transition exemplified the all-American middle class family idealism that one family member’s problem became every family member’s problem. The entire family had temporarily re-organized their lives to accommodate Gill’s surgery — the women went to Trinidad with Gill while dad stayed home to work and take care of the dog.

“Alexis” not only exemplified the all-American woman who dedicates her life to raising a family, but she also embodied a particular over-protectiveness which I came to notice in most other mothers who had accompanied their transsexual youngsters for surgery in Trinidad. Almost all mothers who came to Trinidad, even those with whose kids I did not work, struck me as not necessarily strong or independent women in and of themselves, but strong and devoted advocates for their children nonetheless. What I felt was even more interesting was the complementarity of their children’s relative helplessness, dependence, and reliance on their mothers throughout the recovery process even if their individual personalities did not express these features in general. I wondered whether this relational complementarity of the strong mother was highly situational because of the surgery or whether perhaps the more general circumstances of gender transition motivates mothers to become stronger parents. Most parents are protective over their children and worry about their well-being - but these mothers had risen far beyond parental concern and support; they struck me as having been transformed themselves by their children’s transition rather than simply adjusting to its circumstances.

Alexis and Gill's relationship was the first of such complementary dyads I noticed; Alexis was vibrant, outgoing, beaming, and attentive. Gill, on the other hand, was quiet and demure, not unlike other shy young women who prefer to be "unseen" rather than drawing attention to themselves in public places. Although Gill warmed to me slowly over the course of our interviews, Alexis and Corinne were quick to adopt me into their midst. I believe their warmth and openness towards me greatly helped Gill to trust me and open up to me as well. Alexis and Corinne would often stay in the room whenever I interviewed Gill and they chimed in from time to time. Initially I was worried about Alexis and Corinne answering my questions for Gill; but eventually, Gill gained her own voice and Alexis and Corinne yielded.

Innocence Lost: Care-giving Practices of Parents throughout GRS Recovery

The style of care which parents provided to their children during the hospital stay and at the MAH initially seemed no different, at least to me, than any other parental care for children recovering from surgery or general illness. Maximizing physical comfort, smoothing aches and pains with empathy and patience, yielding to any wishes for particular foods or places to rest comfortably, parents rarely missed an opportunity to be parents again, even though most of their children were already living on their own independently. What was different, however, was the changing gender dynamic which now turned mother-son relationships into mother-daughter care-giving relationships, and father-son relationships into father-daughter caregiving relationships. Here, caregiving challenged the distinct cultural boundaries in which pattern of gendered care become visible: whereas mothers are usually prepared and designated to address questions or problems pertaining to reproductive functioning in girls, fathers tend to assume this responsibility for boys. It could be argued that these cultural boundaries are rooted in Freudian

psychology or Incest taboos in terms of intimately relating to children's genitalia, at least past the point of puberty. Similarly, most children are generally socialized to address same-gender parents with concerns relating to puberty, sexual anatomy, or sexuality. However GRS provided and necessitated an unavoidable context in which personal care required intimacies and engagement with body parts and functions which adult children generally shield from parental knowledge or exposure.

This new practice of gendered care-giving required emotion work in both, parents and their adult children; if there ever was such a notion of parents retaining a sense of sexual innocence of their children into adulthood, watching their children undergo GRS most certainly symbolized an ethos of innocence lost. And although most parents had come to terms with the natural sequence of their children becoming adults and thus sexual beings, the omnipresent awareness not only of newly constructed body parts but their ultimately intended purpose required new sensibilities of parenthood. There is a fine line between talking about, viewing, and touching one's own children's genitalia when they are young, and when they are sexually functional adults; this careful negotiation between empathy, curiosity, and trying to gain an understanding about how their children physically and emotionally processed the surgery required not only a new sensibility of parenthood, but also a wholly different practice of relating to their recovering children.

The paradox of adult children temporarily reverting to a state of need and reliance of parents' physical as well as emotional support contrasting with personal and private physical boundaries between parents and children since adulthood, became apparent in every parent-child dyad. Negotiating privacy and involvement, I felt, was far more difficult for fathers than mothers. Although I was not present for those intimate moments in which post-surgical privacy

boundaries between children and parents were negotiated behind closed bedroom doors, I could sense varying comfort levels between parents, with mothers predictably faring better than fathers, from our frequent conversations on the MAH porch. I felt that fathers made a tremendous effort to comfort their transsexual daughters in ways they felt were appropriate. Most notable however, was their own sense of helplessness, trying to relate best they could to take part in their children's experience. For example, I wondered to myself how "Jack", Nadine's father, processed thoughts about Nadine having to dilate shortly after surgery. Jack was a good-humored retired engineer, ever ready to lend a helping hand to others in the house, and never missing an opportunity to engage with other parents or patients on the MAH porch. Jack and his wife had adopted Nadine when she was a small child, along with a number of other foster kids; he was a devoted father and like Alexis, protective, attentive, and consumed with parental concern about Nadine's post-surgical recovery. Although I felt that they had a close relationship, Jack seemed lost and nervous whenever Nadine retreated into her bedroom to dilate; and although he understood the need for physical privacy, I think he struggled with the very thought of his sexually inexperienced teenager privately exploring her sexual anatomy, preparing herself for eventual heterosexual intercourse in the future. I imagined that Jack was not the only father who struggled with this new ethic of care giving. And although I had the chance to personally observe and interact with only two fathers, I would guess that fathers generally would experience more relational difficulty throughout the reassignment process of their biological sons than mothers do. Nonetheless, I also felt that fathers embraced the care-giving challenge as much as mothers did.

Although I did not officially conduct any interviews with parents of patients, I had ample opportunity for casual conversations, and moreover, to observe how parents began to relate to

each other and share their own experiences at the MAH. Indeed, even if parents had installed themselves in a nearby B&B because of spatial limitations at the house, many came and spent days or afternoons at the MAH for its socializing aspects which both Marci and Carol encouraged. Assuming an experiential commonality, most parents were eager to meet others, reminisce about watching their gender dysphoric children grow up, and discuss similar problems their kids were having or had dealt with in the past. Even though most parents had procured counseling support for their children, and sought professional advice for themselves in addition to joining a parental support group, I felt that meeting other parents at the MAH while their children underwent GRS was therapeutic to them in that they felt less alone throughout the process. I felt that parents, much like patients, created temporary bonds, some perhaps a bit more permanent, seeking each others' company and advice, helping each other when need arose, and more importantly, being in an environment where they didn't feel like they had to feel shame, secrecy, or guilt about their children's or their own lives. For many parents, the sociality at MAH thus became unofficial contexts for covert group therapy while at the same time letting parents relax and forget — if only for a few hours — that their child was so very “different” from others because everyone's child here was “different” in the same way.

Nonetheless, the stress of surgery, recovery, travel, inconvenience, expense, and unfamiliar environments was not just hard on patients; parents had to adjust all the same. From managing the oftentimes taxing 24 hour care for their youngsters, who were alternately too doped up on painkillers to do anything for themselves, or cantankerously irritated from being in constant physical discomfort, to checking in with families and jobs at home, and keeping everybody updated on the daily progress, parents worked hard not to succumb to the exhaustion of surgery-by-proxy. I sometimes felt that while their kids regained their physical and emotional

strength, most parents looked increasingly more depleted by the day. And I suppose that without having had the primer of at least 18 years of parental experience, few individuals sustain the demands of intensely self-sacrificing care for their own flesh and blood.

Surgery Ties which Bind and Un-Bind: Wives, Husbands, and Partners of GRS Patients

One afternoon at Mount San Rafael, I was talking to Nancy about what GRS “gave” her which she answered by telling me what GRS “took away” from her wife Petra. Nancy held on to the bed-gate with her perfectly manicured hand, leaned over, and, referring to herself in the third person, she said “Nancy took her [Petra’s] husband and now she took the final part of it”.

Nancy’s implicit allusion to her penis being gone reveals the physical reality of GRS for many of the wives or female partners who enjoyed, at some point or even up to the point of surgery, a sexual relationship involving their transsexual partners’ genitalia. Although for most transsexual women who have been taking feminizing hormones for a few years, penile erections no longer become possible, for some, this is not the case. But even if full erection is not or no longer possible, some wives or female partners who remain sexually interested, still desire sexual engagement with their partners as genito-anatomical males. And even if the penis is no longer directly involved in sexual stimulation, for many wives, the sheer presence of male anatomical parts suffices for sexual engagement because regardless of penile involvement, it engenders the sexual act as essentially heterosexual which confirms most wives’ sexual orientation. Indeed, even if husbands or partners have fully transitioned and present full-time as women, the sexual reminder of male-ness often becomes symbolic for the still-heterosexual relationship against which some wives of transsexual women define themselves. Post surgery, however, this last symbolic tie which binds partners together anatomically as male and female, irrelevant of actual

sexual involvement or both partner's current sexual identification, is severed permanently. And while this does not automatically render a relationship "lesbian" in the eyes of its participants, the culturally objective interpretation of it pre-occupies many wives in that they openly reject its assertion, at least when or if prompted for sexual identification (Sanger 2010).

The wives or pre-transition partners of transsexual women I had met in Trinidad confirmed this sentiment in our casual conversations. Although I did not find any hostile attitudes towards gays or lesbians among heterosexual-identified wives or female partners, I did sense a variety of subtle rejections of lesbian sexual identities in partners, especially wives who had been married to their husbands for many years. And even if they still desired sexual contact with their partners, wives were generally at a loss for visions of future sexual engagement, and even more so for changing requirements on their own sexual involvement (i.e. sexually satisfying their partners). But for couples in their late 50s and 60s, sexuality had also been largely replaced by companionship as the glue which held their relationships together, which perhaps reflects the larger course of long-term relationships or marriages in general. Married couples who came to Trinidad together usually evinced strong bonds of such companionship, cohabitation familiarity, and that indefinable, "old married couple" flair where people don't realize that they engage in habitual bickering whenever they do. I saw a sweetness and a genuine caring disposition between many such couples which had already weathered through various years of transition. By the time they got to Trinidad, all the major issues most couples had grappled with because of gender transition were long "off the table", processed, and filed somewhere between family photo albums and old family feuds. Indeed, those couples' interactions and communications were remarkably in tune despite this most unusual circumstance in which any couple could find themselves.

However, I did catch a glimpse of wives' discontent here and there, and as much as agreement and appeasement is part of being a supportive wife, a few wives took the opportunity to tell me how they really felt about their husbands' surgery. Mostly, wives felt that life with their transsexual partners post surgery was a "wait and see" situation. Still, I was astounded to find, that despite the obvious difficulty imposed on their relationships, most wives felt that the person they were with now, was still the same, but "happier"; in essence, what they were telling me was how they benefitted relationally from this transition. But I also felt that there was a complementary side to it: their husbands were feeling a sense of guilt about their transition which must be read against a sense of obligation to their wives. I thought it was quite thoughtful, and not just guilt-relieving, as some might interpret, that some husbands who were soon-to-be physical women indulged their wives with gifts and freedoms to do whatever they wanted to do for themselves. Some couples also found that they could relate better to each other now and most felt their relationship had somewhat improved, rather than diminished through transition as expected. Being able to share things which are usually gendered activities, couples now could explore closeness based on shared interests, not obligations. I felt that although many wives shared a common character trait being motherly and yielding, their former husbands also tried to respect or compromise on personal limits their wives would set. While I wouldn't go so far as to say that their husbands' transition empowered wives to become more assertive, I would say that it necessitated certain levels of assertiveness outside of the relationship. The symbolic "loss" of their husband, most prominently physically, was balanced by gaining a new female companion with whom sharing of companionate intimacy was highly desired. Still, while that same person was "still there", meaning the shared memories and experiences gained from that relationship

were still providing the context for connectivity, the interactional contexts had changed significantly, especially when interactions with outside persons were involved.

In terms of relationships then, the surgery is perhaps even more of a physical finality for wives than the person actually undergoing it; transsexual women have many times imagined themselves as women in all of life's ordinary intersubjective engagements including sexuality — it is other people who have to get used to this new type of gendered relationship. Nonetheless, even if everyday life with the person who used to be a husband and is now either a roommate, best friend, or differently-bodied partner, has been absorbed and its newness has faded, I found that wives were both embracing the increased happiness of the person they loved as well as being silently sad for the loss of the person who had helped to shape life as they knew it, and who was both “still there” in embodied memory, yet gone forever from their immediate reach, physically and emotionally.

Since there was only one husband who accompanied his wife (Joyce) to Trinidad, this example cannot be extrapolated into generalizations but is nonetheless indicative of the effect of GRS beyond the person. “Luke” was a sturdy built, quiet, and husky guy who had met Joyce in a support group for Veterans. Both Joyce and Luke looked forward to heterosexual engagement once Joyce's vagina was healed up and they could actually “consummate” their heterosexual marriage. Joyce had told me an interesting story one afternoon about Luke's desire to please her sexually which Joyce usually rejected as she did not want Luke to touch her penis. One day, however, when addressing his frustration, she daringly proposed that he “suck her dick” or “give her a blow-job”, putting into words a graphic description that easily engenders such sexual acts between two biological males as homosexual. Since she explicitly referred to her own body parts as male anatomy to remind him that pleasing her sexually in this way carried homosexual

overtone, he refrained. And although I am not sure whether if she had said it any other way he would have actually engaged in male-male genital contact, the literal expression of what such acts of “pleasing her” would entail objectively, was intended to remind him that Joyce was still a biological male. What I found most interesting about this incident, however, was that it may not have been Luke who would have experienced the most discomfort about performing oral sex on his wife, but rather that Joyce would have had to witness her heterosexual husband engage in what she felt was homosexual behavior. Joyce repeatedly stated that Luke was heterosexual and had never been with another man, nor was he remotely interested in men. This of course not only validated her but evaded any allusions to their relationship being at all homosexual.

Other than Joyce, only Elsa had brought her young boyfriend of 6 months along with her mother. Elsa and “Sam’s” relationship had started much like most other young people’s today: they met online, started talking, and eventually met each other in person. Sam identified as bisexual and had no “hang ups” about Elsa’s transsexualism. The two seemed quite attached at the hip, as much as this was possible given Elsa’s surgical circumstances. In the MAH’s Danny Lee apartment, which they shared with Elsa’s mother, the two had set up their lap-tops on TV trays, side by side, and played video games while Elsa was recovering from her surgery — I hardly ever saw one without the other. Yet, I wondered to myself how Sam was processing this experience: having only met Elsa six months ago, there he was, in a small town, in a house full of other trans women, helping his new girlfriend recover from GRS, with her mother by their side.

Other women who had met their transsexual partners during or post transition posed a different framework for experiencing GRS alongside of them. Those women who accompanied their partners to Trinidad impressed on me an image not very different from parents who had

come to support their children. For example, Sonya's and Trish's young girlfriends transformed into attentive and loving 24 hour nurses, taking a very active part in their partner's recovery. For them, the experience of witnessing the daily bodily changes and processes throughout the surgery and recovery of their partners was perhaps the most closely involved of all. On one hand, as for being involved in daily check-ups, clean-ups, or dilation practices, female partners were not subjected to maintaining personal or privacy boundaries around genitalia. Indeed, it seemed that having female partners involved in the process of recovery allowed for a new type of intimacy based on newly shared embodiment. It felt as if female partners, in a sense, became reference points for the appearance and function of the newly created vaginas which are initially only surgical wounds. This sharing in this visceral experience was also highly precarious because after all, the sexual anatomy of partners generally constitutes, or is supposed to constitute, an impetus of desire. Here, however, I wondered what kind of cognitive effects witnessing the creation of genitalia had on future sexual attraction to them. This is a notion which is so uniquely strange, that it quite possibly defies all laws of sexual attraction: how can bodies or body parts become at once so de-sexualized as to override any notions of sexual arousal or engagement while at other points be re-sexualized to create it? Of course, the same question can be asked of men who have watched their wives give birth, except that giving birth does not change anything about the intended function of female genitalia nor does it change its previous and future potential for sexual arousal. I would even argue that there is no before-and-after imagery of any bodies which could even remotely compare to then-and-now visuals of sex changed bodies.

Then again, as they Sonya and Trish were currently sexually active with their partners, the changing visuals of their sexual anatomy may not have had as profound an impact on their girlfriends as it may have had on spouses who had been married to their transsexual partners for

decades; moreover, Sonya and Trish had perhaps had more opportunities to negotiate a pre-operative sexual engagement which was most comfortable to them and which their partners respected or accommodated. As is the case with many pre-operative trans women and their sexual partners, involving the penis sexually may pose a sense of discomfort, especially if female partners desire penetration despite perceiving their transsexual partners as female. And although commonsensically, lesbian-identified partners of transsexuals are thought to see male genitalia as either unattractive or as barriers to sexual engagement generally, it seemed that among participants who were in relationships with lesbians, the greater discomfort about pre-operative genitalia was usually on the side of transsexual partners.

From Experience to Expression: Connecting Bodily Changes to Social Identities

As much as the surgical process, recovery, healing, care needing and care giving can be a shared experience, and as much as family members or partners can become part of the transformative experience of GRS, receiving unconditional support does not necessarily mean that others can understand what it means to be a transsexual, nor what it means to undergo GRS. In the next chapter, I thus move from descriptions of the surgical and recovery processes to transsexual women's narratives articulating their own perspectives on being situated as patients in the medical model. However, as medical anthropologists have shown, *experiencing illness* does not unproblematically enable subjects to *talk about experiencing illness*; here, narrative takes a central place in analytical approaches to corporeal changes and their effects on the social self. GRS patient narratives reiterate the constraints of medical discourse in creating and limiting how individuals establish themselves as medical subjects and refocuses the analysis on authorship:

how does medical discourse inform, legitimize, and shape patients' explanatory models of illness and healing experiences?

As the surgical drama of GRS concludes, the interchange of corporeality and identity continues to play out on transsexual bodies as they move out of the clinical recovery room back into the social world; and where medical stabilizing of vital bodies end, the social, integrative healing of the individual begins. And while on the operating table, surgical bodies are silenced and passive, post-surgical bodies speak and become active contributors to experiences of transsexual embodiment and identity. As transsexual women and those who accompany them in the process move through the various phases of physical recovery and reconnaissance of their medically modified bodies, new body-selves become vocal in distinctively cultural bound ways. Thus, transsexual women becoming female bodied create not only a renewed sense of ownership of the body, but also a renewed sense of authorship of the self. And it is precisely this authorship of the self, and more specifically the gendered self, which emerges through narration about the personal meanings, hopes, and expectations invested in GRS.

Chapter 5: Patient Perspectives on GID as a Medical Problem
Individual Gains of GRS

Completing Selves: Body, Mind, and Medicine

This chapter explores patient perspectives on GID as a psycho-medical problem and GRS as its biomedical solution. I first focus on patients' narratives as to whether GID constitutes, as current medical models suggest, a mental disorder as classified in the DSM. Secondly, I explore patient narratives and thoughts about the meaning and symbolism of GRS and its contribution to patients' holistic sense of self to advance an understanding which reaches beyond the metaphor of being "trapped in the wrong body". As a major critique of GRS follow-up studies, I suggested earlier that patients' expectations, hopes, and meanings invested in the surgery are generally not obtained or considered in such studies. If anything, they are usually collectively assumed rather than individually assessed in follow up reports. However, I propose that patient-centered narratives provide a key insight into subjective ideas about transsexual embodiment which are instrumental in analyzing GID from a cultural perspective. I was particularly interested in how patients narrated the symbolism associated with GRS beyond its surgical realities. While biomedical practitioners may not always be attuned to GRS being a means to an end rather than an end to itself, anthropological perspectives on transformative events to the body need to consider its symbolism to deepen a cultural understanding of such processes.

Third, I examine patients' views on whether or not GRS constitutes a cure for GID and the rationales behind it; conversely, I return to the meaning of GRS for patients by asking patients about the hypothetical inability of obtaining the surgery to underscore its therapeutic potential for the individual. In other words, what I examine here is the medical "problem - diagnosis- treatment - cure" model from a patient perspective by engaging them with the clinical

understanding of GID and GRS. Drawing on Kleinman's notion of Explanatory Models (EMs), patient perspectives on their own pathologization and corresponding treatment constitute an important aspect of ethnographic work on gender reassignment because it reveals the differences and commonalities between medical models of illness and patient perspectives. Lastly, I turn my attention to an alternative cultural interpretation of GID, especially expanding on mediations of having had a socially male history as constituting an important symptom of GID, as well as the cultural meanings of and motivations for GRS reaching beyond the elimination of body dysphoria for the individual.

Although this and the following chapters essentially explore patient perspectives and explanatory models of illness and healing experiences, I have also included the surgeon's (Marci) perspective on several topics discussed. Marci's opinions on her patients' experiences as well as transsexualism as a medical problem are invaluable here for several reasons. Because doctors are often said to hold divergent perspectives on illness and health from their patients, the doctor-patient relationship is a common analytical problematic explored by medical anthropologists. However, assumptions of divergence between clinical and personal accounts of illness are often idealized or exaggerated as opposing when in fact they may align more than diverge. Secondly, Marci's unique position as not only a GRS surgeon, but also a transsexual woman who has undergone the process of gender transition and GRS herself, complicates the doctor-patient relationship as constituting distinctly opposite positions in the medical model. On the other hand, Marci does represent the authoritative voice of medicine even if she at times disagrees with its underlying premises. Lastly, comparing Marci's perspectives with those of her patients side-by-side reveals an important insight into the multiplicity, rather than singularity, of

identity as she is at once speaking as a surgeon, as a transsexual woman, and as a former GRS patient herself.

In this chapter, I want to try and contrast the singular medical focus on connecting the body to the mind with the individual motivations and gains from such connections reaching above and beyond its medical dualism. The body and its social meaning, according to Lock (1993), constitute dual modes of expressing belonging and dissent which are “conceptualized as culturally produced and in dialectical exchange with the externalized ongoing performance of social life” (141). Good adds that “the body is not simply a physical object or physiological state but an essential part of the self” whereby “Consciousness itself is inseparable from the conscious body” (1994:116). Therefore, Good recommends focusing not on the body as “the object of medical practice” but rather on the body as a “creative source of experience” (118).

Unlike medical concepts of mind and body as dualistic and separate entities, I found that transsexual bodies are always engaged in dialogues with the self. “Recognizing — or even being — one’s self unfolds in narrative language, includes attention to others, and takes account of the body” writes Charon (2006:73). “The body has taken on great importance in understanding the self” Charon continues, as the body “has become our most legible signature...corporeal evidence proclaims the individuality, the authenticity, the singularity of the self” (76). The various ways on which participants have described their anatomic discomfort and its connection to their subjective identities shows how identical medical interventions can have different individual rationalizations. However, “What appears to be a common destination on the pilgrimage for identity is the shrine of flesh and blood...” Charon remarks (87) which complicates both the connection and the disjuncture between self and body if multiple interpretations of these are possible. Acknowledging this multiplicity of body-relatedness, Frank poignantly asks “Is my

body the flesh that ‘I’, the cognitive, ethereal I, only happen to inhabit, or is whatever ‘I’ am only to be found as my body? Do I *have* a body or *am* I a body?” (1995:33, italics in original)

Scheper-Hughes (1987) similarly rejects the Cartesian mind/body dualism in favor of conceptualizing “the body” as “the three bodies” – the individual body, the social body, and the body politic. The individual body refers to the “lived experience of the body-self”, the social body refers to “the body as a natural symbol with which to think about nature, society and culture...”, and the body politic refers to the “regulation, surveillance, and control of bodies in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference” (8). Of particular interest to Scheper-Hughes is the body politic, which she theorizes in the framework of post-structuralism as suggestive of “why and how certain bodies are socially produced” (8). Placing the body in the context of medicalization following the mind/body distinction, she argues that clinical medicine focuses too much on locating illness and disease either in the mind or the body because of a lack of discursive resources with which to explain suffering from an integrated, holistic perspective. Being thus “trapped by the Cartesian legacy” strongly mirrors the “being trapped in the wrong body” metaphor often found in transsexual autobiography and psycho-medical discourse on transsexualism. The transgression of mind into body and vice versa in the context of “curing” transsexualism by making “the body fit the mind rather than making the mind fit the body” as I have discussed earlier, thus exemplifies Scheper-Hughes’ point that “medicalization inevitably entails a missed identification between the individual and the social bodies, and a tendency to transform the social into the biological” (10).

Scheper-Hughes concludes that “The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as

well as the locus of personal and social resistance, creativity, and struggle” (31). Thus, the problematic position of the transsexual body in a bio-medical perspective, which follows the Cartesian mind/body dualism cannot be decontextualized or theorized away from the lived, everyday experience of transsexualism. The transsexual body is the individual, the social, and the body politic in that cultural meaning is attributed and inscribed on it intersubjectively by the persons who inhabit it as well as by those who institutionalize, legitimize, regulate, and thereby control it.

Is GID a Mental Disorder?: Patient Perspectives on GID and Diagnosis

I want to begin by exploring a fundamental question about what transsexual women think about their own pathologization. This is a very important starting point because trans activists from all kinds of different cultural backgrounds have taken up this very debate since transsexualism became classified as a mental disorder in the 1980s. I found that the question of whether GID is, or should be viewed as, a mental disorder is not really a yes or no question, but rather reveals how GRS patients negotiate, incorporate, and challenge psycho-medical discourse about themselves.

The vast majority of participants felt that GID was not a mental disorder and should not be included in the DSM although its inclusion grants transsexuals access to medical services and resources such as hormones and GRS. Out of all participants, only Mary was fully supportive of the model, the diagnosis, and its DSM inclusion. Those who did not outright reject the mental illness model or GID still had ambiguous or mixed feelings. For example, Gill noted that “Disorder perfectly describes it” although she thought that placing GID on the same level as “being insane” was insulting. And although she didn’t necessarily feel that the diagnosis in and

of itself was stigmatizing, she poignantly noted that “No one diagnoses any good things...”. Reece also did not have too much of a problem with the GID diagnosis but found it frustrating to have to follow the *Harry Benjamin Standards of Care* (SOC) protocols. Sonya, Lisa, and a few others also felt somewhat indifferent or undecided on the issue because medical treatment was conditional on the diagnosis, and Sia would not have a problem with it if insurance companies generally would cover the surgery. Kelsey also felt the GID diagnosis was very ambiguous — on one hand she felt that GID made the condition “official” and therefore “more ok for society”, but on the other hand, the classification as a mental illness suggested that there was “something wrong” with her.

A significant amount of participants conceptualized GID as a physical or medical, not psychological problem, and some conceptualized it as a physical “deformity” or “birth defect”. Reece aptly framed GID as a “physical disorder that manifests itself in psychological problems” and Sonya similarly agreed that psychological issues stem from dealing with being or living as a transsexual, and not from having GID. Others emphasized that even if there was some validity to the condition, the distress they experienced was more sociogenic, and not intrinsic to GID. Tina felt GID was a necessary label but she did not think she had a disorder — people who didn’t understand her as a woman, she said, had the disorder. Carly thought that GID was not necessarily a mental illness, yet she noted that lots of transsexuals suffer psychologically from the stress associated with living with GID. Jesse didn’t feel that GID should be in the DSM as a pathology, but rather that people “need help with the stressors surrounding GID”. Felicia felt strongly about GID being a societal issue, not a psychological issue. The only stress she experienced was society treating her like she was “some sort of weirdo” — her fear was about how people reacted to her, not about living as a woman.

Joyce felt that nobody who was labeled mentally ill should have any kind of surgery as it indicated a “complete contradiction” — she did not believe that it was possible to have a physical solution to a mental problem. Like Joyce, Lana strongly felt that GID was not a mental illness because “you can’t be mentally ill and get the surgery”. She thought the diagnosis was “bullshit”; and that she felt she had “cross-gender-phoria”, not gender dysphoria, emphasizing a positive feeling toward her identity as a woman. Luna added “it’s not that I want to be a woman, I am a woman” — but of course statements like these were the reason, she reiterated, transsexualism was labeled as a mental disorder in the first place. She saw it more like a physical disorder: “it’s like having an elephant trunk on your forehead” she remarked. Carla felt that GID was not a mental disorder needing treatment but that “the stress caused by it can be addressed by mental health professionals”. May refused to accept GID as a mental condition; she felt it was a physical problem and that her resulting mental issues and stress were created by society, not GID. But social stress alone because of a physical situation, May noted, is not a recognized disorder in and of itself. While GRS addressed the physical problem, the stress was psychological as a result, not a cause. Haley also felt that GID was not a mental disorder, comparing it to homosexuality: “it’s like saying you have a gay identity disorder”, she noted.

Rose felt that the GID diagnosis was good in a practical sense as it could be used for insurance purposes. Also as of recent, she noted, GRS became a federal tax deduction because it was recognized as a medically necessary treatment, which is why she did not think it should be removed from the DSM. Although Rose felt transsexualism was a societal problem, GID as a psychological condition was based on primarily internal struggles, not external realities. Rose’s explanatory model was based on a brain differentiation theory which legitimized her brain as having developed female. Having to be socialized to forcefully imitate and emulate male

behavior rather than female behavior constituted the primary stressor for her because she felt this even before she knew anything about transsexualism. The social repression of her condition drove her into isolation, affected her career and led to substance abuse. Rose felt like she was locked in a prison, watching the world go by, excluded from social participation.

Zoe felt that GRS was “correcting a physical deformity” and that if at all, GID was an extreme form of body dysmorphic disorder. She felt that transsexuals were not delusional in thinking they were women but that society was delusional by focusing exclusively on genitalia to gender people. She didn’t feel that she had a gender identity problem — she simply felt that her gender did not match what she looked like. Dara thought it was “ridiculous that you have to be diagnosed with GID to have the surgery”. Her case exemplified her frustration as she did not consider herself transsexual or transgendered but intersexed which is why she did find medicalization necessary to accessing medical care. Nancy thought the DSM diagnosis “is a crock”; permanently having the term “disorder” in her medical records proved difficult for her as a law enforcement officer because “they wanna make sure you’re not gonna go ballistic”. Vicky’s thoughts on GID were that “I don’t think I’m mentally ill...I think that I’m very very sad and sullen and that I’ve missed out on a great deal because of the fact that my brain didn’t match my body”.

Like her patients, Marci felt that GID is not an identity disorder; people know who they are at an early age. Gender dysphoria made some sense to her as she took it to refer to being uncomfortable with one’s natal sex. She noted that often GID and GD are confused or used interchangeably; the newly proposed term, Gender Incongruence, fits a little better but is not perfect. “No semantic term is perfect,” notes Marci, “because of the tremendous amount of difference, range within the diagnosis”. I asked Marci whether the current notion of GID

describes her patient body, and she said, “No, there are subtleties, so many differences”. She felt that the diagnosis is merely necessary to access treatment. Marci’s biggest argument for the DSM removal of GID because of its stigmatizing aspect was that if people do not view transsexuals as psychologically equal, or having mental health equality, they will unlikely attain civil rights.

In summary, it appears that Marci and the vast majority of her patients agree that GID is not a mental disorder, but rather a physical disorder which needs medical attention. This also reflects the growing consensus among trans-positive mental health specialists, and particularly those who are advocating for a current DSM reform reflecting this point (see chapter 1). The consensus importantly reiterates that participants seem to suffer more from the social stigma attached to both living as transsexuals in society as well as being labeled mentally ill.

Becoming Whole: The Meaning, Symbolism, Expectations, and Hopes Invested in GRS

The most unanimous expressions of what GRS symbolized for patients were “completion”, “wholeness”, and a sense of “seriousness” communicated. The many different metaphor patients used to express the symbolism of GRS are very insightful descriptions about transsexual embodiment, reaching far beyond the over-used “trapped in the wrong body” metaphor which suggests that a fully formed person is somehow hidden in a body, waiting to emerge. While this may still hold true, at least conceptually, for the beginning stages of transition, this did not apply, nor was it reiterated in regards to GRS.

Some patients saw their surgical transformation as a “rebirth” or a “correction of a birth defect” while others similarly equated it with a “new beginning” or “new start” in life. Nancy said that “GRS is everything, it’s being complete...it’s being a whole woman...It’s like a rebirth,

it's a new day in your life". She literally told her wife "I'm going to Trinidad to complete my birth". For others, it symbolized a rite of passage - for instance, Joyce felt that GRS symbolized having "full membership" to the club (womanhood) whereas before she felt she only had a "guest pass", and Violet felt she had finally been allowed permanent "entry into the club". The sense of finality and permanence was often imagined graphically as "a period at the end of a sentence" or "a punctuation to your life", whereas some patients distinctly referred to visualizations of "the icing on the cake" or the "final piece of the puzzle". But a few patients also reiterated GRS as just one step, rather than a major or final step of transition where GRS symbolized either the beginning or the "closing of a chapter", suggesting there may be more to come yet.

In practice, GRS was unambiguously described to enable some patients to move on with their lives in whichever direction they could not have headed before. For them, GRS was more than a highly transformative step and profoundly affected or enabled core aspects of their identities and well as everyday lives. For example, Reece noted that she would have never wanted to live as a transgender woman without surgery. Mary had never had a sexual relationship with a man or a woman and considered herself a virgin who was now ready to find a life partner. For Nadine, GRS enabled her to return to school and escape the social isolation of being home schooled.

While I was surprised at the poise most patients retained as we talked about something deeply meaningful to all of them, a few were emotionally moved to tears as they reflected on having surgery. Dara felt very emotional about what the surgery contributed to how she felt about her own possibly intersexed identity since intersex children with ambiguous appearing genitalia are often surgically reassigned shortly after birth and then raised in the gender which

matches the reassigned genitalia. “Well, that’s an emotional point for me” Dara said, “because this is how I should have been...so it’s finally going to what I was supposed to be to begin with...and whatever choices were made, why they were made, I’ll never know...but it’s poignant that they could have gone in either direction...[]...so this is my triumph over what was forced on me without me having anything to say about it...and to feel that my body matches how I’ve always felt”. For Dara, GRS symbolized the completion of a journey she didn’t choose, a “final milestone” so to speak. But more profoundly, her narrative also shows that both intersex and transsexual individuals can suffer the same sense of ‘wrongful’ embodiment retrospectively.

Violet reiterated a few times that “they can’t take it back [GRS], I get to be Violet for the rest of my life”. Violet also felt quite emotional when she reflected on the surgery just days after. “It’s such a gift”, she said. Jean felt she no longer was “a man desperately wishing to be a woman”. She felt GRS symbolized a seriousness which made her transsexualism no longer about homosexuality, and by extension, cross-dressing. Similarly, for Zoe, GRS symbolized gendered commitment as she did not want to be “stuck” in being seen as a cross-dresser. Emma, Zoe, and Mia emphasized a sense of unity between disconnected selves, bodies, minds, and souls. Mia repeatedly talked about GRS enabling her to see a “unified self...it’s like the unification of Germany, the walls are coming down”. Previously, she had “built this secondary self to live in...but eventually it eats at you...eventually you gotta reunify, putting myself together as one again, not ‘the two mes’”. She explained “You have two selves: you have your true self and then you have your shell self that you use to insulate yourself in the world...your public self, your male self...and now that those two have come to one...it’s a unification...the walls are gone”. After the surgery, Mia didn’t feel “the figurative split anymore....Mia is now one person, 100% Mia, the best me”.

Marci's opinions on what GRS means for her patients "changes constantly". When she first started, patients would come up to her and say "thank you for saving my life". But mostly, she noted, it depends on patients' individuality; for some, surgery doesn't make that much of a difference if they have been living as women for years. Marci noted "if patients have socially transitioned and pass well, nothing much changes — surgery isn't anything". But for another subset the opposite is true. Marci said "they put all their hopes and dreams into it" suggesting that GRS will "solve my relationship issues, get a job as a woman". Regrettably, she noted, 2 of her earlier patients had committed suicide after GRS. "They think they function perfectly as women after surgery" she noted "...all these dreams they have...love and family hopes, 'normal life' dreams...but a lot of them end up very lonely after GRS...(that's why) intimacy deprivation is the biggest problem...the leading obstacle to people being happy". Marci related a story of one of the women who committed suicide. After surgery the woman reached out to her, was always calling her, as she was rejected by her family. Marci reflected "maybe I should have picked up on this...there's a sadness which hangs with me". In this case, the woman had struggled with other mental health issues such as bipolar disorder. Since comorbidity is usually a "red flag" for proceeding with surgery, Marci called the woman's therapist and discussed the woman's case but her therapist told her "if you were to deny her surgery, she'd kill herself".

When I asked what GRS symbolized for her patients, Marci's first answer was "a sense of peace". She talked about a young Latina trans woman who had, after the day of surgery, undergone a "transcendent passage" which changed her demeanor to "demure and sweet". "That patient" Marci noted "was complete", echoing the single most commonly used word by her patients to describe the symbolic meaning of the surgical process. When I asked Marci if she could think of other life changes that GRS could compare to, she instantly, or perhaps logically,

in her case being an OBGYN, likened the process to natal females' pregnancy. Like pregnant women, trans women go through different levels of maturity throughout the reassignment process. Once they begin taking hormones and living full time, they enter what would equal the second trimester of pregnancy. "It's like feeling the baby kicking" she said, "there's lots of talk, what's it like, there's support groups...their bodies are changing, expectations...". And like pregnant women, the climatic highpoint, or perhaps end point for many transsexual women, is its highly anticipated completion resulting in giving birth — to themselves. This sense of completion once more resembles Charon's notion that " There are two bodies: the one lived in and the one lived through. One body absorbs the world, and one body emits the self" (2006:88). When these two entities are transformed from being antagonistic to harmonious, feelings of unity are expressed in ways which foreground the importance of corporeality, which accounts of gender primacy often overshadow by dismissing sexed anatomy as distinct from the mind.

The common narrative thread of completion, wholeness, and seriousness communicated through the surgery, then, suggests a concept of self-identity which is not singular, cohesive, or permanent, but rather fragmented, additive, and interchangeable. Anthropologists interested in psycho-cultural perspectives of the self, personhood, and identity have reiterated this notion in numerous ways (Harris 1989, Lee 1982, Heelas and Lock 1981, Lewis and Brooks-Gunn 1979) .

For instance, Harris (1989:601) notes that:

To work with a concept of self is to conceptualize the human being as a locus of experience, including experience of that human's own someoneness. In the psychologized view of the West, reflexive awareness of the individual is seen as yielding a duality of self. In one aspect, the self is subject, author of behaviors known to their author as the latter's own and so distinguished from the behaviors of any other someone. In its other aspect, the self is an object some aspects of which are brought within its own purview by the normal human capacity for noticing one's noticing. The latter is the activity that makes human beings (and perhaps some other animals) self-

aware. The self as existential "I," though intermittent, is fundamental to a sense of self-identity.

Strauss (1997) notes that subjective selves in modern worlds are partly fragmented yet partly integrated as fragmented subjects are always constructed by “diverse social discourses”, while at the same time “partial integrations can be traced to emotionally significant early life experiences” which people “can talk about in a way that links their past and present” (379). In Strauss’ analysis of partial selves, cognitive schemas permit subjects to reframe and reiterate social discourse in various ways to talk about their lives. The completion and wholeness schemas expressed above also reflect this attempt to integrate past and present through illustrations and metaphors about the body as integral, and not separate from the self. On the other hand, the body is also seen by some as the missing piece to embodying a “whole” or “complete” self: here Lock’s notion of bodies which can communicate a sense of belonging or dissent become evident as before surgery, schemas of segregating the male body from the female mind are apparent while after surgery, schemas of body-mind inseparability become apparent through unification. Further, ideas of “autonomous selves” which supposedly shape our lives can always be questioned in terms of how these ideas have been introduced into our ways of thinking in the first place (Rose 1996). “In the everyday world” adds Good, “the self is experienced as the ‘author’ of its of its activities, as the ‘originator’ of on-going actions, and thus an ‘undivided total self’” (1994:124). And “Selfhood” writes Bruner “involves a commitment to others as well as being ‘true to oneself’” (2002:69). This notion of being “true” or expressing a previously “hidden” true self also underlines ideas of bodies as places where several selves can cohabit, at least temporarily. However, “A self dissociated from its body will rarely seek and discover terms of association with others, so the disciplined body becomes *monadic*” remarks Frank (1995:41)

and drawing on Lacan, he also notes that “what we call the self is always a sedimentation of images from somewhere else” (46)

It is this agentic act of unifying or aligning mind and body which in essence communicates a consistently reiterated “seriousness” or realness which GRS communicates to others; “The body itself *is* a message;” writes Frank (1995:50, italics in original). Almost unanimously and very similar in narration, participants expressed that GRS might make them seem more serious in the eyes of others, and take their claims to womanhood more serious. The dedication and commitment to plan for, pay for, and endure the pain and inconvenience of the surgery, participants felt, communicated a seriousness of both the disorder (this person “really” had GID) and identity (this person is “really” a woman).

GRS As An Unobtainable Goal: The Fine Line Between Hope and Despair

The question of what would happen if GRS were not a possibility for patients yielded an interesting variety of responses, ranging from well thought-out “plan B”s to utter desperation. While it is commonsensical to assume that GRS, given its high emotional and financial cost and effort, must hold at least some significance in participants’ lives, its life-saving importance for some supports the continued medical and legal justification for the surgery. What struck me as most notable, however, was the notion that even just the hope that GRS was, or could be, possible in the future provided participants with a sense of faith which greatly helped them move ahead with their transition. This kind of hope cannot be underestimated in importance — without this vision for achieving gender congruent embodiment, many of my participants and many other transsexual women would suffer a profound sense of personal resignation resulting in stagnation of entire lives.

This data also confirms why the categorical distinction between transsexual and transgender is not just a semantic problem of unnecessary and cumbersome theoretical or political categorization: transsexuals, sometimes considered to suffer the most “extreme” sense of gender dysphoria, are distinguishable from transgender individuals precisely because they so often reiterate the wish for GRS. For “true” transsexuals, GRS is an inevitable building block of their desired gender identity. Although it may seem of secondary importance to those who see transsexuals as individuals primarily wishing to live in or as the opposite gender socially, my data shows that GRS and its eventual possibility and anticipation clearly sets them apart from other gender-variant individuals who may feel the same discontent about their gendered bodies, but for a different reason, mainly the frustration with the rigidity of the existing gender binary. Most transsexuals, however, do not have significant issues with the existence of the binary, but rather, not being able to fit into it. And although transsexuals are generally sympathetic to the political aim of transgender agendas to draw attention to the binary’s oppressiveness, most want to at least be able to situate themselves into it, before they may decide to participate in undoing it. Indeed, it has always surprised me to learn that many very public, very outspoken, self-identified transgender activists actually have had GRS (or other equally gender affirming surgeries) while at the same time critiquing the very rationale which makes these surgeries available in the first place. As participants related their own thoughts about GRS as an impossibility to me, a good number also mentioned that for other trans women they either knew personally or had heard about, GRS is a “life and death” situation. Many were highly aware of the severity of need, even if this was not necessarily the case for them. As expected, since GRS gave participants a sense of completion, not being able to have GRS would make them feel incomplete in turn.

While all participants agreed on the need for completion, the consequences of remaining incomplete were somewhat differently expressed. For instance, if GRS was not a possibility for Gill she would be “less happy but not despairing”. Annie would continue to feel incomplete but would have “gone on with life’s goals”. Although GRS made Donna feel more complete, it had never been a life and death question for her — it was something she wanted, not something she had to have. She said “I wasn’t so messed up that my life was on hold”. Although Donna did not think GRS would change much in her everyday life, she felt that if GRS were not possible for her, she may “regress into a cross-dressing mentality”. She feared that she may even revert to living as a man. Deanne felt that GRS was the best thing that ever happened to her and that she would feel more depressed if she couldn’t have it. She had always felt like “2 people trapped in one body” and that she lived “2 different lives”. Now she felt assurance and completion. However, Deanne had lived pre-operatively for so long that she felt she could have continued, especially since she had a supportive fiancé who loved her. If Felicia couldn’t have GRS she’d have to “live a lot more cautiously”. She’d fear discovery scenarios where someone would call the police and say “there’s a man in the changing room”. Even though she was only 18, Nadine said GRS gave her a life, a new beginning. She said if she couldn’t have GRS, she would be “really sad” because it enabled her to feel normal around other girls her age who were all about teenage crushes over a popular young actor - something which put a sparkle in her eye.

For others GRS was primarily enabling sexual or romantic relationships they could not have engaged in before. If Joanna couldn’t have GRS, she would have to resign herself to being asexual for the rest of her life. Dating would thus be most affected for her because “it’s harder to be rejected if you have the right parts”. She felt that although she had sexually identified as bisexual before, now she had the means to express it and she would be disappointed if GRS

changed nothing about her dating situation. If Doris couldn't have had GRS she would have to continue to "deal with a nuisance", that makes life much harder as she was a very sensual person and if she couldn't engage with people that way she'd feel like she'd be wasting her life. Kacey felt that FFS had a larger impact on her than GRS, however, she would feel limited and awkward if she couldn't have had GRS as it would make relationships very difficult.

Those participants who felt they absolutely needed to have GRS often noted that the consequence of not having surgery would result in severe depression and requiring extensive amounts of psychotherapy. If GRS was not an option for her, Joyce noted bluntly that she would feel "totally fucked up". She said she may not be alive and would feel "completely stuck"; Joyce said she didn't choose to have the surgery, she *had* to have the surgery. If Carly couldn't have had GRS she would feel like she would be "back to square one again" and Jean said she "wouldn't have anything to hope for" - she told nobody that she was coming to Trinidad because she was "scared to death" that someone would stop her. Jesse would feel as if she would be living a "half life, shadow life" — it would have been "heart breaking over time" she said, "a significant blow, a major negative" because it would have "continued to be the most significant stressor in her life". Elaine said that if she could not have had GRS it would have been a "huge disappointment," that she would "go to pieces" and "feel trapped again". As she craved balance, she noted that before the notion of surgery entered her life she would "go to bed and didn't care whether I'd wake up" but now she looked forward to every day. Not being able to have GRS for Lana would feel like "being in jail" and Luna emphasized that she "absolutely needed it" and that she would "fall apart" without it. If she couldn't have GRS, "it would be awful" for Vicky and her life would be "extremely limiting". Jane felt that if she couldn't have GRS, it would be "very crushing" as she would "always feel stuck in the wrong body". For Reese, GRS was part

of transition and she was never interested in just living as a trans woman without surgery because she felt a severe discomfort about her penis which hindered her socially on all accounts. Peggy said if she couldn't have GRS, she'd have to be on anti-depression drugs "much better than the ones I'm on now" which was a "horrible thought". She thought GRS was a life changing experience, very different from any cross-dressing sensations which is why Peggy celebrated her GRS day as her "new birthday". Audrey said she would have a continued sense of incompleteness and would be depressed if GRS would never be a possibility; something she'd find "very hard to live with". If she couldn't have GRS Pam would find it "devastating...I think I'd have a lot of problems...it would not be good...I'd have to have a lot more therapy".

If GRS were not possible for transsexuals, Marci, like Pam, thought it would be "devastating"; she had only had to send 3 people home who came to get surgery because they either had inadequate letters, had not lived full time long enough, or were in generally poor health conditions. Marci confirmed many of her patients' conviction that GRS can be a lifesaver and that even just the hope for the surgery has a profoundly positive affect on patients's psychological well being. She also strongly disagreed that GID was what Kleinman called an "illness without disease", and which some early critics of GRS designate as a purely psychological problem which shouldn't warrant physical treatment. "That's like saying there's nothing wrong with a cleft palate or a facial deformity" she said, "but patients don't see it that way...it's like anything else we treat surgically". Marci believes that "the problem with labeling something a physical deformity is highly subjective". "Where do you draw the line?" she asked, "It's like Hitler's line of thinking in dividing what constitutes an impairment" and she loudly exclaimed "*I call that an impairment!*" She then compared the US policy restriction on calling the surgery "elective" with other countries which do not. "Countries in Europe, Cuba, Iran don't

think it's an elective surgery...it's part of who we are as human beings...if we can treat it, we should" she remarked, and with reference to the hippocratic oath, she said "I know I help people."

Marci tended to agree with follow-up studies noting a global improvement of psychological functioning after surgery as these findings clearly represent strong evidence in favor of GRS. Put differently, based on follow-up outcomes as well as what my own participants had to say, it seems clear that not letting people have GRS could potentially be much more costly in terms of increasing depression, isolation, and suicide ideation or perhaps successful attempts of such. And although many participants interpreted GID as a physical problem which manifests itself in psychological stress, some also noted that if a physical solution is possible in general, but not for particular individuals, the psychological stress would become even more severe. What becomes visible through these narratives of surgical necessity for psychological well-being is the critical role of biomedical technology in constructing identity which speaks strongly to how modern medicine shapes trans-subjectivity (Hausman 1995). It also reiterates that the phenomenon of transsexualism and its illness experience is culturally specific and cannot be compared to gender variance cross-culturally where other factors may contribute to constructions of identity and subjectivity and where GRS is not interpreted as a solution to the problem at hand.

Exit Clause: Does GRS "Cure" GID?

As I showed in the very beginning of this ethnography, all patients were asked whether they felt that GRS diminished, lessened, eliminated or "cured" GID. While I was aware that this was an intentionally simple question, it is nonetheless and justly based on the biomedical model of

“problem - diagnosis - treatment - cure” which warrants its asking. The variety of responses showed how patients engaged with notions of “cure” and “healing” in negotiating what therapeutic potential the surgery held for them. This data is particularly interesting in considerations of current DSM revision debates which I have discussed in chapter 1, which might include an “exit clause” stating that once a person diagnosed with GID has concluded transition (including GRS), they no longer have GID. This biomedical rationale is highly contentious because it focuses only on the individual and not on the social aspects of illness.

As I have already noted, most participants felt that their genital dysphoria was eliminated by GRS but that this did not in and of itself suggest that patients felt cured of GID. Only Annie, Nadine, Elsa, and Maria explicitly said that they felt cured and that they no longer had GID, even if their explanatory models for why they felt this way were quite different. For example, Maria had survived more than one suicide attempt in the past — she emphasized that she would be dead today if she had to live as a man. She felt GRS was very necessary for her: “I think it’s the only treatment...because I would have rather died than not having a vagina and be a woman, having the appearance of a woman....it was close...I had too many suicide attempts...[]...every time I thought about going back, you know, I could only see being dead after a while...I didn’t see a future...and the surgery was my future, I could see beyond that...[]...If I went back as Mike, there was no future, there was no dreams, there was nothing, it would only be disappointment...so yes, I think surgery is a cure”.

Everybody else however, took issue with both the word and the meaning behind a “cure” and the majority of participants drew a distinctive line between no longer feeling dysphoric about their bodies and GID as a whole. For others, the “cure” for GID had little to do with the surgery but simply living full time and starting hormone treatment. Reece felt that living full time

successfully was 90% of the cure; GRS relieved the body dysphoria she had even though she had high levels of social approval. Sonya felt the surgery cures the body dysphoria but there still remained a sense of uneasiness; in other words the surgery alone does not fix anything.

Sia did not feel that GRS resolved GID although it alleviated the symptoms. “It’s not curing the overall problem. To me, the overall problem is that I was not born a girl”. She likened the process of dealing with not having been born a girl to the German concept of *Vergangenheitsbewältigung*, which loosely translate to mean “coming to term with one’s past”. I found this term, which is usually related to how Germans have processed the holocaust as part of their collective history, quite fitting because like historical atrocities which cannot be undone, social histories of gendered lives are similarly resistant to reparative processes in the present. Sia’s own coming to terms with her past thus constituted the major part of healing, which for her meant that GRS constituted the end of her transition and that she was now moving on as a woman, not as a transsexual.

For Donna, a disorder meant that it could be fixed but she did not feel that this was possible in the case of GID — she noted that the physical surgery “doesn’t go anywhere near the mind”. GID could never be cured she said; even if it provided a relief for body dysphoria, it was not a cure. For Donna, 64 years of male life were more of a concern than the body. Even if she had felt like a lesbian all her life she felt that she couldn’t say “I’ve been a lesbian all my life”. She also said that whenever people talked to her about something from her past, she thinks of herself as a male and that was something “no surgery can undo”. Much like Donna, Leah felt that GRS alleviated some of her symptoms and was part of the cure for body dysphoria. For Leah life now was joyful but she said that sometimes she got a little wistful having missed out on girls’ experiences but she was aware that she could never “change that or cure that” because she

couldn't have transitioned earlier without incurring a great risk. Lisa felt that GRS can be part of the course of change and address a discomfort but in the end "GRS is just an operation". She didn't feel that GRS solved any identity issues at all - true identity issues had to be worked out in the mind. However, GRS presents a more congruent person to the world. For her, the beginning of the cure was to be seen and addressed as a woman. Yet, GRS was necessary "when it preoccupies you so much that can't move on with your life".

Joanna felt that GRS did not cure her because the resolution for her was internal. She never considered herself a transsexual, she felt that she was female with a "transgender modifier". GRS for some also did not "cure" or resolve the problem because the rationale against accepting transsexuals as women remained along the lines of "it's still a penis". Mary felt that GRS did not cure GID, it was just another step in the journey which not everyone completes. For her hormones and living out was the cure but she felt physically more complete now. GRS cured Elaine's physical problem as she always had a fear of genital exposure but did not make her transsexualism go away; she likened it to being an alcoholic which is about not being drunk one day at the time. Tina did not feel that GRS was a treatment for GID and that there was no "real" cure as it did not change one's past. Tina never hated her body but she did hate living as a man.

GRS for Carly was not a cure but it made life possible, just like anti-depressants do: they don't get you "out of the hole", she said, but they "get you to the rim so you can pull yourself out". Analogously, she felt, GRS gets a person to a point where they can help themselves. However, it did not make someone a woman. Carly's emotional reaction to not having had a female past exemplified the emotion of wistfulness even though she framed what she was feeling in terms of regret. "How can I cure my regrets of never having born a child...or having been a college girl, or a middle aged woman...how can I ever cure that with anything?...how can that be

cured?” She felt GRS was “no magic bullet” as the problem of GID was too multi-factorial; but for the first time ever, she did not cringe when she looked at herself in the mirror — for her, clearly, body dysphoria was just a symptom of GID but that, she notes, gets cured. Carly emphasized that the AMA had confirmed that GRS was lifesaving and that denying to some people could be life threatening. Carly agreed with the severity of GID in that “for years, I had to work minute by minute not to kill myself”, like an alcoholic or drug addict for whom not drinking for one hour is a victory. She credited her son being in her life who needed her as the reason she stayed alive. For Carly, the worst part of living with GID was not being able to participate in women’s life. She also had not had a sexual relationship in 6 years. She felt that GRS was like “getting out of a wheelchair” as her body had felt so inadequate to her for so many years.

Jesse felt that GRS was “not going to fix all that ails you”. She felt that for some people, GRS was a cure as it solved their dysphoria, but she never felt in the “wrong body”; she just felt more connected with it now as it resolved the conflict within herself about her body. Trish felt that in some ways GRS did cure GID as it was the best solution; but she also felt GID began to dissipate as soon as she began transition. Similarly, For Felicia, the “cure” was transition; she felt that GRS was a medical procedure but not a medical cure. GRS made her feel safer and resolve the body dysphoria. Jenna did not feel that GRS cured GID but thought that for others it might be true. Luna felt that GRS resolves or makes the body problem less severe but did not cure GID.

For April, GRS did not constitute a cure for GID: “I lived as a guy for 26 years, that’s not gonna go away cause that’s what made me who I am”. She felt that social acceptance regardless of passing status would be the “cure” for transsexualism “because the loss of jobs, that’s society, the loss of family, that’s society, the loss of friends, that’s society, being scared because of your

genitalia that's different and you're trying to present as something else, well that's society, everything leads back to society". Carla no longer felt gender dysphoric after GRS because "the day that sort of saved my life and took care of the big depression issues was the day I started living full time as myself...and so SRS just sort of tied up the last of the loose ends". Suzie felt GRS was right for people with extreme cases of GID like her and GRS was the closest thing to a cure; still, she felt that "cure" was a funny idea as there would still be repercussions to living as a transsexual. She noted that medical science can only change the body so much and that GRS "helps calm the problem but it's not a cure all...[]....GID is a disease. And alcoholism is a disease. They both can be treated and you can recover from them. But it doesn't eliminate the fact that it happened in the first place".

Violet felt that some people had unrealistic expectations of GRS as a "magic pill". She noted that most people knew she lived as a man for all of her life but once she settled into being Violet, she felt she did not have a disorder anymore. So for her GRS was not the cure, but being allowed to be Violet was. May felt GRS did not cure GID nor did she think GRS made the body completely female; she didn't see herself as fully female because social problems continue to exist after GRS, as people saw no difference. May had struggled with male embodiment all her life; she was a drinker, a cutter, and had found a myriad of negative ways to relieve stress about her body. But she noted that it was more than an obsession with singular body parts (penis), she felt her whole body being male was wrong which was one of her daily stressors. Vicky felt that her body dysphoria had been dissolved but "I know that I can't change the past...I'm doing everything I can to change my future and I'll be damned if I'm going to dwell on the things I can't do anything about".

Haley felt that for some people GRS was the cure but she also noted that GID was often accompanied by other factors like depression. However, for her she felt GRS was the best solution to her physical problem. On the other hand she felt that surgery did not solve GID; her past would always be part of her life. GRS resolved Kellie's GID in that "I can actually take my clothes off and take a shower and look at myself in the mirror and actually, for once in my life, love the person I see in the mirror back". Still, she wished she didn't have to miss out on girls' rites of passage, such as being a cheerleader, dating boys, experiencing high school as a girl, having pajama parties and pillow fights. Jean felt GRS merely corrected the appearance of genitals and that GID was not over after the operation, that it was not a magic bullet but a new start.

Emma felt that her physical discomfort was gone after GRS, that the Real Life Test (RLT) was the most important part of transition, and that 12 months were not enough time to prepare for surgery: "One year is not enough to learn to tolerate intolerance" she noted. Although GRS for her marked a new beginning, she felt that the "journey to womanhood" was never over and "the cold hard facts" of being a transsexual for life remained even if she now felt as if she were a "whole" and "complete" person. She mourned the fact that she would never be able to be a biological parent even though she greatly desired to have a family with (adopted or fostered) children. Yet, Emma felt "as complete as medical science can make me". Jane felt that GRS was part of the cure, but not the whole cure since she couldn't change the fact that she wasn't born female. Peggy felt cured the first time she saw herself in the mirror after GRS. "It's a woman!" she exclaimed; although she felt that her dysphoria was gone, she retained a sense of wishing to have done it much sooner.

Rose felt that GRS was not the cure for GID but part of the treatment. She felt the social transition was much more important and in her case, almost eliminated GID. GRS to her was essentially just about genitalia and yet it affected a significant part of her life as she couldn't be sexual as a woman before. Audrey didn't feel that GRS was a cure for GID because she didn't "have anything to be cured". Pam felt that GRS was a treatment but not a cure; surgery merely completed her transition as "the ultimate step". She felt a sense of calm, relief, and satisfaction as GRS "is as good as it gets". Kelsey felt that GRS did not cure GID as she still had a very insecure sense of being a woman, mostly based on her advanced age. "Personally, it bothers me that I sometimes feel like I'm a poser...like I'm entering into a world that I really don't belong in...I don't know if these are normal feelings but I do have these feelings...maybe that gives me that feeling of insecurity". GRS simply gave her an image of anatomical correctness in the mirror. For Kelsey, beginning HRT was more of a cure because her "awful feelings of sexual tension" were gone. She felt that hormones were the cure and she no longer felt dysphoric because of it. Still, Kelsey felt that she had missed out on so much socialization and experiences not having lived her life as a female that it made her cry sometimes.

The consensus among most participants appeared to be that GRS did not cure GID as after GRS patients' body dysphoria had either been eliminated or significantly lessened but their social histories remained and constituted a major source of distress. As I mentioned above, one of the proposed revisions for GID in the forthcoming DSM-V 2012 allows for an "exit clause" which Marci reiterated as "once you've transitioned, your GID is over". Comparing GID to other mental illnesses, Marci felt that once someone had completed full treatment, they no longer have it. "You don't wear a life time diagnosis" she added. "But for people who are not passing, people assume that you [they] still have it". She felt that GID is successfully treated when an individual

does not have thoughts of gender issues dominating their psyche: “when you don’t have to worry about it, when you’re not constantly apologizing for your gender issues” but she also noted that the social transition is far more important than the surgery because “80% of trans people never have the surgery”. Still she felt that “GRS does lessen the body dysphoria, that’s why it’s so important to people looking in the mirror in the morning...”.

And yet, Marci felt that surgery is not necessarily the “end” of GID. “People always feel like they missed out on things, even successfully transitioned ones...it’s not easy...you’re still having to live the double life if you’re stealth”. Marci’s remark “it’s a problem of society, constantly bringing people back” underscores the notion that it is the social history of patients which makes social acceptance in their new gender difficult, even if patients wish to leave the diagnosis behind just like any other social position they once occupied.

A Pain No Surgery Can Remove: Wistfulness as a “Symptom” of GID

Elsa sat on her bed as we talked, fiddling with the ears of a stuffed teddy bear on her lap. At some point, my gaze must have wandered from her face to her hands holding the bear. In the middle of a question, she interrupted me and asked whether I thought her bringing a teddy bear to Trinidad was “kiddy-ish” (childish). I was at a loss for a quick answer but not because of the oddity of Elsa bringing a children’s toy along for the trip, but because I had observed a number of other younger patients emulating the comfort-seeking behavior of children who clutch stuffed toys when they are afraid or in pain. Since quite a few patients brought stuffed toys like teddy bears with them to Trinidad, I started to think more deeply about the cultural analysis of such objects and their meaning. Was the teddy bear perhaps just another signifier of female identity

communicated through openly expressing the emotional vulnerability of girlhood? Or was this an expression of forlornness related to missing out on childhood experiences as girls?

The more I listened to participants' narratives about the therapeutic benefits and limitations of the surgery, the more I realized a distinctly emotional commonality of *wistfulness* participants expressed. Wistfulness is commonly defined or framed as wishful yearning, being pensively sad, having feelings of melancholy, experiencing or showing sorrow or unhappiness. Other elements of expressions of wistfulness include longing, dreaminess, musing, reflectiveness, forlornness, mournfulness, contemplation, meditateness, and disconsolateness. When Claudine Griggs realized that she would forever be "trapped in a transsexual body" because she felt there was no cure for not having been born a woman, she described her feelings as a pain "no surgeon can ever remove" (see Introduction). Wistfulness is the expression of that pain.

While some participants have explicitly noted sometimes feeling wistful when they thought about having missed out, others implied wistfulness through their emotional tone when we talked. Marci's sense that patients' feelings of "having missed out on things" and Carly's comment on never having born a child, been a girl, or a middle aged woman, reflect the common notion of GID as resistant to elimination through surgery and why transsexuals may struggle with this their entire lives even if they have transitioned successfully and have ample social support. I also began to believe that even if individuals experienced no social stigma at all and wistfulness is the sole cause of any distress related to GID, it remains a significant stressor which may trigger post-transition depression at anytime.

It seems reasonable to argue that if a transsexual person reflects on all they have "missed out" on, the value of the remainder of life diminishes. I would imagine that this would be similar

to a person who has struggled with chronic illness their whole life and toward the end of life is “cured”. Although I felt that my own participants, especially the older ones, had an incredible sense of optimism and positivity about their current and future lives, a sense of having missed so much of one’s life can hardly have no overall and lasting effect. And while this seems rather commonsensical, the omission of *Vergangenheitsbewältigung* or coming to terms with one’s past is thus far lacking from discussions centering on distress in the DSM or other literature. It seems to me that treating professionals do not acknowledge wistfulness as a serious manifestation of GID, but rather an unfortunate side effect in those cases where either onset of GID and/or subsequent transition occurs late in life. However, even younger patients like Elsa can suffer from mourning a “lost” childhood and thus suffer from wistfulness.

If wistfulness based on one’s socially gendered history were recognized as a serious psychopathological stressor in gender dysphoric individuals, it would follow that those individuals who are permitted to transition very young and with full support of medical aids and social environments could avoid wistfulness as a pathological manifestation of living with GID. My research strongly supports the notion, albeit being logical, that older GRS patients experience more wistfulness than younger ones and that younger patients struggle less with an extensive and consequential social history problem even if the severity of physical distress experienced is equal to older patients. There is no cure for transsexual wistfulness, a yearning for something which will never materialize: experiencing a girl’s or a woman’s life with all its coming of age rituals or rites of passage. Yet, the symbolic nature of GRS providing completion or wholeness seems to speak strongly to counterbalancing all that was “missed” so far which is why transition is often talked about as a “second puberty” and why GRS is often framed in terms of “rebirth”. What is completed is thus not a literal addition of something that was missing and

has been dynamically added, but rather notions of completion represent an enabling mechanism of seeing a retrospectively “whole” life, not a recently completed life in consecutive parts.

Wistfulness is an embodied experience just like anatomical or genital dysphoria. The ways in which GRS patients express wistfulness appear across “lost” childhoods, puberties, marriages, parenthood, and careers. Wishing to have experienced all these things in a different body, a different gender, and most importantly, in different social relations in the past is a great psychological burden for some. Although the focus of transition and GRS is positively aimed towards the future and the now, the pain of the past can only lessen by gradually and consciously fading or moving into the unconscious. However, this possibility is oftentimes undermined precisely because social histories aren’t really history at all; we embody our pasts, we carry them in our minds, our behaviors, our daily decisions, and of course, our memories which we draw on constantly in everyday interactions and exchanges. But even more importantly, social histories and memories are socially shared; even if we could “forget” who we once were, we live in highly social environments that serve as constant reminders that we are products of our histories which are constantly being generated anew. Shared cognition and knowledge about one’s past life or social statuses are omnipresent in interaction even when they are not addressed directly. And even if transsexuals can “successfully” transition and fully adjust to live in their desired gender, wistfulness often remains as a cognitive buffer to reflecting positively on one’s life history.

From a psychological perspective, wistfulness can hardly be considered a diagnostic criteria for GID, nor would wistfulness constitute a serious or clinically significant factor of distress. Most individuals, transsexual or not, probably have longed or yearned for a different life or life circumstances. However, wistfulness is inextricable from GRS patients’ social histories, and since the social histories are primarily responsible for much of the social stigma experienced,

it could therefore be argued that they do cause significant amounts of distress. From an anthropological perspective, wistfulness illuminates why transsexualism as a social problem carries a great weight: what transsexuals yearn for or feel they have irretrievably lost or missed out on is the participation in distinctly cultural activities and practices which shape gendered social lives and histories. And while I would imagine that the wish to have been born as someone else and having had different life circumstances is by no means particular to transsexuals, transsexuals appear to suffer far greater pains from such unfulfilled wishes because they live closely analogous or parallel lives to those they desire to live (i.e. in the other gender). The lived experiences as natal girls or women which transsexual women desire are constantly “lived out” right in front of them.

When the childhood desire of wanting to be just like other girls transforms into an adult realization that this will never be a possibility, wistfulness may well appear as a precursor to serious resignation and subsequent depression. Wistfulness thus takes on forms of emotional capitulation for which gender transition and eventual physical transformation cannot really compensate. Finally, wistfulness must also be carefully delineated conceptually from the notion of regret. While a few patients have expressed regret at not being able to transition earlier in their lives, regret implies *choice*. This means that even though transition may not have been possible for patients in their respective lives, it nonetheless was an option which was objectively available. Wistfulness however, refers here to a longing or yearning for something which would not have been possible for them by the fiat of being transsexual.

But while wistfulness about patients’ pasts seemed to shape much of their emotional sentiment about their socially gendered past, this sentiment also seemed to shape their agency in determining their socially gendered future. While many participants, much like Griggs, yearned

to “untrap” themselves from their male bodies through surgery, they also tried to untrap themselves from their masculine gender through distinct expressions of dis-identification. As I will discuss below, this agentic dis-identification is closely related to achieving that often reiterated sense of completion. The surgical role in completion thus not only removes the penis from the transsexual, it also removes the transsexual from the penis — and what I mean by this is the penis as a signifier of manhood on other male-bodied individuals who share a common social marker of gender transgression with transsexual women, but from whom most transsexual women seek a divisive and permanent distinction through female embodiment.

Men in the Dresses vs. Women in Pants: GRS Hierarchies and Trans-Stigmatization

The more I heard participants talk about seriousness communicated through surgery, the more I realized that GRS was the principal cultural enactment of definition against not just being seen as men, but as men in dresses, as I have suggested in the introduction. The important distinction that was declared with surgery was that these individuals were not “just” cross-dressers or transgender individuals but embodied and lived a full-time life of a woman. From this perspective GRS serves as a *cultural* message of identity achieved through *medical* message of permanent embodiment against gender play, pretension, fantasy, or desired gender/sex ambiguity.

Without question, cissexual culture exemplifies a heightened sense of anxiety over acts of gender transgressions committed by men while women are oftentimes permitted to challenge or bend social norms of gender appropriate expressions and behaviors. Transsexual women retain a sense of this anxiety as being read as incredulous “pretenders” of womanhood, rather than “real” women. GRS thus serves not so much the purpose of making someone “more of a woman” or

“less than a man”, but rather more than “just a man in a dress”. Alongside notions of identities as generally fragmented and partial, this makes perfect sense: if physical womanhood is acquired gradually, through different stages or “percentages”, then the directionality toward “completion” reveals GRS as a certainty against which gender identities can be measured. I have noted in the introduction that the androcentrism, which informs much of the social reading of gender, magnifies the violation of gender norms if a man is wearing a dress whereas “discovering” a woman wearing pants would hardly raise an eye. Surgery as identity distinction then, justifies a change of positionality from which transsexual women, and many of my participants in particular, could articulate themselves against cross-dressers, transgender individuals who did not desire to have GRS, and generally all other trans identified individuals who purposefully rejected permanent embodiment or only “played” with gender temporarily.

Most participants reiterated this notion of identification against “just a guy in a dress” by contextualizing it within their varying experiences with other transgender individuals in either personal or support group contexts. This explicit dis-identification can be read as a sign of intra-group stigmatization which reveals that transsexual women are not immune to stigmatizing others. Indeed, when I asked participants whether transgender people stigmatized each other in terms of passing or transition hierarchies, I oftentimes could not even finish the question before getting affirmative answers. Only a few participants either had no decisive opinion or had not had enough contact with transgender support groups or transgender individuals to make this assessment. But the vast majority not only agreed, but gave me similar examples of instances in which intra-group stigmatization occurred. What makes this question so illuminating in understanding social stigma is that it shows that stigmatization is not uni-directional, flowing from cissexual members toward transsexual members of society; in some cases, participants had

even suggested that trans women stigmatize each other more than cis people did. Perhaps this is the most salient evidence of high degrees of internalization of societal or cultural attitudes toward all transgender individuals as deviant which is also reflected in the questions pertaining to the worst effects of stigmatization (i.e. internalization).

The data below also shows that although most participants had at one point or another, and for varying lengths of involvement, participated in transgender (TG) support groups, few held such groups in high esteem or found them very helpful in the long run. This did not surprise me; it is well known among at least MtF transgender support groups that after people undergo GRS, they gradually extricate themselves from not only support groups, but the transgender community in general, even if they do not decide to go stealth. Of course, some stay involved because they have developed personal friendships within these groups or because they feel it is important for political advocacy reasons; however, most deliberately distance themselves from being associated with TG support groups but not because they feel they have completed transition, but rather because of the association of such groups with cross-dressers which are somehow seen to “hold them back”. Consistent responses occurred on my question on whether participants felt that there existed a hierarchy in the community in terms of passing and or being further along in transition which clearly elevated some trans women over others; almost all participants were conscious of such a hierarchy even if they had never been to a support group or participated in other ways in the transgender community. I suppose then that it does not take much exposure, if any at all, to realize that both passing and surgical status produce, maintain, and communicate social capital.

Reece agreed that trans women stigmatized each other and she felt partly responsible for doing it as well. She didn't want to have pre-op/non-op friends; she didn't think she was “better”

but she simply couldn't relate — especially now that she had surgery, she felt like she had no connection left with them. She didn't want to be tied to the community and seen with cross-dressers as she felt it took away from who she is. Sonya agreed with the hierarchy within trans groups but she also drew on the “gay until graduation” analogy to note the common “trans till post-op” trajectory many trans women take. Rhonda agreed that there was a hierarchy in the community and she said that she still had “internal issues” with not wanting to be perceived as trans. She sometimes felt uncomfortable around older trans people who don't pass well because she feels that it outs her more and makes her more of a target. Sia remarked that there was “without a doubt” a passing hierarchy within the trans community which divides people into those who were worshipped for being pretty and passable, while ignoring others. Popularity cliques would form, not unlike high school, around lines of sexual orientation and transition advancement. As is often the case in at least initial meetings in support groups, people would introduce themselves via credential sheets of how long they have been out, full time, on hormones, of which surgeries they had already undergone. Sia framed this kind of talk “factoid giving”, including surgeon name-dropping and putting themselves on a scale of transformative progress.

For Leah attending a support group was a means to an end, and she, too, saw a division between cross-dressers and transsexuals although they shared a commonality in the beginning. Yet, transsexualism was a temporary state for her and she had minimized contact with “just cross-dressers.” Interestingly, Leah noted that as men, people have been conditioned to feel that hierarchy matters, to get ahead, and be better than others. As women, they have been conditioned to compete visually with other women as beauty was rewarded socially. This analysis was quite fitting to explain the hierarchy of both passing and transition stages. Leah felt that trans women

often blamed non-passing trans women for societal non-acceptance of transsexuals although it was also often trans women who denied others their claim of womanhood. Lisa also felt that trans women stigmatized each other in terms of completing “check marks” of transition. Although she felt that the community spanned from simple pleasure seeking to full identity, the perpetuation of GRS equaling complete womanhood at the top of the hierarchy persisted. It also bothered her that people over-emphasized how long they have been living full time. She felt that transsexuals also stereotyped others based on their own prejudices such as lesbian transsexuals being less “authentic”. Others who still saw and treated her and Kelly as a couple, Lisa felt, were also not really acknowledging her as a woman.

Joanna was part of a TG support group that included only trans women, and only people under 40. She felt that older trans women had a different philosophy, approach, and goal about transitioning and becoming women. The main dividing line for Joanna was along people’s views on gender being more or less fluid. She agreed that trans women stigmatized other transgender people but she felt that this was more applicable to early phases of transition and typical of “newbies” who are older. Mary did not look at trans women stigmatizing others as a hierarchical issue because she thought people were just on different stages of the same journey. However, she was supportive of the Harry Benjamin Standards of Care (HBSOC) because it “weeds out” people who shouldn’t have GRS (i.e. cross-dressers). Still, she felt that TG support groups should be inclusive and reciprocal. Elaine found it hard to relate to her few trans friends (presumably because they were more non-conforming than her). Elaine felt that transsexuals stigmatize others who hang on to the trans label and that there was both a passing and a transsexual/cross-dresser distinction, creating a pecking order between transsexuals and the ubiquitous “man in a dress”. Doris felt that some transsexuals stigmatized others but it depended

on the shared environment. “Some people will not talk to you unless you’re on their level” in terms of transition and passing. She felt that the “alumni” mentality was “bullshit” in that the point of support groups was to share experiences, not put others down; yet, she noted that there was a disdain for and misunderstanding of those who did not want to have surgery.

Joyce felt that TG support groups were all about lonely people who were unhappy and wanted to share their agony which she did not think was supportive. Like others, she had a disdain for the “alumni” mentality of trans women who had had surgery and she was very critical about the support group exchanges which had the tone of “we’ve come before you...this hair is real...my boobs are natural”. She noted that people walked around with number ratings on who is ‘better’. She argued for a separation of transgendered people from cross-dressers, drag queens and others whom she labeled “pretenders”. She noted that cross-dressers in particular were usually running support groups as a reason to dress, that much of the social stigma was due to cross-dressers portraying “horrible representations of women” and that many transsexuals did not want to associate with them as it held them back. She thought that asking a transsexual whether they had surgery or not was the most inappropriate question and that it was transsexuals who asked it the most — unabashedly. Joyce added that she felt the more unhappy trans women were, the more they want to tell people they had surgery which she took as a sign of immaturity.

Carly did feel that trans women stigmatized others based on how feminine one looked. She felt that when she first went to a TG conference, some people wouldn’t even speak to her. She noted that especially at conferences, there was an “inner circle” atmosphere based on transition status and passing. She never had a support group but felt fortunate to have the support of natal women in her various social groups. Jesse agreed that there was a hierarchy within transgender support groups and communities which divided between hyper-femininity and not

passing. She felt very cautious about the “man in a dress thing” at the bottom compared to white, beautiful, post-op, passable woman on top of the hierarchy. At the same time, she felt that she couldn’t tell cross-dressers anything because then she would just become part of stigmatizing society. Although Jesse passed well, she rejected the trans standard of “evening gown and Tammy Fay make-up” which distanced her from TG groups; she felt like she looked MORE trans in a dress. At the same time, she felt that the “man in a dress” template is the default experience for many transsexuals in the beginning stages; however, many transsexuals at the top also turn their own experiences into social leverage within the group.

Trish agreed that transsexuals stigmatize each other and she knew a lot of transsexuals who would not hang out with others who could not pass. She reiterated the common consensus that transsexuals are women but cross-dressers are men. Although she tried not to be judgmental towards cross-dressers, she felt reminded of her cross-dressing past about which she still carried a lot of guilt. She was doing “porno shows at night, high school during the day” — she noted that she would have never survived that life, couldn’t have lived as “merely a cross-dresser”, hiding a double life. Dara also felt that some transsexuals stigmatized others, by being very “catty” about especially those who did not pass. She said the issue unfolded rather subtly because nobody would say to another trans woman “if you wouldn’t walk like a line backer you’d pass better”. Felicia agreed that there exists a hierarchy within trans support groups and that this is also why trans groups are limited: they only benefit people in the beginning stages of transition and the hierarchy is most challenging for new members who can’t pass well or not yet.

Kacey felt there was a hierarchy in the community dividing people into cross-dressers and transsexuals. She noted that she didn’t feel “better” than others but she did not want to befriend others whose public image is highly sexualized on social networking sites. Kacey was

highly aware of stigma by association and did not add such individuals to her friend list. Jenna thought that there was no distinct hierarchy but that some people were more comfortable than others, feel jealous of others, and that there was a division between those who had “graduated” and those who were stuck (in the trans community). Luna felt that if you looked like a “line backer” with beard stubble and dressed too young then you would be judged on appearance just like other women. This image communicated a “fake identity” to others when “you don’t look like who you say you are”. She felt that there was a hierarchy in the trans community along the lines of the “trannier than thou” idiom or folklore in the community. April thought that the hierarchy within transgender communities was based on both passing and being post-op and she was also highly aware of ‘passers’ tendency to dissociate from ‘non-passers’; “there are times where I don’t wanna hang around a lot of transgender people because I’m going stealth” she noted.

Carla definitely thought there was a passing hierarchy in terms of feminine vs. not and surgery vs. not. Passing, she felt, makes things easier as passing is social capital. Violet’s limited experience with online trans groups made her aware of the hierarchy in TG groups being actively discouraged by moderators — they fought comparisons of being “less masculine than she is” chatter. Ruby felt that not only did trans women stigmatize each other but that trans women did this even more so than non-trans people. She noted that she was also very critical about how trans women present themselves. Ruby identified as a woman and not a transsexual and planned on being less involved with her support group in the future. She felt that if a transsexual person can pass, they might never have to say “I’m a transsexual” again. She felt that there was a high level of “cattiness” in support groups, and that particularly trans women dating each other earned them derogatory comments behind their backs.

Deanne lived in stealth but felt that in the black queer community people were often competitive including elevating themselves over others in terms of surgery status. Deanne felt it was this competition which prompted passing comparisons as if to keep people firmly grounded in reality. She told me of a friend who was “taller than this ceiling” and of another who was “walking in heels like Andre the Giant” and looked like a “big moose”. Passing as the ultimate social capital appeared to choke any type of deliberate put down. Deanne’s involvement with the House system offset her life in stealth. She had connections to the drag scene and was intimately familiar with some of the individuals featured in a popular documentary about House culture. She had integrated herself into the kinship system of the black gay community and had both had gay mentors and was being a “mother”/mentor to younger trans identified people. Deanne was the only person in her house community who had the surgery, which afforded her a high organizing position in the system. Furthermore, she was a role model to others as she was able to have a career and live a responsible, ‘normal’ family life. However, Deanne drew a firm line between her public and private life, dividing gay/queer contexts and heterosexual contexts.

Tracy, felt that people look up to others who are further along but she also noted that different subgroups within transgender groups do not associate with each other. Vicky also acknowledged the hierarchy in TG support groups and felt hypocritical, saw it in herself (stigmatizing others). She felt judgmental about t-girls who dressed slutty, showing off. She noted that groups often break into sections, separating the community even more with the “true transsexual” on top of chain, and post-ops being higher than pre-ops. Passing, she confirmed, was also part of the hierarchy. Maria felt that there was a passing hierarchy within TG groups and didn’t think women who liked their penis were transsexuals at all. People who did not want the surgery were cross-dressers to her. “Being a girl is not having a penis”, she stated.

Haley felt that not only did trans women stigmatize each other but gays and lesbians did as well. But while gays and lesbians may have a more fundamental opposition to transsexualism, trans women were quick to point out each others' physical flaws such as big hands. Interestingly, a transgendered friend of hers had advised her not to have the surgery because "then you'd be just like every other girl". This notion of having a penis making you some kind of "special girl" denotes a subset of trans women who live somewhere in a border-zone between drag, queer, gay, and trans; these individuals are often viewed as either not "really" transsexual or too focused on genito-centric (and thus male) pleasure, yet, they seem to gain a sort of sexual empowerment from retaining precisely what other transsexuals try to get rid of for the same purpose. Kellie felt there was a hierarchy within the community and that post-op trans women belonged to an elite group as if to say "I am more woman than you". Kellie found it ironic that trans people within the community stigmatized each other despite being part of transgender as an "umbrella" category.

Jean felt that other trans women stigmatized each other and agreed there was a transition stage hierarchy. Emma felt that transsexuals stigmatized each other similar to high school girls being "mean girls". Although she felt that most transsexuals realized they all shared a "hard journey", some frequently and openly made ugly, catty, rude, or vile remarks about others. Jane agreed that trans women stigmatize each other but mainly she noted that trans women post-op just disappear from support groups although groups help them at first. Rose thought there was the dividing line between her and people who "ghettoize" themselves and stay within trans communities only. Rose agreed that there exists a "trannier than thou" hierarchy within trans groups but with younger people, the distinction is all about how young you transitioned. She felt there was a huge bias against having been married as it took away from being a "real" woman.

She did agree with the notion that trans people did not like to associate with other visibly trans people. Rose was hesitant to bring other trans people into her personal friends circles and she also did not like being the “tranny” in the group as it becomes primary to all social interactions. However, another trans woman had also ceased being social with her — so she had been on the receiving end of it as well.

Zoe agreed that there was passing hierarchy in the trans community and she also thought that people who did not want to have surgery were not really transsexual. She noted that not just in support groups, but even at social gatherings and conferences, there was a distinct divide between people who are “just cross-dressers”. People would break into cliques, groups, and Zoe felt that other trans women held the most stereotypes against each other. She once met a trans woman who asked her to meet her as she was considering joining the church group just to see “what kind of t-girl I was”. Zoe was well aware of the common prejudice trans women have against other trans women based on passing and not wanting to associate with “obvious” trans women. But she also felt that trans women who did not have surgery were “still just a guy in a dress”.

Mia also had never been to a support group and although she had no contact with other transsexuals, she understood the idea about the trans hierarchy and felt that “surgery authenticates you as more of a woman”. Kelsey didn’t know any other transsexuals personally. Yet, on the issue of transsexuals stigmatizing other transsexuals, Kelsey noted that the trans community constituted a “culture of embarrassment” as some transsexuals are uncomfortable socializing with those who do not pass. Nancy felt that there was definitely a hierarchy between those who have had and those who have not had the surgery; Nancy felt that she now (post surgery) belonged to a “very exclusive club” within her local TG group.

My participants' experiences with trans-trans stigmatization based on passing or transition hierarchies are by no means unique. Sanger (2010), too, found that some trans women are quick to draw a dividing line between them and others. Very similar narratives about othering practices such as calling trans women "men who were dressed as women" and distinguishing between "true" and secondary transsexuals emerged in Sanger's samples. Sanger also acknowledged a hierarchy among transgender support groups and communities. "A trans hierarchy is articulated with 'true transsexuals' at the top and transvestites at the bottom, reinforced through the division of trans people into 'real' and 'larger than real'" (64-65). Similarly, Schilt (2010) found a surgery-related hierarchy among trans men she studied, based on differential "body projects", meaning varying desires to change their physiology through hormones or surgeries. The differences, Schilt notes, "could create a hierarchy among transmen - what transmen described as a 'trans-er than thou' attitude" (45). Schilt also noted that age divided trans men as younger transmen who were not too focused on surgery found it more difficult to relate to older transmen whom some perceived as "conforming to hegemonic stereotypes of heterosexual maleness" (45).

Connecting Bodies to Selves: Exiting Body Dysphoria, Entering Post-Surgical Life

What emerges from these narratives and reflections about the disconnect and reconnect between body and self reiterates the notion that GRS is highly beneficial in eliminating or lessening anatomical dysphoria in the individual patient. Patients' feelings of relief immediately after surgery are undoubtedly narratives of self-affirmation which hold a high clinical or medical value, because they translate so well into successful medical intervention — refocusing the problem of, and solution for GID about the body aligns both medical and patient perspectives of

“matching” the body to the mind. However, as I will address in the remainder of this ethnography, what this matching or alignment means to patients in a broader social sense deserves equal, if not more attention as it shows that transsexualism as a social problem remains outside of the all-reaching, all-encompassing biomedical grasp. And while genital reassignment surgery retains its therapeutic logic in the interpretative framework of turning penises into vaginas, its cultural equivalent of turning men into women constitutes a vastly different therapeutic as well as social reality.

As I have tried to show, while the medical rationale for GRS rests on eliminating or lessening body dysphoria associated with GID, the cultural rationale for GRS rests on eliminating or lessening identification against cross-dressers or transgender identified individuals. Because the latter attempts of dis-identification and identity distinction are more complex communicative endeavors centering on narrative constructions of the self, the following chapters focus heavily on interview data collected to show that the anticipated social gains of GRS are both illuminated and complicated through narration of gendered embodiment past and present. This notion reiterates that while biomedical processes of identification through surgery are individual achievements, cultural processes of dis-identification through narration are distinctly social achievements.

Chapter 6 - Patient Perspectives on Transsexualism as a Social Problem

Anticipated Social Gains of GRS

Social Selves, Social Bodies, Social Histories

Now that I have explored patient perspectives on how GRS affects the individual, I examine how patients thought about the broader, social effects of the surgery. Having shown how patients think about the connection between body and self, I want to explore how patients think about the connection between self and society. As many scholars have noted before, gender transition does not just affect the individual person, but rather all people who are involved in the transitioning person's life past and present. I now want to turn my attention to these social aspects of transition and their effects by exploring what patients believe or hope the surgery will ultimately effect or not effect for them socially. The third part of this dissertation thus focuses on patient perspectives on how GRS will effect their life worlds, their social landscapes, their interactive contexts with families, the work place, sexual or love relationships, and social/friend circles. Although a lot of issues explored here are more central to transition in general rather than GRS in particular, GRS is nonetheless part of transition, and the end point for many. So while a lot of this data centers on occupying a transsexual status and what this means in the course of everyday life, the surgery remains representative of the finality and permanence of transition, and, as I have shown in the last chapter, constitutes an integral part of transsexual identities.

Data on what patients individually anticipate or hope to gain from GRS is a critically important counterpart to follow-up studies from which it is generally missing. As I have already discussed earlier, follow-up studies on GRS are usually assuming, rather than assessing that all evaluative criteria are equally important to transsexuals, and that little or non-improvement in specific areas must be interpreted as some sort of "failure". More importantly, however, social

benefits of transition or surgery are often only minimally or superficially addressed although GRS, like all medical treatments, must be evaluated as a means to an end, and not an end in and of itself. And although I have shown that even though GRS holds a highly therapeutic potential for the individual, mainly eliminating dysphoric feelings about one's body, but this does not mean that transsexuals necessarily feel cured of GID, here I will explore patient explanatory models about what kinds of social gains life after surgery might hold. What I hoped to learn from focusing on patient perspectives on their past and present social lives was the reflection of themselves in a imaginary social mirror. More importantly, I hoped to learn more about the cultural symbolism of gender and genitals in the context of one's life history: how much social weight do genitals hold when a person's gender changes? In other words, what sort of social variables might GRS gains be read against?

Initially I approached this problem heuristically by assuming that if your gender has always been the same and only your genitals changed over time (for whatever reason), this would make very little difference socially whereas if your gender changes but your genitalia do not, the opposite would be true. Excluding physical intersex conditions, if you have always been a woman with a penis, or if you have always been a woman without a vagina, or conversely, if you have always been a man with a vagina, or if you have always been a man without a penis, your social status would never really be that of a transsexual. Another way to illustrate the primacy of social personhood is this: let's assume hypothetically that a person was indeed born with male genitalia but raised as a woman. If this person then decides in adulthood to become a man, this person would by definition become a transsexual because transsexuals experience an incongruence between gender and sex which they wish to correct. The person would also be a

transsexual if they have lived socially as women or men and have thus been engaged as gendered beings with the world.

Conversely, such individuals with non-normative genitals but normative gender identities are not automatically transsexuals, because they do not transgress gender boundaries when their sexed anatomy changes. This is an interesting point to consider because if a person would present themselves to a mental health specialist as having always lived as woman with a penis and simply wants to change their gender to match it, there would be no diagnostic GID criteria to apply because a male body matching a masculine gender does not constitute a pathology. The difference is of course that transsexuals reject both, the body and the gender identity expected to go along with it. But my point here remains that if the individual has always lived socially as a man or a woman, changing their natal sex to match their socially confirmed gender would not make the person a transsexual while if a person changes their socially confirmed gender to match their natal sex it certainly would, even if technically, there is nothing pathological about biological males wanting to be social men. Thus, it is not just the biological genital history that matters in whether someone is socially a man or a woman, but more so the person's socially gendered embodiment history. It is precisely this socially gendered embodiment and its shared, intersubjective meanings, which I want to explore in the context of what GRS achieves socially for patients.

Expected GRS Effect on Sex/Love, Family, Work, and Social Environments

To begin exploring the expected or desired social effects of GRS, I asked all participants which general area of their lives they thought would be most affected by undergoing GRS, giving them a quadrant of four basic areas to choose from:

1. Sex/Love/Relationships (current or future, including wives and husbands)
2. Family (including both natal and created)
3. Employment/School (current and future)
4. Social environment (friends, interest groups, support groups, etc)

Sex/Love Relationships

Thirty-five out of 50 participants said that their sex/love/relationship area would be most affected by undergoing GRS (see also Lawrence 2005 on sexuality before and after GRS). While this seems perhaps logical or commonsensical, the fact that this category was not unanimously stated as the primary anticipated effect is nonetheless important to note. Furthermore, the statement that this area was expected to be most affected does not mean that this was also the most desired effect. However, in most cases expectation and desire overlapped, but not always. At the time of research, 9 participants were married, 13 were currently dating or in a relationship, and 29 were single (including 1 widowed person). Out of the married participants, only Joyce had a husband, all other participants had wives. Out of those 8 remaining married participants, Zoe's wife was "antagonistic" towards her transitioning partner while the others were supporting and at least for the time being considered staying in the relationship. However, in 3 marriages out of the remaining 7, the couple no longer had sexual interaction even if they considered themselves to be a couple. In those relationships GRS was a negative, or disabling factor sexually. Sanger's study on trans people and their partners (2010) found similar results as some who stayed together as couples "no longer had a sexual relationship, and some did not see each other as intimate partners any longer..."(106) because sometimes either partner can identify as strictly

heterosexual. On the other hand, current sexual relationships which began after participants' transition, were thought to improve or be enabled in the first place after GRS.

What is noteworthy here is that participants' negative experiences with being rejected by new or potential future partners or lovers in the past had very little to do with rejection based on their pre-operative genital status. Rejection, at least in my sample, was almost always based on embodying a differently gendered history, and not simply a pre-operative transsexual status. Although both GRS and the term transsexualism are sometimes critiqued for its over-emphasis on sexuality, my data shows that for most participants undergoing GRS, sexuality and love relationships were anticipated or desired to be most affected by the surgery. While this is not at all surprising, it nonetheless conflicts with transgender advocates' viewpoints, as well as the narratives of my own participants who insist that transsexualism has nothing to do with wanting to have sex. Although I agree that transsexualism is neither about sex nor a sexual problem, my research shows that an improved sexual life, even if not necessarily being the only motivating factor for the surgery, is nonetheless the most frequently expected result of GRS — with one important modifier: singling sexuality out as one of the core aspects of love relationships and therefore constituting its unquestionable foundation is erroneous in this case; many participants yearned for a healthy and committed relationship based on love and intimacy, not sex. While this may not be different from the general population, I would suggest that at least for the older participants, sex and love were more often differentiated in importance.

As I have already suggested, sexuality, sex, and sexed bodies matter most where embodiment is central to social interaction, and least where it is not. What was also quite interesting is that sexuality seemed to matter more to people who were either already engaged in relationships (with current partners who had only known them in their current gender) or who

had been normatively, to highly, sexual before transition but felt that being pre-operative hindered their sexual engagement altogether. Those who had hardly had any sexual experience or few partners did not seem to emphasize sexuality all that much, even if they expected that their sexuality would be most affected by the surgery.

Similar to my impressions, Marci felt that the surgery is important because humans are sexual beings; however, how important sexuality is to patients in part depends on whether people have partners going into the surgery or not. She added that some transsexuals are asexual going into surgery. Generally, Marci felt that patients' sex life was affected on a very individual level. "For many it's not very important" she notes, "a shockingly high majority don't ever use their equipment for the intended purpose". However, given the advanced age of most of her patients, she doesn't find it that unusual when compared to other, cisgender women in their 50s. It would be like asking them "how important is your vagina to you?" she added. For some, it might be very important, and for others, not at all. How much or how often GRS patients have sex depends on "where they are socially, how attractive they are, how well people do socially, how well they adapt to their new gender role" Marci said. "If you're socially perceived as a woman" she noted, "you'll have more opportunity for intimacy".

Marci remarked that lesbian trans women think that if they have a vagina, it will make them more attractive to women "but then they are disappointed". But if they are already partnered, then GRS can have a positive impact. Marci also noticed the recent trend of more wives coming in with patients having surgery. She credits this to increased social acceptance and the shame being lifted; wives are not as scared to stay — they now have less fear of being social outcasts. In addition, a lot of MtFs come from a heterosexual background whereas FtMs, in contrast, come from a lesbian background. Lastly, Marci noted that "a lot of female partners are

very ‘dykey’, very masculine”, suggesting that their own gender non-conformity might aid in accepting their partner’s. However, she also noted that younger partners tend to leave relationships more often because sex is more important to them at younger ages.

Family

Seven out of 50 participants said their families were most affected. The common reason given was mostly positive, where participants hoped for greater acceptance based on the “seriousness” factor communicated. They hoped that their families no longer saw their transsexualism as a “phase” or as sexual deviance and that this in turn would promote increasingly being addressed by their chosen names and with gender appropriate pronouns, and more importantly, that they would be able to either maintain or resume kinship roles and responsibilities within the family (I will discuss this in more detail in the next chapter). For example, Tina hoped that she would be better able to interact with her grandson as his grandmother without fear of genital discovery while Elsa thought GRS would legitimize her position in her family for “future additions” (children, affinal kin, etc).

Kelsey hoped that GRS would make her more acceptable to those in her family who had the most problems with her — her sisters’ grown up sons. Her sister’s oldest son in particular was reluctant to accept and interact with her because as his uncle, Kelsey had built a strong relationship with him since he was born. “He lived vicariously through me”, noted Kelsey, referring to sharing her life adventures as a man with her nephew. But since transition, their relationship had changed drastically. “Now, all of a sudden, you know, what am I to them, you know? I’m nothing to them now...in that regard...and I met Dean, Kelsey met Dean in February...[.]...and there was definitely a chill in the air, and I made him hug me...and I said

‘come here’ and I gave him a hug and it was one of those kind of like ‘crotch really far away’ kind of hug with a pat on the back sort of thing...there was obviously some discomfort”.

Interestingly, Kelsey’s example about the “crotch-really-far-away” hug reveals that while it may have been permissible to hug before Kelsey changed gender, the hug now becomes sexualized as both homo- and heterosexual because Kelsey’s gender change had transformed both their sexual dynamic and their kin relationship.

Marci felt the area most affected were the patients’ families including children and spouses. She noted that families often experience the “loss of a child” and by extension the loss of a father or husband. Similarly, as I have already suggested, spouses undergo a metamorphosis with their partners who are still the same person, even though their relationship changes significantly (I discuss the notion of “loss” throughout a person’s gender transition in more detail in the next chapter)

Work

Six out of 50 participants said their work or place of employment was most affected. The common denominator in this case had to do with resolving pending or past bathroom issues. In their previous places of employment, Audrey, Betty, and May were explicitly forbidden to use women’s bathrooms and had to leave the company’s premises on their breaks. Audrey initially refused and got fired within 2 weeks. Betty was eventually relegated to use a special bathroom on which a sign must be placed to indicate occupancy which other women who used it frequently “forgot” to change — so she was often kept out. At first, Zoe was told she could not use the women’s bathroom until after surgery, however, Zoe cleverly refuted the argument of having proper genitalia by noting that “checking out” someone’s genitalia would constitute harassment

and that they would have to check everybody's genitalia as well. Although Kelsey could use unisex bathrooms at work, she had to change in the bathroom and not the women's locker room. She had been compliant but she felt that now, after GRS "I'm going to push it, using the female locker room". Similarly, Peggy had bathroom use and locker room issues at work and had to use a single, makeshift room to change. But after GRS she planned on polling the women with whom she would share a locker room and if all agreed, she planned on sharing theirs. Jane was outright forbidden to use the women's restroom at work. Corporate Lawyers had sent her a letter saying that until she had GRS, she could not use the women's rest room. Although most women supported her, a few objected; one woman said "I wouldn't feel comfortable changing a tampon with you in the next stall". Jenna hoped that post GRS she would be able to use the women's bathroom whereas before, like Betty, she had to use a bathroom with an "occupied" sign so no women could come in — but she was the only one who had to flip it over, other women simply ignored it.

Nancy was currently suing her employer over not being allowed to use the bathroom. Like the others, she anticipated that GRS would make a significant difference in the matter. When Nancy had to undergo her annual physical exam, the medical staff took notice of her medical records indicating that she had been diagnosed with GID and was on HRT. "They had a lot of questions", she said. Nancy felt pressured to undergo the surgery sooner than she had planned because of the bathroom issue at work. She was forced to use the single stall in the men's bathroom which she found very denigrating: "here I am, legally recognized as a woman by the state of Colorado, recognized legally by the government as a woman, why am I the only woman being forced [to use the men's room]?" She added with conviction that "SRS will fix the problem at work".

The company Carla worked for had a policy which indicated that until she underwent GRS, she could not use the women's bathroom. Since she worked at a place that required employees to change into uniforms at work, the company assigned her to change in, and use a unisex bathroom located behind a structure on the rather large grounds of her place of work. "But unfortunately I had some problems with some coworkers who would claim that that I was not using that place to change...and they continued to report me until I eventually got fired and then I had to use the union to get my job back. And in the process they transferred me to another area where I wasn't around no one I knew from before. So in this transfer process they told me that I should probably keep things on the down low and not tell people that I'm trans and I was more than happy to do that...but then they tell me that the [unisex] bathroom policy still applies...[]...and I'm thinking 'if you want me to go stealth and be down-low about this and you got me around all these new girlfriend coworkers, how am I supposed to explain to them why I'm not using the bathroom with them?'" Sometimes, Carla had to walk 20 minutes to use the bathroom designated for her.

The prevalence of policing gender segregated spaces like bathrooms is of course not unique to my own sample which is why it is not at all surprising that where genitalia are hyper-emphasized, genital embodiment of transsexuals matters greatly. Marci thought that although generally, the area least affected by surgery was work, she agreed that GRS might "make the bathroom issue go away". However, as some participants have pointed out, tolerating shared bathroom use at work does not necessarily mean greater acceptance of transsexual coworkers in general.

Social Environment

Not one participant said that their social life would be most affected by GRS, however, all participants could cite examples of social contexts in which embodiment mattered such as public bathrooms, changing rooms, and all-female environments emphasizing some aspects of potential nudity. For instance, Kacey was planning on sharing the women's communal dorm room on an upcoming ski trip and Carly planned on attending an all-women's spiritual retreat which involved possible nudity in bathing in hot springs. But other social contexts such as women's exercise classes or dance ensembles also constituted a barrier to inclusion in which GRS may or may not make a difference. Especially changing rooms in shopping or sports facilities were highly coveted communal spaces participants wished to enter post surgery. While these contexts seem secondary, or at least not of constant importance, trans women's desire to participate in exclusive women's activities or enter exclusive women's spaces was expressed frequently and consistently. And although there are of course practical benefits to sharing women's spaces, this kind of inclusion is also highly symbolic in that it provides the much desired validation of gender for trans women.

However, where friends' circles or social groups had already disintegrated because of participants' initial disclosure of their transsexualism, little hope was invested in GRS as a mediating factor to social inclusion. Although some participants, as I will discuss in more detail below have expressed that some people who were "on the fence" might be more accepting of them in the future, past acquaintances who had already severed friendship ties would be unlikely to come around. For example, Joanna used to organize large social gatherings pre-transition for over 4 years. Eventually she handed over organizing responsibilities to someone else but wanted to stay involved with the group. Once she came out bisexual to the group, she noticed a drop off in attendance of about 40%. Once she came out trans, 90% of the group stopped attending and

the remaining 10 percent eventually shut her out and cut personal ties with her. Trish had lost the majority of her friends to transition and her colleagues gave her the “invisible woman treatment” socially. Most friends took her wife’s side after the divorce and she no longer had any contact with her wife’s friends. Trish felt that she got less and less invites to community events and this made her feel like she had “an ice shell around me”. Trish’s best friend had abandoned her shortly after she came out to everyone. “She kept my secret for 8 years” but within only a few months she wrote Trish a birthday card saying that she never considered Trish to be her friend, and sided with her ex-wife ever after. Trish pointed out that as long as she was not out, everything was fine, but the minute her friend had to publicly support her, she wrote her off. She continued “and you can say ‘their loss, their loss, their loss’ all you want and I believe it, but it’s also my loss and I feel that loss a lot”. Although Kelsey felt that her family and friends were supportive, she felt that some of her male neighbors treated her distinctly different from her female friends. While some men treated her well, “other guys who have known me as Paul still think...if my little four-wheeler breaks down or something, maybe I should fix it...(laughs)...if I were a genetic female, I think they would go ahead and do everything they could to help her”. Gradually, most men who used to congregate on her patio for sociality started to stay away.

Marci noted that that above all, GRS improves patients’ self perception and confidence, a notion commonly agreed upon by most psychiatrists or psychologists working with transsexuals; “Looking in the mirror in the morning and being able to say ‘I am a woman’ or a man is a powerful resonance of day to day functioning”. However, she added, socially there’s not much difference as people can’t see genitalia. I pointed out that even if people can’t see trans women’s genitals, they are generally quite curious about their surgical status. Marci’s response to this was that “I think they ask people who don’t pass well that question. Nobody asked me if I had

surgery”. However, the popularity of the surgery question prompts an important inquiry into the connection between social stigma and transsexual embodiment. As the above examples show, genital reassignment is expected or anticipated to effect primarily those contexts in which genitals matters directly (sexuality and nudity in gender segregated spaces). But how would GRS effect the social perception of trans women as stigmatized individuals in contexts where genitalia have no bearing on social interaction or inclusion?

GRS Effects on Stigmatized Social Identities: Could GRS lessen Social Stigma?

My question of whether GRS lessened social stigma was intended to critically and directly tie together two major research questions: one, how much does genital embodiment matter to being socially perceived as men or women? In other words I wanted to know whether the common assumption that the social stigma of transsexualism was really based on biological determinants of gender held true. This question could also be framed by asking what difference would GRS make in cases where stigma is distinctly rooted in *essentialist* notions of gender based on natal sex. The second question I tried to answer was why GRS would make any difference to social acceptance as women when transsexuals remain anchored in their male social history. This question is framed by the notion that stigma is distinctly rooted in social *constructivist* notions of gender based on socialization. Of course, these two rationales, essentialist and constructivist are not necessarily mutually exclusive: a transphobic or cissexist person is likely non-accepting of transsexual women because they were not born female *and* they have not been raised as women. However, as I have tried to illustrate above and will try to show in the data below, it is the latter variable of non-acceptance which makes a much larger difference because it is also the variable which is more troubling to transsexuals themselves. As I have already tried to assert,

transsexualism as an individual problem is not so much about the problems which can be resolved *medically* (anatomical dysphoria/permanent sexual reassignment), but rather about the problems which cannot be resolved *culturally* (wistfulness/permanent gendered history). Hence, transsexualism as a social problem follows the same logic that it is not so much about problems with transsexuals changing their genitalia, but rather about problems with transsexuals changing their gender. And because people interact and build relationships with people, and not genitalia, the purpose of these questions then, was to get at patient rationales of why, if at all, and how post-op transsexuals would be more accepting to society.

I began to explore the relationship between GRS and social stigma by asking participants about their own definitions and meanings of stigma in the context of transsexualism. Their responses yielded a vast variety of conceptions and explanations; there was no clear consensus on what constituted transsexual stigma, which confirms the notion that underlying rationales could be multi-faceted and highly idiosyncratic. On the other hand, there are general central themes such as societal lack of understanding of gender/sexuality differences (i.e. conflation of homosexuality and transsexuality), religious opposition, and rejection based on equation of transsexualism with sexual deviance and mental illness. Still, some interesting differences emerged based on different ethnic backgrounds of participants. For example, as a Latina, Tina had been called a “coconut” as to indicate being brown on the outside but white on the inside because of her transsexualism. Deanne noted that black people often blamed both homosexuals and transsexuals for the spread of AIDS in black communities, and conflated homosexual and transsexual deviance. April felt that MtF transsexuals were especially stigmatized because women held such low social value in Chinese and Chinese-American societies. And Annie

thought that in the Philippines, transsexuals are seen as deviant because most people are very religious and view transsexuals as morally degenerate prostitutes and drug addicts.

As for the effects of stigmatization, it seems that most participants agreed on two major themes: fear of violence and rejection, and internalization (self stigma), which kept people either completely in the closet or at least in hiding or living in secrecy. The most common result or consequence of these effects for trans women was social isolation. For example, Elaine felt the worst effects rested on societal prejudice and the resulting separation from society. Doris said the worst effects of stigma were ridicule and exclusion, and people were short with her and ended some work relationships. She felt a “forced isolation” in environments which were not accepting, which made her “wall up” and which ended in depression: “it’s horrible” she added. Susie also felt that isolation was the most negative effect of social stigma; “it is the worst thing you can do to a person” she noted. She likened it to being in prison and put into solitary confinement: “for the transgendered person, the world is one big solitary...and it rips people up, and the physical danger just emphasizes that...and it’s very hard for people to understand...and people just react badly, too. So you don’t wanna say anything to anybody...so you’re isolated even further...[]...and it ends up you lose everything...[]...I lost just about everything...nearly my life...and it’s all because of this isolationism, all because of being isolated from the rest of society...and that’s the one thing that hurts transgendered people the most”.

Vicky believed that a lot more transsexuals lived in the United States than are officially known. “We just live in silent suffering” she noted, remarking on having lived a lie her entire life, staying away from social events and groups in fear of being outed, and felt very lonely having lost “some really great relationships”. Maria felt that the effects of stigma made her not understand herself, considered self a freak, and that she was very harsh on herself. She also felt

very lonely, very secretive, and physically vulnerable as she had a fear of rape and being in powerless situations. Like many other participants, Rose thought one of the worst effects of stigma was that transsexuals internalized stigma and become scared of becoming the object of prejudice. Trans people were thus subjected to an all consuming fear and self-loathing which was even more difficult for those who could not pass and were afraid to even leave the house. In addition to the narratives above, it was quite clear to me that participants had an accurate understanding and high awareness of what stigmatization can entail which in turn reflects the current research on LGBT discrimination, prejudice, and violence experiences (Lombardi et al.2001).

Marci thought that transsexual stigma constituted the “not quite women”-view which arouses suspicion although Marci felt that “they certainly are women” and that especially the older ones “pose little threat to society”. She felt that there are regional differences in terms of experiencing stigma, some in which it was tougher than others to be “average people with an unusual problem” and that the best case scenario, not unlike that Native American Two-spirit people, is that of being “gifted”, being perceived for unique characteristics and to de-emphasize transness (although she doesn’t like “third gender” ideas). But publicly, she noted, transsexuals are still seen as “circus acts” which is why it is difficult to de-emphasize being transgendered. She feels annoyed by newspaper articles about her which have little to do with transsexualism but which still mention her transgendered status. “Why is my personal medical information relevant after 14 years?” she asks.

As for common effects of stigmatization, Marci agreed with participant comments on loneliness, exclusion, and isolation. “Social isolation is very difficult for people” she said, “...it is the most detrimental aspect of social stigma but it’s getting better...a lot of people come with

support”. Marci felt that social isolation and marginalization have a lot to do with age and how people look because there are not that many choices for trans women in terms of intimacy. But she also noted that it is difficult for her to assess social isolation of her patients because she does not have a lot of contact with patients after GRS. Marci felt that some of the more pertinent stigmatizing stereotypes of transsexuals are about being mentally unstable, being psychologically imbalanced, and that people are not who they appear to be. But she also noted that it is different for FtMS because they are “much more accepted as men. Nobody questions them like MtFs. It’s remarkable”. Other, perhaps lesser stigmatizing views are that MtFs are obsessed with sex in an autoerotic sense even though GID is a gender issue, not a sexual issue.

The wide variety of patient answers show that conceptions of social stigma and its effects are not homogenous, and yet, it is possible to develop a notion on sharedness and commonality of experience. What this exemplifies is not so much that stigma is conflated with discrimination, prejudice, rejection, or outright hate, but that stigma can cover a lot of ground with very little “enacted” (in Scambler’s term) efforts. Given the divergent definitions and meanings of social stigma, and in contrast, the converging consensus on its effects, I now want to turn to whether patients felt GRS could lessen social stigma experienced. Here, patient explanatory models of why and how GRS could lessen stigma diverged on whether this would or would not be the case whereas the underlying rationales converged into a consensus.

Not surprisingly, most participants related that GRS would communicate a seriousness of identity against the notion of being “just a guy in a dress”, i.e. a cross-dresser even though this may not necessarily lessen social stigma. As for the surgery’s effects on lessening stigma Gill’s answer reiterated my suggestion that if a transsexual’s surgical status changes, the stigmatizing rationale changes from essentialist to constructivist but the stigma remains nonetheless. Gill

noted that whereas pre-surgery, trans women's identity is often questioned by people's notion that "you're just playing dress up, just put on a costume", but when trans women pursue GRS "then they change their attitude to say 'oh, you're just a mutilated man'". In the same sense, she didn't feel that negative societal treatment would cease after GRS: "Surgery is not going to make people treat you differently...they are not gonna say 'oh you've had the surgery, I'm sorry, I'll stop now". She emphasized that GRS won't change transphobic people's attitude toward transsexuals because "Transphobic people have made their choice about how people see transpeople. [They] would always see you as the pre-operative person...You can't deny that you were born the other gender...it doesn't take away my past, I still have that male history...I can't deny my past life". She explicitly referred to her shared memories with her brother "You can't erase the knowledge they have...it didn't NOT happen". All in all, Gill thought that GRS "still hasn't confirmed your gender socially in their eyes" and she felt that there is little she can do to change social stigma. "You just have to learn to live with it...it's sad".

Donna felt that GRS might not make much of a difference in acceptance but she noted that many trans people might *perceive* it as different after GRS even if it isn't any different at all. But at the same time, she felt that people think of transsexuals as more dedicated and serious for doing it. She noted that transsexuals, if perceived as such and internalized it, could never overcome being "just a guy in a dress" even though Donna' felt that personally, surgery would excavate her from the "guy in a dress mentality". She felt that GRS would raise her confidence level, especially in business interactions with men because she "completed everything humanly possible to be what I appear to be". "It's not a game," she added, "surgery eliminates the game" — she was a full-time woman now which made her feel "true to my skin". "I am what you see", she said because she would be embarrassed to say "yes, I am still a male" living the life she does.

GRS was also taken to communicate a validation of GID (“this person really had this”) as well as a validation of gender (“this person really is a woman”). Furthermore, most participants also agreed that if people are already accepting, or not at all, GRS makes no difference. Elaine thought for those people who were on the “fence” of acceptance, GRS might make a difference, but for those who are already accepting, it did not. However, Tina and Lisa asserted that if people only accept them or treat them better after GRS, they would be equally upset.

Similarly, Gill and Trish noted that GRS can actually have aversive effects as people who have genital reassignment can appear more freakish as if to say “I let someone chop off my penis”. Luna felt that GRS could actually increase the social stigma because you’ve had a “sex change”. Luna re-emphasized that some people considered GRS to be a mutilation but if people identify your gender by your genitalia, then yes, GRS could make a difference in societal acceptance, especially in bathroom issues. Carla didn’t feel that GRS lessened the social stigma because some people would see her new vagina as a “mutilated penis”. For those people, GRS could make matters worse (“now you’re a freak”) even though some people would consider having sex only with post-op transsexuals. On the other hand it also distinguished transsexuals from homosexuals. For example, Doris felt that the main stereotype people held against her was that at least until surgery, she was seen as a gay man who wanted to present as a woman.

Another most commonly brought up point referred to the effective barring of trans women from gender segregated spaces and it is here that GRS might actually confer the most practical social capital. Especially bathrooms and locker rooms were thought to become more accessible if the obvious marker of difference were no longer there. For example, Carly hoped that GRS would lessen stigma in all-female situations involving nudity as she saw her penis as an obvious barrier to inclusion. She thought that GRS might make a difference socially in bathroom

situations as the penis as an object or symbol of power was no longer there. She noted that people had bathroom anxiety around transsexuals based on the notion of the “lurking penis”. In a society which was basically hostile to women, she felt, the bathroom was the one place where women could be safe publicly which is why transsexuals seem so intrusive in such places. Felicia believed that GRS would have the greatest social effect in all-women environments as post-ops “no longer look like a dude who is in the wrong changing room”. Kellie felt that the only difference GRS made was in situations where bodies were closely scrutinized. Jane hoped that GRS would fix the bathroom issue at work and it may make those few women who had problems with her come around because she “had the right plumbing now”. Jane felt that for those women, GRS might motivate a psychological shift of seeing her no longer as male because of changed genitalia. But overall, Jane expected no significant change after GRS. Lana also noted that in school environments, people might be more comfortable with post-operative trans women: “if something [i.e. adult male child molestation] *cannot* happen, it’s less to worry about”.

Some participants also emphasized that when trans women cannot pass, levels of social stigmatization do not change. Deanne felt that GRS made no difference in how people saw transsexual women if they still looked male as people can still say “that used to be a man”. For April, GRS had little effect on lessening social stigma because “If they perceive what appears to be a man in woman’s clothing the shit hits the fan quickly”. Tina had observed that another trans woman at work who did not pass and had GRS had experienced no change in treatment whatsoever. She noted that people said “that’s still Don” about her coworker. Jean said that even if her intersex condition was factual, “all people can see is that I used to be a guy”. “Whether or not main stream society will view a person any different really depends on how well they pass as that gender...[]...Once a person can demonstrate that they are their chosen gender then others will

have to accept it so long as they aren't doggedly holding onto an image which never fit in the first place” she said. Betty felt that “I’m not going to be accepted as a women by people who know I’m a transsexual”, yet she felt that people who meet her for the first time accept her “because I am a senior woman, and they don’t have to be quite as feminine as younger women”.

Lastly, a few participants believed that GRS may lessen some social stigmatization of transsexual women by lesbian or heterosexually identified male partners. Jesse felt that GRS might make a difference to lesbians because the symbol of power is no longer there and Lana felt that she would be more authentic to the people she wished to have sex with. She didn’t feel GRS made much of her difference for her but that it mattered most in disclosures to sexual partners. Mia thought that GRS does make a difference in dating and romance because “people want to trust what their eyes are telling them”. She also noted that the potential for sexual violence was much greater for pre-ops but “if you have undergone the surgery, that must mean you are serious”. May felt the only difference GRS may make is that it may place transsexuals back into the binary at least as far as genitalia are concerned as for many, especially potential dating partners, having a penis matters. Haley felt the only real difference GRS would make in her case was in terms of intimacy.

Rose felt that GRS might lessen stigma coming from lesbians who object to pre-operative transsexuals but she felt that knowledge about one’s past matters greatly in acceptance; it was harder to conceptualize people as men if they have no visual references, old names, etc. — she didn’t want to create a male image of herself in people’s heads. Rose felt that as soon as people learned about her trans status they stereotyped her as just wanting to have sex with men and assumed she was over-sexualized. The only context in which GRS would make a difference in acceptance was for people who equated having a penis with being a man as the penis was

symbolic. But for her, her penis was nothing more than a “sixth finger” and surgery would not help her gain more social approval, only more social conformity. Still, Rose hoped that maybe lesbians would accept her more after GRS and that it might offer her a healthier sex life.

Marci felt ambiguous about whether post-operative transsexuals are somehow more acceptable to mainstream society because she agreed with some participants in that acceptance often “comes down to passability”. But often, there is no difference of acceptance if people already know the person because nobody sees their genitals: “It’s not as liberating as you think; certainly to the individual, but not in a work place”. Marci, like the vast majority of patients asked, believed that passing greatly determined social acceptability of transsexuals because visual markers are “how women are measured”.

Marci reiterated that if a person is known pre-operatively, then GRS makes no difference either way. For some, GRS may enable sexual relationships but for others it does not. Although GRS does not make people more passable directly, Marci noted that throughout the whole process, the softening of the face and the overall more feminine appearance of the body via the removal or suppression of testosterone through orchiectomies or GRS does make a difference. Nonetheless, she noted that patients “are sometimes (disappointed) because they have unrealistic expectations of how the world is going to treat them...that is one of the problems of post-op depression...they have nothing else to look forward to...‘is this it?’”. Furthermore, she added “people still think this is a man who is masquerading as a woman even though you’ve had your surgery. It can be very disappointing”. Especially high expectations for dating struck Marci as problematic “they think it’s gonna solve all their dating issues...suddenly they are this attractive diva...[]...it has to do with how you present yourself...[]...People don’t suddenly want to get in your pants because there’s not a penis there”

The Potential of GRS in Transforming Transsexual Identities Post Surgery

Most participants' definitions of trans identities followed the general consensus within and outside of transgender communities that "transgender" denotes an umbrella category which encompasses any and all gender variance (see also my Terminology section) whereas "transsexual" distinctly denotes several things: to identify unambiguously with the other gender and the desire to live as such by some means of physical and social transformation (intention included). After establishing the consensus of transsexual terminology, the question of whether or not transsexuals are still transsexuals after GRS shows that GID and transsexualism can be two distinct ideas, with transsexualism encompassing a much broader spectrum of the issue than GID. This also shows that the proposed "exit clause" may describe a person who has completed transition and is no longer engaged with the medical system but even if in this model, this person no longer can be diagnosed with GID, he or she may nonetheless still be considered a transsexual person by transsexuals themselves, medical doctors, and society in general. My interest in asking "Are transsexuals still transsexuals after GRS?" was distinctively aimed to illustrate transsexualism as a persistent cultural problem of identity categorization based on social history in which medical intervention is rather limited.

Most participants agreed with the statement that transsexuals are indeed still transsexuals after GRS and that the label sticks no matter how hard some transsexual women are trying to shed it. Only a few claimed that post surgery, they no longer considered themselves to be transsexual. For those who no longer identified as transsexuals, the surgery denoted some sense of closure. I noticed that those who rejected the trans label the most (pre and post surgery) also had the most invested in keeping their trans status private and planned or were already living in

stealth as much as possible. For example, Annie would say that she was a transsexual before surgery but that she was a woman now. However, she said she couldn't deny the truth of having been born male even though she did intend at some point to leave her past behind and live in total stealth as a woman. Generally, April felt that "if you are transsexual, you are not going to be accepted quite so easily". Her desire to be socially accepted and seen as a woman kept her from disclosing her transgendered status and it bothered her if people found out. In the eyes of others, she said, "[A] transsexual will always be a male masquerading around as a female, it doesn't matter if you've had the surgery, it doesn't matter if you dress differently, it doesn't matter if you act differently, you're still a man". April didn't want people to know that she was trans because "once you know, it's hard to get it out of your head". Deanne felt that socially, other people were still transsexuals after GRS, but for her the prefix "trans" meant to cross over so in her case the notion of "sex change" means "you've changed", indicating a sense of finality. Kellie felt that since from her point of view, transsexuals were born in the wrong sex, after GRS she no longer felt like a transsexual. Elsa's overall strategy was to try and blend in as she yearned for social acceptance; she noted that she would keep her trans status private because of "known social reactions" to coming out. Nancy no longer considered herself to be transsexual after GRS although she was out in transgender educational contexts; she now self identifies as a "woman with a trans experience". "I am not a transsexual" she added "I am a woman by every definition you can find".

Even those who, at least in certain social contexts, were open about their transsexual status did not like being explicitly referred to as transsexuals. Susie was very open about her transsexual status because "when you hide stuff, that's when bad things happen"; still she did not like being called a transsexual. Susie now had a handful of close friends from whom she did not

hide anything, even though she felt herself to be a very guarded person. May felt reflective about her post-operative status — “what am I now?” she wondered. Although she was trans-identified in LGBT contexts, she otherwise identified as a woman. She didn’t want to be addressed as a transsexual or trans woman even though she was open about it. Haley felt like a “45 year old virgin” after surgery yet she felt she would be transsexual for the rest of her life. She had no problems with her transsexualism as long as people did not refer to her as the “big tranny in the room”. Jane still saw herself as a transsexual woman since she had a very public transition, living in a small town. Peggy was aware that she’ll always be transsexual as she had lived as a man and did not intend to hide it. To say “I am a woman now” seemed incorrect to her — she couldn’t just drop the label — and she felt that her friends would probably always see her as a man even if they accepted her as a woman. GRS made things better for Audrey, but she felt that was still a transgendered person who underwent surgery. On the other hand she felt herself to be a woman now whereas she felt more like a transsexual before surgery. Being referred to as transsexual wouldn’t bother her too much “because it’s true”, but she would prefer if people saw her as female now.

Most participants noted that they did not identify as transsexual to begin with and that transsexualism was not part of their core identity. However, all were keenly aware that there would always remain a disjuncture between their own sense of identity and their social histories. Gill thought that “once you have that transsexual label, you’re never gonna lose it”. Reece felt that transsexualism just described a part of her life; yet, she said if she had one wish it would be “to have been born female” and she did not like the reference to her being a transsexual. She felt she had always been a woman and had a transgender history but not identity. Sonya thought that in medical terms, GRS “changes the interface but not the interior” — she would always be a

transsexual even though she now had the body of a woman. She was most bothered that people confuse transvestite and transsexual. Sonya thought that GRS lend more credibility to being a woman — it was harder to argue that one is a woman with a penis.

Sia felt compelled to shed her trans-ness as her primary identity because she was tired of social “tokenization” of transsexuals which people often liked to include in diversity increasing contexts. At the same time, Sia felt that “you are always a transsexual”; the difference being “whether you choose to express it” or not. On one hand, transsexuals are seen as “a guy getting his penis cut off” and on the other hand a surgeon’s authority legitimized it. However, Sia felt that GRS did not change people’s pre-conceived attitudes about deception because post GRS, transsexuals now have “fake vaginas they are trying to fool you with”. Donna noted that GRS won’t change her past: “You’re raised in a male world” she noted, “so you’ll never be just like any other woman”. Donna noted that the indicators ‘pre’ and ‘post’ denote that one is still a transsexual after surgery. She felt that people who rejected their transsexual status after surgery were in denial. For Donna what mattered was the now. She felt that nobody would care if someone said “I used to work at Walmart but I am a doctor now”. This was her justification for discarding her own transsexualism as a “phase” but not an identity, and yet, she did concede that she would still be a transsexual, at least in the eyes of others.

Leah noted that she would always be a trans woman but it was not her primary identity. Like being Caucasian, it was not important, it was just a fact — it was immaterial to her identity now, it was just how she got here. For her, being a transsexual was more about the “psychological stress of living a life that is not yours”. She thought GRS might make a difference for her socially as there was now “no penis to be found” which speaks to people’s deep-seated fear of transsexual seduction or duping. However, Leah was aware of the remaining

cultural bias of “you’ve been a woman with a penis” at some point. Lisa felt that she was always going to be “a woman with a different history”. She did not necessarily agree with the “I have always been a woman” narrative because before she was 20, she didn’t even have the gendered vocabulary necessary for self-declaration; she couldn’t articulate herself. Now she can only retrospectively project but not mean it literally. Lisa noted that it would be frustrating if “every conversation would be about trans” — she would not want to be trans “24 hours a day”.

Although she didn’t mind educating people, she thought references such as “he or she or whatever” were highly offensive. Mary considered herself to be transgender before surgery and transsexual after. She said that if gender is the goal, the GRS would be like getting “a gold medal”, and that transition was like a “pothole in the journey”. Elaine felt she would always be a transsexual because, like a recovering alcoholic, not drinking now did not make her not an alcoholic. However, she did not want to bring her trans status into her every day life. Like many others, she had felt herself to be a woman before and after surgery, she just felt complete now.

Doris had had several suicide attempts but had come to terms with having a male past; “I can’t throw away 24 years of my life because suddenly I have a vagina. My life is built on those 24 years, my experiences helped define who I am...[.]...you are still a construct of everything that ever happened to you”. She noted that she has “always been a woman and always been trans... surgery doesn’t change this for me”; removing ‘trans’ would mean removing part of herself. Joyce noted that she had successfully transitioned to live as a woman but she could never “pull off” not having a penis. She felt that ‘transgender’ should only be a term describing the condition, but not an identity. Although she was aware that many people saw GRS as a “graduation” to womanhood, she felt like she couldn’t just wipe away 20 years of male history. The only way around this, Joyce noted, was to transition very young because GRS did not make

you a woman if you have lived socially as a man. Jesse felt that she was still “de facto transsexual” given her personal history, but she did not feel this was her identity. Yet she objected to the space-less connection of ‘transwoman’ as one word; “you don’t say blackwoman with no space,” she noted. Jesse didn’t mind being a transsexual but she minded the meaning of the label — to her it was “segmenting people away from the woman category”.

Trish would always identify as a transsexuals because she was not born a natal female but she felt it was ok now to be trans. She could not consider going stealth and she was critical of those who think they could run from it (transsexualism). Trish was sensitive about her image as a transsexual as she had no other choice but to accept it; she felt she could never “shed” the “t”. Surgery or not, Trish noted, “they still have to look at who I used to be”. For Kacey, her penis had been a reminder than she had spent 50 years as a man and she still considered herself a transsexual based on this history. More importantly, she said “if I were truly considered a woman, the conversations wouldn’t be about being transsexual primarily”. So for Kacey, those who did not speak about her transsexualism with her, at least not on a frequent basis, saw her as more of a woman.

Jenna noted that it is very difficult to transition when people have “known you as guy for so many years”. She did not identify as a transsexual — this was always the identification of others as she felt that GID was a societal problem, not her problem. She was highly aware that she was always going to be a transsexual and she thought it was an unrealistic goal to think that people will be more accepting after surgery; she was prepared for more rejection as she was already used to being alone. Although Lana wanted to experience what it was like to be made love to as a woman, she didn’t feel like GRS made her a “real” woman. Lana did not have a problem with still being trans although she would like to have lived without “having been born

handicapped”. Luna felt that rejecting a transgender identity after the surgery is just another form of denial. The ideal scenario for her was to get rid of the suffering but be ok about being transsexual. Part of why transsexuals would always remain transsexuals is that after all, vaginas are “made out of penis parts”. Yet, Luna explained her identity like “I can’t say I’m not a transsexual but I can say I am woman”. She, like many others, did not want to be reminded of it all the time; “You are not a diagnosis”, she added. In other words, as long as she wasn’t being denied womanhood, being transsexual was ok.

At first, Violet had to “push away my old self to create a little hothouse environment to grow the new one, and then gradually I could start integrating my old self back in”. Nonetheless, she said “I am a product of my past”. For Violet social acceptance meant that people treated her like a woman, not a transsexual; yet she said she was always going to be a transsexual because of her history which she was stuck with, like being a father. Maria knew she had to live with the transsexual marker for life. Even if she didn’t like to be referred to in public as trans, she felt she was a “transsexual no matter what”. Transsexualism for Rose defined a medical status but it was not an identity to her — it was simply a static fact. Rose realized that she would always be a transsexual woman but noted that being transsexual does not *not* make you a woman; GRS may have changed your birth sex but didn’t change the social history which would always be with you; further, GRS did not make one a woman because “non-ops are women, too”. It did not however, change anything in the eyes of others. Zoe noted that her gender had always been female but that she was a transsexual because she had indeed changed her sex. She didn’t feel that GRS made her a woman in society and she was not going to “try and pretend that my past doesn’t exist...that is more of mental disorder”. She also felt that it was wrong for trans women to insist that people saw them in a certain way - she said this was a big mistake most trans

women made. Mia felt that she would always be a transsexual because “that’s how most people view me...[.]...you are a product of your history.... I don’t feel as though I or anyone will ever be able to make a complete break”. “I’m not embarrassed about my trans history” she added, “I’m not going to hide it because I’ve seen what hiding does...it destroys you”.

Marci’s definitions of “transsexual” and “transgender” reflected most participants’ definition in general. She defined transgender as anyone who expresses — via role or identity — discord with their genitalia. But transsexuals physically desire to change their body to match their gender, and want to live completely as the other gender. While most patients varied in their precise definitions and distinction between the two terms, almost all agreed on the defining aspect of transsexualism being the desire or intent to modify their bodies permanently, to approximate that of the opposite gender. Marci agreed with the notion that GRS removes, at least in some ways, the transsexual marker from one’s social status. She felt that people are no longer transsexual after GRS and she personally hates when people hang onto the label and when people constantly refer to her as trans. “The reason I am still a transsexual is because I am out...strangers know my social history so I don’t escape that”. She referred to herself as a “woman with a transgender history” but added that her day-to-day existence is that of a woman. Marci agreed with my notion that it was easier for people to pass and go stealth in the 50s before the idea of transsexualism entered into mainstream cognition. This was also the age before “t-dar”. Lastly, Marci remarked that because it is so difficult to shed the social marker of transsexualism many transsexuals live a rather lonely life but transsexuals also often turn to the transgender community for a sense of belonging and befriend other people. She also noted that older transsexuals connect better with each other, and sometimes maintain social networks better than even their natal counterparts.

I wondered whether belonging to, or identification with, the transgender community could be the key indicator as to why or when some trans women are more likely to accept or reject the trans label. Furthermore, I wondered how much, and what kind of public media representation of transsexuals figured into whether trans women incorporate transsexualism as a personal identifier. Since transsexuals are only rarely featured in the media outside of a transsexual context making them thus “visible”, most older trans women in my sample only recognized themselves as trans through those transsexuals featured in the media. And since they also had less opportunities to “start over” or go stealth and divorce themselves from an entire lifetime of achievements, family, and shared sociality, trans-identification seemed not so much of a choice, but perhaps more of an unavoidability. On the other side this was also the generation who grew up in the age of the clinical recommendation or expectation of stealth as the norm of post-surgical life. In contrast, I wondered why younger trans women who had many more resources for transsexuals at their disposal and who lived in an arguably more accepting society would choose or try to go stealth and reject the trans label? To answer this, I now turn to situating my own participants in the public media record of transsexual representation past and the present.

Transsexuals in the Public Eye: The Generational Legacy of Christine Jorgensen

A number of participants over the age of 60 had been alive when the Christine Jorgensen story broke in the United States in 1952. These older participants did not necessarily recall the initial news story, but they lived through the aftermath of mainstream media’s decades-long fascination with Jorgensen’s life. Although most participants had a notion of who Jorgensen was, only those in their mid sixties could vaguely recall the event. Before Jorgensen, there was virtually no

publicized mainstream information specifically describing transsexuals — hence Jorgensen was the first and enduring public figure who introduced the word “transsexual” into every American household. Having no other point of reference, some participants remember learning about Jorgensen and could identify themselves with her or recognize that they had a common problem.

Some participants recalled their own exposure to Jorgensen in similar ways. Felicia, like so many other trans women who were born in the fifties or earlier, was first exposed to transsexualism through Jorgensen but she couldn't relate her own issue to Christine's glamorous, public lifestyle. She also noted the horrible stigma attached to it and it was not until the advent of the Internet that Felicia figured “I could do this”. Elaine had learned about transsexualism through Christine Jorgensen but identified more strongly with Rene Richards as she, too, was an athlete — she recognized herself in Richards. When Violet first found out about Christine Jorgensen, she thought she was a freak and Violet “didn't want to be a freak”. She didn't find out more information about transsexualism before the advent of the Internet. Ruby first realized there was something “wrong” with her shortly after the Jorgensen story broke. Jane felt she had internalized social stigma about transsexualism by learning about it through Christine Jorgensen and thought the whole world was going to look at her as a freak or weirdo. When Jorgensen transitioned, Zoe thought she was an oddity which society associated with indecency and perversion; people like Christine Jorgensen, she said, were seen as “freaks of nature”. When Peggy learned about Christine Jorgensen and Rene Richards, she learned that “there was an answer to my problem”.

Although Jorgensen was at least initially coddled and glamorized by the media, over the years, her public image slowly degraded to tacky nightclub performances and appearances on less serious television shows (Meyerowitz 2002). Jorgensen loved publicity and self-promoted

her image through every opportunity. However, Jorgensen also seemed to have struggled with never being able to have a private life which was exempt from her publicly known status as a transsexual — everybody knew her as America’s first and most famous transsexual. Ironically, even though every American adult and child knew that Jorgensen was a transsexual, there was hardly a story told about her which did not in some way or form reiterate the obvious; Jorgensen stories became the template from which all subsequent news stories about transsexuals were crafted — the “before-and-after” template. Whenever I talked with my participants about news stories about transsexuals, I asserted that it is impossible to tell a transsexual story without telling a before-and-after story with which participants agreed. In other words, there would be no possibility of talking about a person’s transsexualism without any reference points to their differently gendered past.

Younger participants did not follow a trajectory of self-discovery channeled through “public transsexuals” like Jorgensen or Richards. Although some did realize their gender issues as such through some type of visual or print media, the information they digested or actively sought out was “faceless” and far more clinical or scholarly; the Internet was without a doubt the most pivotal tool of self-discovery. Moreover, transgender culture within alternative youth cultures or college contexts greatly increased participants’ consciousness about themselves at an earlier age. And while many participants had very early notions about there being “something wrong” or harbored and even expressed wishes of being girls instead of boys, access to discourse about transsexualism was in all cases intrinsic to realizing, expressing, and acting upon gender identity issues. Another interesting point was that younger participants neither recognized themselves in Jorgensen nor did they feel that current media coverage of transsexuals represented their own stories. 20 to 30 year-old participants found that the media focused too

much on homogenizing images of trans women as Jesse pointed out. For those who followed a purposefully more androgynous style of presentation, media portrayals of “typical” transsexuals only alienated them further. And they were also the ones who concurred or reiterated most strongly that transsexual stories deliberately exploit the before-and-after templates of telling transsexual stories.

“Freaks Talk Back”: Modern Media Exposure of Transsexuals

Media representations of transsexuals invariably capitalize on the before-and-after template by “revealing” the social history transsexuals achieve before transition. My impression from having watched dozens of trans-related documentaries is that in addition to before-and-after imagery, producers also tend to pick subjects who do not pass well, or at least not initially when the documentary covers lengthy periods of transition. This is possibly meant to amplify the effect of transformation from “man” to “woman” but in reality it only reinforces the viewer’s idea that these are still men, even if the position of the producers is one of compassion and the intent is to increase public acceptance based on arousing compassion. But the result often tends to negate rather than support transsexuals’ credibility to be women or men.

Many of my participants shared this notion. Sia felt people needed to understand that transsexuals were not just a “burly football player in a dress” feeding into media stereotype of visual representation. She herself had done sensitivity training and felt it had a positive impact on people but she did not allow a newspaper which was writing an article on her to publish before and after pictures of her. She felt that before-and-after stories fed into people’s sense of voyeurism and was not constructing trans people as human beings; especially when stories always put the chosen gender of people into question marks, as in the case of Thomas Beattie,

the “man” who was having a baby. Leah felt that media should focus on de-sensationalizing transsexualism in the public sphere and emphasizing sameness over difference. Lisa felt that representation of trans people was usually negative. Even Oprah, she said, who is usually highly respected and revered among many trans women, is focused on before-and-after stories about transsexuals. Lisa remembered an incident about a planned program about an FtM transsexual where the show’s producers said “oh, by the way, we need a picture of him in a dress”. Lisa felt these shows were always about ‘the great reveal’ which was ironic within American culture where you are “supposed to be yourself” but this notion does not seem to apply to transsexuals. Lisa attributed this to the “Horacio Alger myth” which is perpetuated over and over; yet, when transsexuals come out, “it is so shocking, it’s worth an Oprah episode”. Joanna felt that media focused too much on portraying transgender people as “tricksters” or being secretive. The ‘big reveal” that “she was a man” scenarios always had a negative effect.

But Mary felt that the media such as Oprah’s show, had helped her and others to accept her. “An informed public is an understanding public” she said. Kelsey credited Oprah for positive and respectful media exposure which helped educate her mother. “Thank god for Oprah!” she noted in jest. Youngster Nadine also liked Oprah’s approach to transsexualism as it communicated “we’re just like any other people”. Yet, Elaine felt that media portrayals were too sensationalized and too many trans people were ‘tokens’ on TV shows. Jesse felt that the media also perpetuated negative imagery about transsexuals because of its emphasis on superficiality, hyper-femininity, hyper-sexualization, fetishization, and non-passing; trans women, she observed, were often captured in the “putting on make up” shot. Other programs which focused on partners of trans women seemed to send the message of “here’s someone who’s willing to sleep with this thing”. She added that the transgender person is always portrayed “lower “ than

the cisgender person so that it looks like the partner “is obviously doing them a favor or there is something wrong with them”. May felt that the media focusing on trans issues made them only more salient as difference. May noted “people see that and say ‘oh, I understand you’” but she felt different from most “typical” transsexuals so she felt misunderstood for the most part. She thought that inclusion of trans people in movies, like black people in the 50s, used to need a “reason” — whereas now some people in movies are “just black”, trans people in movies are never “just trans”. Haley felt the media focused too much on the outrageousness of transsexualism via pride parades. Peggy felt that the media just heightened awareness of people who do want to do harm and it was thus counterproductive.

On the other hand, like many other participants, Nancy blamed The Jerry Springer Show for perpetuating stereotypes about transgender people through the media; taking it one step further, Nancy noted that shows like Springer are the cause for the social stigma transsexuals endure. She also mentioned that shows featuring “sex changes” usually present them as “back-room operations” promoting ideas that these are somehow “sketchy” or have an illegal connotation. Donna noted that it was because of transsexuals on Jerry Springer that people saw “a man in a dress” and not “a man trying to become a woman”. The typical “overdone-ness” of trans women on Jerry Springer make people wonder why so many trans women were not like that in real life. Joanna felt that the public’s frame of reference for transsexualism was Jerry Springer’s transgender guests being portrayed as “plastic surgery and sex-crazed” which she also credited with why she didn’t fit the mold of the “typical transsexual” at all. Still, “once you’re pigeon-holed, you’re pigeon-holed” she noted, and trans people would experience stigma “no matter what you do”. Tracy felt that social stigma persisted because people have been over-exposed to bad stereotypes resembling “Fred Flintstone in a dress” on shows like Jerry Springer.

Vicky felt that Jerry Springer encouraged views of transsexual mental instability and that the media over-emphasized the connection between criminality and transsexuals.

What is noteworthy here is that both trans women's identities and social perceptions of these are shaped, at least in some ways, by public representations of transsexuals, always playing on, always referring back to notions of transsexuals as not quite women, yet not quite men either. As quite a few participants had been actively participating in public education via various organizations and media outlets, I was able to gain some insight into how participants envisioned to change the mostly wrongful public perception of transsexuals as "just men in dresses", and thus try to lessen socially stigmatizing effects based on such assumptions.

All participants agreed that education in one form or another was helpful but during my interviews I realized that education could not be extricated categorically from media exposure or sensitivity training as communication mediums. One exception in this case was public speaking outside of a sensitivity or diversity training setting such as high schools or University campuses. However, oftentimes the underlying intent of such speaking engagements was increasing sensitivity or diversity sensibility in a less formal setting. The second exception was featured newspaper stories about participants who had volunteered to be interviewed for trade magazines or school newspapers. Public "Education" was thus mostly understood to mean media exposure, mainly through television and film, and sensitivity training at places of employment.

Indeed, a fair number of participants had themselves participated in either public speaking events or sensitivity training and this coincided mostly with those who were actively involved in LGBT or TG organizations and/or support groups. Most participants agreed that the focus on such speaking or educating engagements needed to focus on normalization of transsexualism and concentrating presentations on success and positivity, not pathos and

weakness. One participant, Sonya, had even incorporated her transsexualism into her performance art. Those who frequently spoke out also emphasized that being proactive in bringing up the subject was beneficial in lifting the language barrier to people asking questions.

Almost unanimously however, participants agreed that there was no substitute for one-on-one interaction, individual contact, and getting to know transsexuals personally. This reiterates Allport's "Contact Hypothesis" (1954) that given the right conditions interpersonal contact is highly effective in reducing prejudice between majority and minority groups. While Allport's hypothesis has informed social psychology and sociological studies on prejudice since its inception, it has also received its fair share of criticism and can only be used here as an explanatory stand-in or a loose reference. Although it has been used to test gay and lesbian attitude studies (Herek and Capitano 1996, Herek and Glunt 1993), the prerequisites or conditions which would validate the hypothesis can not really be applied to transsexuals because a) they often do not see themselves as part of a distinct culture, b) they are sometimes not "seen" (passing), c) the element of "deceit" or "secrecy" which is revealed via voluntary or involuntary outing adds incredulity to their "true" identities, and d) many have shared, at some point, equal status with majority groups. Further, to facilitate better understanding through one-on-one contact, the opportunities to "meet" transsexuals are already primed by settings which problematize transsexualism (i.e. sensitivity training).

My greatest critique of the Allport model, despite the studies cited above, rests on my findings that some of the worst reactions to coming out, transition, or GRS stem from people who have already known the person and have had established relationships with them. It becomes clear that the Contact Hypothesis cannot account for intersubjective social histories based on relations which are now disturbed, disconnected, or subject to distance due to the

transgender individuals' change. While it appears that most participants agreed that people who have only known them in their current gender are more accepting, this does not mean that if they learned about the person's trans status or extensive past, they would still feel the same way. Again, Allport's thesis does not account for disclosure of difference, only perceivable or assumed difference. However, I would credit Allport's thesis with some validity only because it has been some of my participants experience that increased exposure at least de-emphasizes the most negative assumption about transsexualism. Nonetheless, I question how well these efforts work when the situational context to engage people socially with transsexualism is already problematic, something I will explore more below.

Problematizing Sensitivity Training: “Why don't you come in here and talk about yourself?”

A 2008 Washington Post article reference to systematic analyses of diversity training programs show that these are mostly ineffective if they are mandatory — they protect the company, not necessarily the employer (Vedantam 2008). I found that most of my participants' narratives about sensitivity training confirmed the research findings of sensitivity training ineffectiveness. And while most sensitivity training sessions are rather inclusive including the most popular foci of gender, race, and disability, fewer included sexual orientation, and only recently — or perhaps only when necessary — did they include transgender issues. It seems that especially when transsexualism is the *only* reason or the impetus for the session to be scheduled in the first place, people would have more resistance to it. It thus seems that the more singular the focus of the sensitivity training session, the less receptive people are to it.

Gill noted that sensitivity training shouldn't focus on "diversity for diversity's sake" because "people will feel forced to be nice to transsexuals. With sensitivity training I don't think it really teaches people to be accepting or understanding of the problem. I think it teaches people 'this is how you act so not as to get in trouble'". Furthermore, she wondered "has acceptance increased or has policy made it so that non-acceptance is a worse consequence or option?" Reese felt that change happened at a small personal level, not at the corporate level (i.e. sensitivity training). Sonya thought sensitivity training was helpful but in order to be effective it had to be simplified to a point where it was not necessarily representative of the diversity in the trans community. Rhonda had had good experiences with sensitivity training but she noted that a key difference is whether it was voluntary or forced. Sia thought that people needed to have personal experiences with transsexuals to overcome social stigma and that sensitivity training was no substitute for it.

Leah felt that sensitivity training can have a negative effect as it suggests things like "every man is a potential rapist". She said that it was unwise to accuse people of being bigots as a starting assumption as that would only shut people down and can be a form of punishment. Trans people can become the "lightning rod" for having to go through sensitivity training and "then they hate the trans person worse if [they are] assumed to be bigoted already". She added that the higher-ups have to model acceptance and communicate that there are consequences for discrimination. Finally she noted that "if you go in confrontational, you'll create confrontation" and that work places should be emphasizing diversity and professionalism, not transsexualism. Her own trans status was "an open secret" but she wouldn't want to be the "poster child" for her University. Joanna felt that sensitivity training was a good idea if it involved positive exposure to trans people but only on the condition that it would be part of a larger diversity training effort

and not because there was a trans person on the staff. Similarly, Elaine felt that sensitivity training was good if it did not just focus on trans issues. She felt that knowledge could diffuse things but that it was personal interaction with transsexuals which helped to break down barriers. Tina felt diversity training “can leave a bad taste in people’s mouth” and that one-on-one education was better. She said “you can’t change people’s minds but you can allow people to change their own minds by being open”.

Carly felt that sensitivity training needed to be part of a company’s basic orientation and should include transgender issues. She emphasized the importance of corporate culture training; however, she noted that it was hard for employees to “see a woman” when they “see maleness”. Jesse felt that sensitivity training could be “really great” or a “horrible joke that can actually do harm”. She likened it to sexual harassment training which broke people up into groups and reinforced the view that women “are just oversensitive”. She felt that talking to people one-on-one would be better. Dara thought that sensitivity training could be worthwhile in exposing people to transsexuals, but she also agreed that it could backfire. Like Jesse, Kacey felt that sensitivity training could be useful but that one-on-one interaction was better. Jenna felt that sensitivity training doesn’t work because people are primed by TV images of transsexuals. Lana felt that sensitivity training was less of a good idea than other avenues; she felt it was a “stick over carrot” situation. Abiding by the non-forcing principle, she felt that “if it ain’t broke, don’t fix it”. Based on her (negative) experience at work, April felt that the few hours of positive exposure to transsexuals in sensitivity training are “completely negated” by the cumulative hours of negative media exposure.

Carla felt that sensitivity training only worked to a certain degree “but not if people get threatened with firing for non-acceptance”. She felt that trans people need to be more pro-active

and help people adjust by saying “it’s ok if you make a mistake” with using proper pronouns and names. Also, she added, transsexuals need to learn to differentiate between accidental “slip ups” and intentional, consistent malice. Ruby felt that sensitivity training may only be effective for a small group of “personality types”, referring most likely to educated people at the University or larger companies which were already LGBT conscious. At her place of work, she gave a long presentation about legal cases and political aspects of LGBT rights, including a “transgender 101” section, and ended the presentation by saying “If you haven’t guessed by now, I’m coming out”. Deanne did not know whether sensitivity training was beneficial as she would not want to be outed at work. Vicky felt that sensitivity training might help as “people should learn that they can’t harass me physically and verbally without consequences”. Haley had done sensitivity training at colleges but in one instance, some kids in the audience were giggling, not taking it all too seriously. She noted that “you might educate but you don’t make them change their minds”.

Kellie felt that sensitivity training, especially with law enforcement, was good but she lamented that generally, transgender people wanted to be more accepted yet not enough people were willing to come out of the closet and help educate the public. Jean said she had “seen sensitivity training sessions that were essentially a joke” — if the supervisor didn’t care, employees didn’t care. Emma felt that sensitivity training was not very effective if it was presented as explicating “you have to learn that”; she felt that sensitivity training only draws more attention to difference. She believed that it was better to inspire self-reflection on one’s negative judgment than to force people to accept or accord special treatment or rights to transsexuals. Peggy felt that sensitivity training only applied to upper management and felt it would be harassment in and of itself if someone asked her “why don’t you come in here and talk about yourself”. She also felt that the group mentality at work would keep down individual

efforts to connect with her — hence sensitivity training made no sense for her. Rose felt that stringent (zero tolerance) policies on protecting transgender employees were good because nobody said anything to her about her trans status. But on the other hand, they were bad — nobody ever said anything to her, period; people had been made too afraid to engage with her at all. Rose felt that this was a terrible backlash of sensitivity training — it has over-sensitized employees and had thereby discouraged all interaction. When I asked Audrey about sensitivity training at work, she laughed dismissively as the company she worked for was small and conservative — “a hard company to come out to”.

Zoe felt that since transsexuals were the ones changing, they’d have to accommodate people and not the other way around. Sensitivity training was best focused on legal aspects, making management aware of what they can and cannot do. Zoe noted that you can’t force employers to change their mind, but you can make management lead by example. Elsa was also skeptical about sensitivity training “I don’t know how effective sensitivity training is...some might feel it’s being pushed at them...you don’t want it to be too forceful, you want to integrate it subtly...[.]... I don’t think society can ever be moved in a quick shift to be less rejecting [of] LGBT...”.

Shaping public and social perception of transsexuals through public media, education, sensitivity training, and one-on-one exposure, seem to over-, rather than de-emphasize the cultural and social aspects of transsexualism. But based on this notion of enduring ideas about transsexuals as people with before-and-after histories, what role does GRS play in such before-and-after scenarios when transsexual women remain trapped in their social histories as men? How are such histories socially articulated and negotiated?

Surgery as Social Capital Reconsidered: Present Embodiment vs. Social History

As I have tried to show in this and the previous chapter, the cumulative effects which can be reasonably expected from GRS are very much individual gains as little is expected to change socially for transsexual women. This is at once a testament to the persistence of social stigma directed against social minorities as well as the limitation of biomedical intervention in social problems; but this is hardly a novel finding. What is however noteworthy here is that although GRS cannot change prevailing attitudes about transsexuals, this data shows that it is not necessarily the essentialist rationale of mind/body disjuncture which is the culprit for non-acceptance. Although especially in bathroom use issues genitalia seem to take a front seat in the debate, and although sexual relationships are expected to change the most post-surgery, this still does not mean that transsexuals lack societal acceptance because of mind/body disjunctures. Indeed, the prevailing stigma does not hinge on what current genitalia can be found on any given body at any given time but how it is they got there (birth vs. constructed), how long they have been there (always vs. recent), and what has been done with them (non-sexual/heterosexual vs. sexual/homosexual) throughout a person's lifetime.

The social, collective memory of what genitals accomplish is inextricably tied to gendered embodiment because genitalia alone do not make sense without bodies that are conscious and act with human agency. Sexed bodies are thus subject to sequential actions which built up their own history; and knowledge of such sequential actions — whether primary or secondary — suffices to once and for all make that connection between sex and gender because male genitalia are usually engaged, sexually or otherwise, on *men's* bodies by *men*. This is why it is so difficult to convince cisgender people that one has always been trapped in the “wrong

body” because that body has innocently accomplished “rightness” in terms of its intended design, whereas the self in the body has accomplished the socio-historical context of gendered life.

Chapter 7: Patient Negotiations of the Social History of Gendered Embodiment

Narrative Consolidation of Past and Present

Social Presentations of Embodied Selves

This last chapter explores how GRS patients' past and present social history is narrated to make sense of two gendered lives lived in, or with, only one body. Although my initial aim was to focus on whether GRS would have a direct impact on how participants presented their current and past life histories to others, most narratives revealed that patients had already devised a script which would not significantly change after GRS. What I wanted to know was whether participants felt more justified in presenting themselves as women, now that the primary physical marker of maleness was no longer there. How do changes in physical embodiment affect self presentation in social contexts? How much significance does socially shared knowledge about embodiment hold in gendered legitimacy?

I first establish participants' subjective positions on presenting congruent or incongruent histories by examining narratives about disclosure models, recounting childhood, compartmentalization, and dishonesty. I then focus on family relationships and kinship because natal families arguably hold the most extensively shared social knowledge about a transsexual family member as family structures follow closely maintained gender lines. I wanted to look specifically at how social histories of differently gendered embodiment affect relationships because all identities are relational. Lastly, I turn my attention to broader aspects of social knowledge and perception of transsexual embodiment where interpersonal familiarity is removed and the focus rests on the more general social perception of transsexual individuals. Here I make the point that witnessing the person's transition or having known the person in their previous gender is not necessary to affect "seeing" them as different than they present themselves now.

Having begun this dissertation with the intent to show that divergent social histories are the main reason transsexuals struggle with societal acceptance and equality, and not so much their natal genitalia and their “inauthenticity” as women, what I want to emphasize here is not that genitalia do not matter to individual or social presentations of the self, but rather that the biomedical assumptions about transsexualism as an individual problem are insufficient in explaining its true locus of pain — the loss of experiencing oneself as a social, and socially equal being. These three sections are intended to once more underline the sociality of identity, the social cohesiveness of life histories, and the significance of the social consensus of gendering people.

In this first section, I focus on discussing how participants narrated the integration of their past and present lives. Drawing on my previous position that the difficulty of credibility lies in the notion that people cannot have two differently gendered histories in only one body, and that it is the intersubjective history which permanently ties transsexuals to their past lives, I now turn to narrative strategies transsexual women use to explain their incongruent life histories. “There may be a cast of varied selves, but there seems to be only one body; how many selves can this one body support?” asks Frank (1995:67). Although GRS had a central part in lessening fears of physical (genital) “discovery” and presenting a more authentic physical self to others, narrative strategies pertaining to themes of disclosure, compartmentalization, or dishonesty, did not take GRS into account. This speaks perhaps most strongly to my argument that social histories require far more narrative integration and explanation than genitals do.

Worries and Fears About Involuntary Disclosure

A commonly shared concern among most trans women is involuntary or accidental outing (disclosure of one's transsexual status) as well as how to come out to people who do not know that a person is transsexual. By asking participants whether they were worried about the consequences of voluntary or involuntary disclosure, it became once more apparent that trans women are acutely aware of these, which in turn speaks again to the internalization of social stigma about transsexualism. Various notions of betrayal, lying, hiding, secrecy, and rumors were embedded throughout their narratives; these notions in turn informed how participants negotiated concealing or being open about their transsexual status.

The idea of starting one's life over after GRS in a different place where nobody has any knowledge of a transsexual person's past life is the classic transsexual trajectory of "going stealth". In the early days of treating transsexuals, going stealth was either advised, expected, or assumed by medical professionals who oversaw a transsexual person's gender transition from beginning to end. The strategy of "blending in" as "normal women" after surgery was considered the best option for a "successful" life after surgery. However, since the 50s and 60s, two contemporary cultural changes significantly challenge the option of going stealth: the first is the increasing public consciousness of transsexualism or transgenderism which allows for a distinct recognition of someone as transsexual whereas before such recognition, individuals could only be read as "masculine women" or "feminine men". The second is the advent of the Internet which facilitates an investigation into just about anybody's past should their current gender presentation be called into question. Companies or institutions often resort to the Internet to do background checks as much of people's employment, criminal, financial, or medical history is now digitally available through modern electronic filing systems. Today, the idea of going stealth then is easily compromised, even if a transsexual person can visually pass.

As for strategies of going stealth or being open about their transgendered status, only Pam decided that she would attempt to go completely stealth and intended to move from Vancouver to Portland. She felt that she knew too many people in Vancouver and would “have to explain too much... So I’m just gonna move to Portland and blend in”. Since Pam felt that she was “really starting over” she planned on denying any rumors about her transsexual past. In some cases, she might quietly educate people and she may disclose her past to intimate partners eventually. But she also decided to tell people she was never married as it was for only such a short time anyways. The majority of participants, however, had a mixed model of self disclosure: few were completely stealth or as much as possible, while few were completely open to everyone or intended to be in the future. Further, for many a key difference and concern was whether disclosure was voluntary or involuntary with the latter constituting a greater loss of control and more negative consequences. The two main areas where negotiations of stealth mattered the most, meaning the areas where stealth and openness were thought to be most consequential were work and sexual or love relationships. Fears of jeopardizing employment were very common concerns because transsexuals still lack the much needed employment protection and frequently lose positions of employment either during transition or through voluntary or involuntary outing.

For example, Joanna was terrified of being outed at work because “being outed by one person affects everybody around that person”. Most of Joanna’s interaction with cisgender people occurred at work which is why her emphasis on going stealth concentrated on this area: “There is such a stigma around trans folk that I know that once, or if they know, that they will be stereotyping me and that basically any treatment or any way they will receive me will be, will change because being trans is different and people can’t help but judge a trans person differently”. She was very worried about involuntary disclosure. “That’s the one problem with

being stealth is that effectively, you're hiding, you're hiding a part of yourself, and so if it gets out at work that I am trans, then that's going to completely change my, that work dynamic, that social, professional social dynamic will be completely changed...[]...So that's like the big fear that my work will change". She often thinks of the consequences of involuntary outing "I do envision different treatment so like people being less willing to help in certain situations, less inclusion in female spaces, I would expect an extreme othering from the male population".

Similarly, Dara's only worry about being outed involuntarily had to do with jeopardizing employment and Felicia was very aware that she could still get fired at work as lacking protection was an every day reality — for her, not disclosing in economic contexts was simply a move not to endanger economic independence and livelihood. Tracy did worry about being outed at work, because she dated a co-worker and that people would treat her differently in general. Vicky was not too worried about involuntary disclosure except if it could cost her a job as it did when she came out. Overall, Rose felt that although she preferred to live in stealth, being outed was not a big deal unless it would jeopardize losing control over situations such as employment security. Like Rose, Mary was not too worried about people finding out unless it would affect her career as a whole. And Audrey felt that although she was generally open, going stealth was beneficial to her at work as she felt disclosure would make people stop talking to her or maybe avoid her.

The majority of participants also felt a strong obligation to disclose to sexual or romantic partners although a few also saw the strategic decision to come out as simply protecting them from physical violence. Fears of jeopardizing relationships however, were much more pronounced than fears of jeopardizing employment because in addition to putting into question the credibility of the individual, the fear of physical violence, personal rejection, and emotional

loss was ever present. For example, Reese was afraid to invest too much into any type of relationship out of fear that discovery would end it, which she thought was a very common downside of going stealth. She was well aware that people “think you’re lying to them if you don’t talk about your history”. Although she would disclose to future partners, she hoped that involuntary disclosure would not happen. Sonya noted that “Transpeople are expected to tell everybody about their past”. Like many others, Sonya thought that people felt betrayed when transsexuals don’t disclose and she did not want her past to come out later in relationships, as this would likely discredit her. Annie was somewhat worried about people finding out, depending on the person, and she would disclose to future partners because she felt wrong about deception.

Joyce would disclose her status to potential long-term partners but not casual sexual relationships. Yet she was aware that even if a sexual encounter was just casual, people would feel betrayed afterwards. In general, she felt that “if you wait too long, you’re likely to fuck up the relationship”. Leah would disclose her trans status to partners but not before ever meeting a new acquaintance in person because she felt people then would judge her on what she was, not who she was. Lisa would disclose to future partners before physical and emotional intimacy for fear of building up emotions and then being disappointed. Carly was not worried about disclosure and thought the only negative consequences would apply to potential future partners. However, she could not conceive of dating anyone who wouldn’t know already that she was trans. Donna was not worried about past life disclosure, but expected some rejection as an inevitable consequence. She would disclose her status to new partners because she felt that people had a right to know and would feel violated if they did not know.

Luna felt that stealth was a “losing battle”. On the one hand if you didn’t disclose your status to future partners, “you could get hurt”, but on the other hand, if you do, “you can send people running before they even get to know you”. Carla didn’t like the implied deceit of ‘not being a woman’; if someone felt ‘duped’ into a sexual encounter with a transsexual, she felt that the enragement could easily lead to violence. But physical discovery was not necessarily the impetus for violence she noted — “just knowing” suffices to commit violence. Rose planned on disclosing her trans status to future partners but not necessarily in a first date. On the other hand, Rose felt that if you told someone about being trans before any sexual encounter, you would be putting “weird ideas about ‘what’s down there’ into their mind”. Rose would only disclose her past to sexual partners but not identify as transsexual or feel the need to disclose it as part of her gender identity. Peggy would disclose her status to new partners so they didn’t feel “used”. Zoe would tell people about being transsexual to give them “a way out” but she wouldn’t do it at the starting point of a date. And although Kelsey planned on going stealth for the most part, she would disclose her status to future partners, but she would make sure to “have a safe distance in case I get hit”, remarking on the Jekyll/Hide propensity of men getting violent when they learn about someone’s transsexual status.

Similarly, participants thought friendships built and social groups joined in the new gender were also subject to quick disintegration or exclusion due to voluntary or involuntary disclosure. Although Joyce did not feel ashamed of her trans status, she did not intend to tell any more people about herself who did not already know. She worried that she could lose friendships due to voluntary and involuntary outing and struggled with the dilemma of which scenario would be worse. Doris felt that if her church knew she was trans they probably would not invite her back to worship; it would be like “a wolf in sheep’s clothing that has invaded out midst”. She felt

that she did not want to mix “politics and faith” as she sought fellowship and community within the church. However, she wasn’t worried about disclosure and would let people ask questions. Yet, her current boyfriend’s father did not know she was trans and she was stealth to him at her boyfriend’s request. Rose suspected that some of her friends may feel betrayed if they found out that she was trans but not because of transsexualism in general, but because of *her* being transsexual, regardless of queer context. May felt that most people can tell that she is a transsexual so she didn’t concern herself with disclosure much. However, she also felt that disclosures can quickly end friendships, especially online where people can’t see her face-to-face. Still, she would rather disclose right away to avoid rejection later and she’d feel dishonest if she did not. Felicia felt that if people found out about her trans status she would experience social exclusion and maybe violence. She felt that everybody in her immediate periphery knew about her trans status but overall, only about 10% knew. Zoe felt that she had an obligation not to surprise people close to her by coming out, yet disclosure was preferable to being “found out”. Leah felt that outing could have negative consequences but pre-emptive outing could backfire as well — some people really did not want to know or have this knowledge verbalized as they then had to deal with it. Nadine only had 2 friends who were not family members who knew about her transsexual status. Yet, she was not worried about someone finding out because she hardly had any past public records to dig up.

Another decision not to go stealth also had to do with participants’ social geography in terms of being well known in their hometown or community. Donna worried that whenever she had to go back home to Nebraska, rumors about her would circulate which she felt she had no control over. Further, she knew that she couldn’t really hide in the age of the Internet — both her past and present was “out there”. Luna did not intend to go stealth as she lived in a small town

and would have to move away. She also felt the more open you were the better people responded to it. Still she said “I don’t want to be a ‘T’ I just want to be Luna”. Violet felt she was prepared to deal with disclosure and thought erasing one’s past and building an edifice not attached to the old person was a mistake; “blinking out your past is shaky” she noted. Transitioning in a small town meant that she had to be open about it as there was “no getting around it”. She was hopeful that the salience of her trans status would dissipate over time and people saw other things about her beyond her trans status. Violet would not resist questioning of her past and was willing to talk about it; “what’s the point?” she noted as everybody knew about her back home even though she was still afraid of losing friends. Yet, Violet felt that being open was “insurance” against others finding out because “they can’t hurt you with a revelation you own”; however, she was worried about people finding out indirectly. And Nancy noted “I live in the city I grew up in so my past life is always around the next corner”. She also felt that “as a transsexual you come out probably for the rest of your life”

Some participants also explicitly commented on the downside of stealth as it prevented people from sharing past achievements which were important to them. For example, Dara felt that it was necessary to disclose her past to people who were important to her because she wanted people to understand her life situation and because without it she wouldn’t be able to talk about achievements in her life which she was proud of such as having been a professional musician for many years. She was worried that her current name wouldn’t be traceable to her past by people who wanted to check up on her music credentials “and then they’d get curious and they go like googling my present name and they don’t find me and then they think I’m a liar”. In another instant she found herself in a conversation with a young musician whose father she had known as a male, many years pre-transition which prompted her to disclose her past.

Kacey was very open because she felt it was “easier to tell than to hide” and she could not conceive of going stealth because she valued her past, marriage, and family. She intended on disclosing as she had a male past she felt people needed to accept. Jenna had no hesitation disclosing her status to anyone who asked. She bluntly stated “I used to be a guy” because she felt that over time she had “blended” her male person with her female person and that her life’s accomplishments constituted an important part of her past, including extraordinary military and financial accomplishments. She also kept old pictures around from her Naval Academy days - she had at one point been a proud Marine Officer.

For some participants, stealth constituted more mental burdens and stress than being mostly out. Lisa noted that for her, stealth would be “psychological suicide” because people who do succeed in living stealth had a “very limited social network”. She was worried about involuntary disclosure, which is why she tried to be open; the paranoia of someone finding out, Lisa noted, created a sense of vulnerability for her. Mia said “I’m not embarrassed about my trans history...I’m not going to hide it because I’ve seen what hiding does...it destroys you”. Lana chose full disclosure to empower herself before others could disempower her. Lana was very open about her status, had no intention of going stealth because it would mean “going right back into the closet”. She disclosed quickly to new people as she felt that “telling people is cathartic”. Similarly, stealth was not an option for Jane as she felt it would move her from one closet into the next. Susie was very open about her transsexual status because “when you hide stuff, that’s when bad things happen”. Susie would disclose right away as she did not want to lie as it would eliminate closeness. But in a sobering expression, she said she would guess that she’d “be alone most of my life”.

Lastly, a very common strategy on how to disclose one's transsexual status focused on pre-determining how new friends or future partners feel about transsexuals or LGBT identified individuals in the first place. Jean disclosed her status to the people she felt she had too: "When I do disclose I usually try to feel them out first to get an idea how they might react, and if I feel confident about a relationship I'll just come right out and say it." Jean would not tell people unless it's absolutely necessary "I would have to disclose to a potential spouse as I wouldn't want to be emotionally invested in a close relationship only to have them find out, and then start hating me for being a transgender".

Beals (2003) has shown that for gays and lesbians, both concealment and disclosure of identity has costs and benefits, while emotional well-being appears to be improved by disclosure. Devor adds that "At any time [transsexuals] may become exposed not only as persons with stigma, but also as persons engaged in deceit" (1989:62). This also seems to hold true for my own participants. But while few participants were completely open and out about their transsexual status, equally few were completely consumed with worry; most realized that going stealth was a lot more costly in terms of losing established relationships past and present rather than being beneficial to establishing credibility as women. I also found that participants had thought about disclosure strategies and consequences a lot in the past. The only commonality I found in alleviating fears of disclosure centered, perhaps quite obviously, on the physical safety obtained by GRS as physical discovery was of course a main concern to all. I also found that in some cases, having had GRS made disclosure easier because participants generally believed that post-operative women are granted more sincerity in the first place. However, if transsexualism was generally met with social disapproval, surgical status was not thought to mediate or increase approval, no matter what the degree of outness or willingness to disclose was.

Talk about Childhoods and Omitting Gender-specific Details

Whenever participants talked about their childhoods, almost all chose gender-neutral phrases such as “when I was little”, “when I was young”, “when I was a child” or “when I was a little kid”. Mia had the most unique approach to childhood referentials by saying, “when I was a little me”. Only Lana chose to say “when I was a little boy” and only 7 other participants chose to say “when I was a little girl”. One common modifier of when or whether participants adjusted or neutralized gendered pronouns, however, depended on the social context or situation; if childhoods were talked about in the presence of individuals who had knowledge of participants’ past lives, participants were more likely to use neutral or masculine pronouns to refer to themselves. If, however, the company was “mixed” (i.e. only some people know), the neutral or feminine gender pronouns predominated.

In terms of referring to their current or former spouses, about half of all participants would either say “ex” or “spouse” or “partner” instead of “ex wife”, and only Lana and Jenna would explicitly say “ex-wife”. Leah and Joyce chose to “un-gender” or “re-gender” their former wives or girlfriends. Leah’s ex-wife was now “just an old girlfriend” and she did not dwell on the details of their relationship or recreate a new narrative — if anything, she said she would omit details as to not lie. Joyce re-gendered “ex-wives” to “ex” and “ex-spouse” and used male pronouns. She had also changed all of her ex-wife’s names to male names. Four participants who were parents chose to say “parent” over “father” and some would occasionally say “my son’s birthmother” or “my child’s other mother”. Only Ruby claimed that her adult son now called her “mom”. Sonya calls her ex-wife “my daughter’s other mom” because nothing contradicts the relationship past and present. If she would refer to her as her daughter’s biological mother, like

many lesbian couples do, it would likely prompt more questions especially, or ironically, because her daughter looks like too much like her.

Other distinctly gendering traits, activities, or events which were often omitted from narratives of past lives included a variety of things. Reese would definitely not mention, “I was gay” except in a very serious long term relationship. Lisa used a “language of exclusion”, leaving holes in stories. Mary joked, “I don’t care what they cut off, I still like football” but she would omit having actually played touch football when she was young. Tina would say she had a military career but adjust the story to reflect a co-ed environment. Dara omitted salient details like being drafted. Susie would omit a phase of sexual experimentation as she felt she had more to lose now, living as a woman. May would omit talking about her rape, as it was male-male and a private issue anyways. Deanne would change “boy scout to girl scout”

Participants had varying rationales for why, if, or when they omitted or changed details about their lives which could out them to others. While some reasons were focused more on making it easier on them, others were focused more on making it easier for others to perceive a gender congruent history. Carly, when talking about her past, would omit gender specific details but she said it was more for her own mental health. Plus, she felt it would be “jarring” for others that she had a boyhood but presented as a woman. Elaine said, “Why confuse people more?” in reference to avoiding complex details. Doris would not re-gender people from her past as she thought it was disrespectful. Furthermore, she thought that it was “too inconvenient to her to alter her past for other people’s convenience”. Kacey would not change past stories to a female pronoun but she was worried about future grandchildren and how they would relate to her. She did not want to be called granddad “because if they [her children] call me dad but their kids are not allowed to call me granddad then that would not work”. Vicky did not want to omit gender

specific details from her childhood but it would be “weird to say certain things because they don’t fit with who I am now”. When talking about her past, Haley occasionally accidentally outed herself when talking about past life episodes such as drag performance. Peggy might change oil field stories as these were clear “give aways”, changing these to a third person narrative. Kelsey would omit being an altar boy and bus boy. A few participants generally tried to omit and avoid all gendering contexts in the past.

One strategy commonly shared was to set up or present a story in such a way that people would automatically “fill in the blank” or keep stories so ambiguous that multiple “blanks” would become possible. On the other hand, participants were also highly sensitive to the always-present danger of being perceived as liars and yielded to forced honesty because of it. When talking about her past Luna left out gender indicators like pronouns but noted that “you would have to fess up that you’re trans eventually”. She didn’t have a girlhood so “you can’t be consistent if you lie”. Kellie would not invent stories about her childhood as it would produce “too many inconsistencies”; she tended to keep conversations very general and did not offer a lot of detail. Although Donna liked and valued her past, she felt the need to alter her story in the professional world. However, she added that, “lying is only getting you caught” which is why she omitted details from her life and kept things evasive. If pressured, she would steer away the conversation first but disclose eventually because she did not want to deliberately deceive people. Kelsey felt that although GRS enabled her to change important documents which made it “easier to hide who you were”, she worried that her credentials on certificates were unchangeable and thus gave future employers an opportunity to stigmatize her or not even hire her in the first place.

Then again, sometimes narratives were adjusted simply for safety concerns. Carly told me of an incident when she was working with a Muslim couple and she was about to perform a pelvic exam on the wife. While the woman was getting changed, the unsuspecting husband asked Carly if she was married to which she responded by re-gendering her current partner because she felt the man would have been uncomfortable with a lesbian examining his wife. She adjusted to heterosexuality as to “not freak the husband out”. Trish avoided awkward explanations when talking to people she didn’t know. Joanna planned on telling people she had a hysterectomy as the reason for why she could not have children.

Compartmentalization

I asked participants about difficulties with compartmentalizing who knew what about their current and past lives. Logically, those who were either living in total stealth or were totally out would have the least problems with “keeping the story straight” because those in deep stealth would adhere to one storyline and those who were totally out did not have to keep any kind of story straight. Conversely, those who had adopted partially stealth identities would have the most difficulty with compartmentalization. However, this was not necessarily the case. Furthermore, participants adopted different strategies to negotiate compartmentalization in various ways from avoiding persons or groups who could out them to categorizing social environments into fields of work, family, and geographical locations, for example.

Reese did not find it hard to compartmentalize; she stayed away from her family mostly out of fear of accidental outing by her mother who still sometimes calls her “he” — it kept her from bringing friends over who don’t know. Annie said compartmentalization was difficult because she didn’t want anybody to know she was trans but couldn’t help the fact. Sia sometimes

had difficulty compartmentalizing who knew what about her. Donna did not have trouble compartmentalizing as she did that “automatically”. Leah didn’t have too much trouble compartmentalizing as she lived in a small town where most people knew. She just did not want to be outed in “mixed” company (knowing and not-knowing). However, when she thought of herself in the past she said “the ‘I’ is now Leah”. She felt that the obligation to disclose rested on the level of closeness with people. Lisa did have more difficulty compartmentalizing in the beginning but now she felt she can “size people up quickly” (to determine whether compartmentalization is necessary). Compartmentalization came easy for Joanna: “if you’re from Michigan, you know I’m trans, if you’re trans then you know that I’m trans, if you’re from California and you’re not trans, then you don’t know that I’m trans...except for one person”.

Joyce felt that she had no problems with compartmentalization because she knew exactly what she told people. Yet, she noted that the more you tell, the more you have to keep track of. This, to Joyce, was the stress of stealth and why she thought it could be freeing to be out. “You can’t live a lie and be happy” she added. Tina did not feel like she had to compartmentalize except with her grandson Donnie — it was everybody else who had to do it, to refer to her as she, Tina, etc. Carly felt it was difficult to compartmentalize until her “double life” ended and she came out. In the past, whenever she went near Sue’s place of work, she had to pretend to be a man and wear men’s clothing. Jesse felt it was not difficult to compartmentalize because she was “good at hiding things”; yet, living in stealth was offensive to her sense of honor. On the other hand she preferred to retain control over her life although she sometimes felt pressured to talk about it. Like Carly, Trish only felt that she had trouble compartmentalizing before transition as she felt she led a “double life” - she had always been worried that she would be discovered by one of her students going to a nightclub dressed up.

Kacey felt it was not difficult to compartmentalize as most people knew everything about her. Jenna did compartmentalize for her best friend's kids — although eventually, they would have to learn about her past as well. Luna felt she did not compartmentalize much as she didn't want to invest so much time in constructing a story. Carla found compartmentalization not difficult: "I can think fast", she said, and did not feel dishonest. Susie did not have trouble compartmentalizing but she did not get close to people easily anyways. If needed, she would choose to be evasive. Violet would compartmentalize if she had decided to move, "just to make things a little easier".

Ruby felt that it was difficult to compartmentalize, as it was "tricky to keep things straight" and "keep one's wits about it". In contrast to being stealth at work, Tracy posted to everybody on Facebook that she was undergoing GRS. Walking a dangerously close line of compartmentalizing select bits of information, Tracy avoided thinking about what would happen if a coworker tried to "friend" her. Maria had difficulty compartmentalizing in the beginning of transition but not now. A therapist had once described her as a chameleon and she felt that she had kept things to herself all of her life. Emma tried to be as honest as she could with people because she believed compartmentalization did not work well and if news about her past got out, it would spread quickly. Peggy didn't feel like she had to compartmentalize extensively, just "be wary of what you say". Both Audrey and Zoe claimed they had no issues with compartmentalization.

What is noteworthy is that some participants who said they had few or no issues with compartmentalization were only partially out, and that some who said they were out to everybody still chose to compartmentalize at least some information about them.

Dishonesty

The question of whether living in stealth or withholding information about one's transsexual status could in some ways translate or appear as "dishonest" has been debated by scholars who have closely looked at media representations of trans-related violence. As such media stories often focus on the aspect of 'deception' as the main motivator and or justification for transphobic violence or harassment. Talia Bettcher writes that "The rhetoric of deception appears deeply connected to deployments of gender attributions that run contrary to a transperson's own self-identifications" (2007:47). Referring back to self and other perception which carry an unusual weight in terms of "discovery" and "revelation" about genital realities, Bettcher observes:

Fundamental to transphobic representations of transpeople as deceivers is an appearance-reality contrast between gender presentation and sexed body. For example, an MTF who is taken to misalign gender presentation with the sexed body can be regarded as "really a boy," appearances notwithstanding. Here, we see identity enforcement embedded within a context of possible deception, revelation, and disclosure. In this framework, gender presentation (attire, in particular) constitutes a gendered appearance, whereas the sexed body constitutes the hidden, sexual reality. Expressions such as "a man who dresses like a woman," "a man who lives as a woman," and even "a woman who is biologically male" all effectively inscribe this distinction. (48)

The question of whether participants themselves felt they are being dishonest when, if, or until they disclosed, as well as when or how they disclosed their transsexual status to others offers some insights into shared ideas about the cultural ethos of honesty. The consensus among participants seemed to be that although they could understand how non-disclosure could be interpreted as deception or lying, they did not share this view because they did not perceive non-disclosure as dishonesty based on the rationale that they were presenting themselves to the world as their "true" or "authentic" selves. However, many realized the following dilemma to "disclose

‘who one is’ and come out as a pretender or masquerader, or refuse to disclose (be a deceiver) and run the risk of forced disclosure, the effect of which is exposure as a liar” (Bettcher 2007: 50)

Reese did not feel dishonest because saying she is a woman was “ a lot more honest than saying I used to be a boy”. However, she added that the surgery in particular authenticated her more and that it was easier in general for people to accept post-ops. Annie would feel dishonest if her partner did not know about her transsexual status but in casual friendships she would feel this way; she did not feel obligated to tell anyone. Nonetheless, she was still heartbroken over the recent break up because she had not disclosed her status initially. This incident in particular made Annie say she was “done with deception”. Sia did not feel dishonest for not disclosing her trans status to those for whom she felt it held no significance. Donna did not feel dishonest because “nobody tells you everything right away”. Nadine did not feel dishonest, she “just had a different past than most girls”. Lisa did feel dishonest up to the point of disclosure as people feel duped if they don’t know. Joanna didn’t feel dishonest because transition and GRS was part of her medical history. “Being trans is almost demanding subterfuge if you want to exist in normal society”; however, she also noted that “people feel that they are entitled to our medical history”. Doris didn’t feel dishonest if she did not disclose right away. Joyce didn’t feel dishonest about not disclosing her past because she felt that nobody is “100% truthful all the time”. Tina didn’t feel dishonest but was careful in straight crowds. Carly did not feel dishonest as she did not feel compelled to tell people everything about herself. Although she felt it was the honest thing to disclose, she would not do it unless she felt safe. Dara would only feel dishonest not disclosing if a romantic partner was involved. Felicia did struggle with the deception aspect when she felt unsafe and couldn’t let people close to her who can only see the label, not the person. Felicia felt

that sometimes dishonesty is necessary as she felt like she is a “product of violence” (having had extensive experiences with physical violence).

Kacey had felt dishonest in the past when a man asked her to dance; out of fear of violence and physical embarrassment she turned him down but danced with another man who knew she was trans instead. Luna did not feel dishonest until she disclosed to people because she was Luna “and that is the truth”. She drew an analogy to physical disabilities: “Am I duping people if I had a fake leg?” she asked. Susie didn’t feel dishonest because all that mattered was what is now. Ruby did feel dishonest about not disclosing but felt that lying constituted “self preservation”. Maria felt dishonest until she disclosed and often felt pressured to disclose. Yet, she wanted to know how people felt about her right away as to not waste her time. Haley felt her life was an open book but that her transsexualism was only a small part of her life. She did not feel dishonest and intended to keep her genital status private. Jean didn’t feel she was being dishonest in not disclosing information especially if someone doesn't need to know. “As far as I am concerned only those closest to me need know anything” she added. Emma did not feel dishonest when she did not disclose right away — for safety concerns. She felt that most transgender people had credibility and integrity issues anyways, which made it harder to disclose the mere fact of one’s transsexual past.

Jane felt dishonest when not disclosing immediately, yet she felt being honest presenting herself as a woman. Peggy felt dishonest when she didn’t disclose immediately but most of her friends would know about her past eventually. But since friends are usually mediums for new acquaintances she was careful not to party with people who “have loose lips” — she would rather have control over the outing situation. Audrey found it sometimes hard to be dishonest when she got close to people. She felt dishonest when she was omitting things and people from

stories. Zoe did not feel dishonest unless she was asked a direct question to which she would respond with a lie. But to her talking about her past was more an act of omission. She felt there was no falsity in having experienced her boyhood as a girl. Kelsey didn't like having to lie but lying yielded to her desire to be stealth and passing because she did not "want to be marked as an obviously transgendered woman". The dishonesty bothered her because one of the joys of transition was not having to lie anymore and that she could now have closer relationships with women as friends.

Participant rationales about GRS in particular being interpreted as an act of deception rather than a private medical procedure follow Lavin's conclusion framed in the context of medical ethics:

SRS is not, then, deceptive... People may care about what their partner's history is, but there is no obligation to broadcast one's history. There are many things people might have liked to know about one another. That does not establish a right to desired information, let alone deception in withholding it (1987:91).

In Summary, GRS mattered very little in narrative strategies of presenting a cohesive self because participants had already been living as women full time. The classic "stealth model" also only applied to very few participants which shows that most transsexuals do not just blend into the "woodwork" anymore after having undergone GRS. GRS thus no longer possesses the "normalizing" power it was once thought to have. Perhaps the greater acceptance of transgender individuals in general has contributed significantly to participants' increased willingness to be "out" and not construct a whole new past. But perhaps the greater consciousness of transsexualism in the public psyche also plays a role in why many participants would consider outright lying or denial of one's past to be morally unsound.

“Losing Sons and Gaining Daughters”: Social History and the Renegotiation of Kinship

In this second part of this chapter, I now turn my attention to how gender transition affects family and kinship roles and relationships by focusing specifically on how kinship terminology regulating kin relations are adopted or modified to formulate relationships within the families of transsexual women. Anthropologists and other social scientists have suggested that ideas about kinship are cultural constructs subject to contextual change, renegotiation, and modification. Feminist and LGBT scholars in particular have focused attention on so-called alternative family structures in which the gendered composition of parenthood accommodates parents of the same sex or gender. These new parenting dyads affect kinship relations across generations and beyond the interactive world of the nuclear family. But while kinship terminology and language has only recently begun to accommodate gays and lesbians, for transgender individuals kinship relations remain problematic because the sexual orientation of parents does not necessarily challenge cultural ideas of motherhood or fatherhood whereas biological male- or femaleness constitute a cultural, legal, and permanent prerequisite for these roles.

Scholarship addressing new kinship configurations including same sex parents commonly emphasize a mixed strategy of assimilation and rejection of traditional kinship models (Dunne 2000; Folgerø 2008; Gagne and Tewksbury 1998; Hicks 2005). While anthropologists such as Kath Weston (1991) and Nancy Levine (2008) have pointed out that kinship has undergone a post-structural transformation, moving away from the centrality of heterosexual marriage as the founding element of kinship and reproduction, other scholars have noted that the family remains a “disciplinary matrix” (Butler 2002; Halberstam 2007) which, even amidst variation, does not “represent a break with traditional norms that encompass family life in society” (Folgerø 2008:136).

In this section, I discuss how ideas about kinship are renegotiated and articulated when GRS patients transition. I hope to shed light on the limitations of kinship constructs which can not always reflect the complexity of the modern family including transgender individuals. I will present four family dyads which are complicated by a gender transition including GRS as the final step, and through which the interrelatedness of kinship terminology, interaction, and identity becomes evident.

Wives of Transsexual Women

Transgender individuals and mental health professionals have noted that the transgender person is not the only one who transitions; wives of male-to-female trans women who chose to stay in relationships with their former husbands are by virtue of their spouses' transition read as lesbians, even if they do not self-identify as such and even if they no longer engage sexually with their husbands. The wife's sexual re-orientation as lesbian also negates having a husband as husbands are socially and legally male-gendered. Further, wives undergo a re-socialization as a couple if the couple stays married, and their own life narrative necessitates adjustment to accommodate the gender change of their husband (see also Coombs 1997). As a result, many wives struggle to have a sensible explanatory model at hand to articulate kinship relations. Even when taking sexual re-orientation by proxy out of the picture, one wife lamented "just how do I explain that I am married to a woman who is also the father of my children?"

For Donna, business meetings were awkward which had announced them as Mr. and Mrs. Miller "and in walk two women". Donna felt like a lesbian but did not see Louise and her relationship as lesbian because of the way had related to each other for 43 years. Donna noted that because of this complex web of interaction, relationships have to be re-learned based on

gender norms and interactive scripts. Lisa's wife Kelly was coming to terms with loss of her husband. "Losing and mourning the spouse without being able to tell anyone" said Lisa, made Kelly retreat into "her own closet". "She had to shoulder the burden of the old me going away" she added. Tina felt pressure to change her referential address to Josie as her "partner" but she still felt and preferred to see and address Josie as her wife. Violet's ex-wife also had trouble addressing her; "how do I refer to you?" she asked. She didn't like referring to Violet as her "ex partner".

Transsexual Parents

When transgender parents transition, kinship relations to their children are equally complicated but to what degree is highly contingent on the child's age and whether the parents remain together and share parental responsibilities. Nonetheless, even if children are accepting and supportive of their father's transition to womanhood, small children and young adults are often puzzled as to how to explain the new family dynamic. In my research, fathers who transitioned were often told that their children felt like they were "losing their father", reflecting Folgerø's finding that fathers are often implicitly associated with being "role models" whereas mothers are not (2008). While all transgender women I spoke to wished to remain involved, loving parents, their day-to-day interactive environment was compromised by a lack of terms to describe their new relationship to their children. Limitations accepting parents in their new gender occurred quite frequently at the level of interpersonal address. For instance, calling their fathers "dad" remained a strong insistence by the children, even if calling their fathers by their new first names was acceptable to them. Carly's son called her 'dad' but used female pronouns - she was understanding of the referential kinship term as he had grown up around her being male.

Although Trish's daughters got the pronouns right, they still called her "daddy". Trish said it was strange to be out in public when her girls would say "but daddy!" which made her uncomfortable even if she felt proud to be a parent.

Felicia's two adopted sons have cut off contact with her. When she came out to her oldest son, "it crushed him"; he told her "I don't know how to refer to you ...I just don't talk about my dad". Kacey was worried about her 24 year old son: "he may have a sense of loss of his father...I still...they call me dad...and I told them I didn't want them calling me mom...because they have a mother and I don't want to take that away from her". Her kids still called her dad in public which she didn't discourage as to make it most comfortable for them. However, once Kacey took her daughter to the mall and she told a friend on her cell phone "I'm here with my dad" which startled two women passing by. Kacey felt that calling her a certain name wouldn't change their relationship nor would her son in particular struggle any less with the readjustment.

Lana didn't mind telling people that she used to be a man and when referring to her children bluntly says "I'm their dad" and May allowed her young son to call her "daddy Mike". Jane said of her two adult daughters "they're losing their dad, they lost their dad in their own mind, not recognizing that I'm still here as the person that was their father but...they really can't quite see that I don't think because they lost that male image". Jane still struggled to define their new relationship "do I want to relate to her woman-to-woman?...[]...But really, I want to relate to her daughter to father...cause that's the relationship we had".

Except for Ruby's adult son, not one child was willing to call their father "mom" although this was also rarely desired by their parents as if to indicate a crossing of an invisible line of kinship-related appropriateness. In rare cases, alternatives could be agreed upon — for instance, one 8 year old son began calling Rose "Emmy", which is a modified hebrew word for

mother and Violet's daughter sometimes called her "maddy" (a mix of mom and daddy). Jenna said she will always be "dad" to her children but she's trying to reach a compromise combining Jenna and dad into one compound word. The compromise of "Jenna-dad" however, is still frail; her son wondered if he should call her "auntie" but she said "I'm always gonna be your dad". Violet's daughter, particularly when narrating shared memories about her father, would refer to Violet as "the woman who used to be my father", pointing to the persistence of a permanent and shared social history.

The difficulty in re-negotiating personal address and past-reference to parent-child relationships shows that heteronormative kinship terminology is a compounding factor in why post-transition kinship relations are so difficult to articulate, and moreover, to embody. As Violet, in reference to her daughter, remarked "I don't know who I am to her", which indicates that sometimes, these re-negotiations never conclude and remain works in progress.

Parents of Transsexual Children and Adolescents

Although more or less accepting of their transgender children, the common notion of "losing a son" whilst "gaining a daughter" was frequently shared by parents who had accompanied their children to Trinidad for the surgery. This notion of "loss" which parents feel when their child or adolescent transitions has also been acknowledged by professionals who counsel and guide both parents and children through the transition process. For instance, Krieger notes that parents "may experience a deep sense of loss when they discover that their child will be changing in outward appearance and identity to conform to a long-felt but previously secret gender identity" (2011:31). Brill and Pepper (2008) also confirm that parents and siblings alike "may feel a sense of grief at the idea they are 'losing' their son or daughter, brother or sister" (47) — as one parent

remarked "It was a hard way to lose my daughter" (65). But some parents also actively resist the notion of loss. Brill and Pepper cite a case where a parent of a 10 year old trans boy said "I went to a parent support group. They were all so accepting and asked me if I was mourning my daughter. I just thought, Hell no, I haven't lost her" (19). Nonetheless, regardless of age, all transsexuals remain someone's son or daughter and the concept of loss (to transition) is no more relevant whether someone's child is 5 or 50.

Lisa's mother's reaction to her transition at first was "you will always be so-and-so to me" and she, too, had a hard time disclosing her son's transition to her friends. Her dad was supportive but then sent her a nostalgic birthday card which read "Happy Birthday Son" in big letters. Tina felt people would always remember her as 'Tom' and her father still insisted on calling her that. Jesse felt like her father was going through a "I feel like I'm losing my son thing": he would go "genderless" on any reference to her "unless he got stressed" (in which case he'd call her by her male name). Like many other patients, Trish got highly emotional when she talked about loss within her family. Within a deeply sobbing moment, Trish said "I wanted my dad to love me...and I don't know if he is always going to think of me as a throw-away son...and I don't know...[]...I still feel like if I write him this letter and let him know I've had surgery...maybe he'll see me...you know, maybe for him it's been about the penis, I don't know". She didn't think the rest of the world would accept her because she had a vagina now. "They've known Gene for so many years, I think that's the fact in and of itself. It's not that I had a penis and now I have a vagina, it's that they can't wrap their head around the fact that I used to be a guy and now I'm a girl". Surgery or not, Trish noted, "they still have to look at who I used to be". Although her father also barely kept in contact with her other brothers and declared "I have no sons", she felt that she had disappointed him the most; he routinely threw away all of her

letters and never listened to messages she left; yet Trish still tried to connect with him, hoping he'd change his mind one day. On the other hand, Trish would also resent it if he'd only accept her because she had surgery.

Kellie's family was accepting of her although they were very religious and conservative and initially struggled coming to terms with her homosexuality. Yet, she claims that her mother accepted her "as her daughter" now. Jean found that "people who knew me before will have an emotional attachment to that old person, and will often want that person to be who they want that person to be, and will selfishly hold on to that image even at the detriment of that relationship". Emma felt that her mom was sad for her because her oldest son would never be able to give her a grandchild. Similarly, when she came home to Texas for a visit, friends and family responded with "you'll always be Larry to us" whilst being at least semi-accepting. Susie's father, she said, could only see her as his son and never called her by her female name. Elsa said "My mom at first was like 'I'm losing a son' but at the same time she'd always counter with 'well I'm gaining a daughter' which is what she always wanted". Although Mia's parents were very supportive at the time, they initially struggled to accept her: "Sometimes they have to view it as the death of a son in order to welcome a daughter" she noted.

As I tried to make sense of the articulation of the symbolic loss of a son or the symbolic loss of a father, it became apparent that the loss symbolized by changing gender is not about the person per se, but about kinship relations which are not only naturalized through biological relevance but also culturally valorized through deeply internalized interactional scripts. We attribute a special meaning to same-sex parent-child relationships conditioned by permissible levels of intimacy, gendered activities, responsibilities, and levels of attachment. Thus, when the gender of a parent or the child changes, it prompts for a different interactional script between the

two — what is in essence lost is the unconscious habitus which instructs our interaction with gendered family members, redirecting the problem toward the changing relationship, not the changing individual.

Transsexual Grandmothers

But while all dyads of re-negotiated kinship were problematic to an extent, the most intra-familial problematic I came across during my fieldwork was the transgenerational triad, composed of transgender parents, their children, and their grandchildren. Within American culture and beyond, grandmothers hold a particularly influential and culturally scripted role in a child's life; grandmothers are female nurturers, caretakers, and often respected matriarchs within their families. All of the transgender women in my sample who were grandparents took an absolute delight in interacting with their grandchildren. For instance, Betty had a 45 year old daughter and 4 grand daughters who call her Betty and who are accepting of her. "Dealing with them [her grandkids] as a grandmother and not a grandfather has been so much fun" she marveled with glee. However, their desire to be grandmothers and not grandfathers to their grandchildren was often compromised, and sometimes hindered, by their own children's non-acceptance as persons assuming this role. Donna would be willing to change her appearance around her grandson at the request of her children but refused to change her gender identification as female around them. Jenna's grandkids know her as both, Jenna and grandpa, but her children call her dad still. Zoe was not sure how her transition would affect her grandkids. Her children could still call her dad but she preferred to be called Zoe and hoped that her grandchildren would eventually see her as grandma.

Tina had an especially close relationship with her grandson but she worried about him finding old pictures and wondering about her past; Tina's daughter and her had discussed the issue but had not come up with a distinct plan of how to explain her differently gendered life. Tina grandson once asked her "grandma how come you didn't marry a man?" which made Tina think that he knows that her wife Hanna and her are together but she was not sure whether he knows they are married. In essence, she wasn't sure what he knew or how he made sense of their family reality. Tina knew that eventually questions would be coming up and she was always afraid someone would out her whenever she spent time with him. The mere thought made Tina very angry. She hoped nobody ever "slipped up" because she would be "fucking pissed" as she felt nobody had the right to out her.

Even if the grandmother-grandchild relationship was permissible, many children were hesitant to deny that their own child's grandmother was also their father. Transgender women's own children often refused to hide or modify shared memories, stories, photographs, and experiences which clearly placed them into child-father relationships. Here again, the inability to explain, especially to children, why, in colloquial terms, "grandma is also daddy's dad", is a clear indicator of how deeply kinship terms structure, and moreover bias, how we relate as a family.

Siblings of Transsexual Women

Much like parents, wives, children, and grandparents, siblings also attribute culturally specific and emotionally strong bonds to kinship relations. Of all family members who held negative attitudes about the transitioning family member, brothers in particular seemed to suffer a great symbolic loss of a family member, and conversely, it appeared that those participants who had

brothers, took the disruption of their relationship harder than those which occurred between them and their sisters. This points to a perhaps greater overall culturally shared value of brother-brother relationships which, in turn, may be attributable to greater value of male-male relationships in families in general.

Donna felt that her whole family could never accept her as a woman because they had too much history. She pointed out that the mental kinship connection, as brother and sister for example, cannot change. She mused that even if a total mental erasure were possible for her, “you’d have to change your history and everybody else’s”. While Lisa’s family was accepting, her wife Kelly’s 2 brothers disowned her, had written her off; neither transition nor GRS would hardly make a difference for them, Lisa felt. Elaine’s brother no longer spoke to her. “As far as I am concerned” he said “there will always be two boys and two girls in our family”. “And that is sad to me” added Elaine. To make matters worse, her brother’s wife told her that she is “ruining” her brother’s life; but Elaine felt he was martyring himself for her and the stress on her family. Similarly, Elaine’s sister told her that she felt like “her brother is dying”. Felicia noted that someone told her that her brother David “is having a really hard time with the loss of his brother”. She has not had any personal conversation with him since. Maria’s half brother with whom she only recently began a relationship also had a fear of losing his new-found brother; his other concern was for how his children would relate to her now. He said “I see you as Mike, but I will call you Maria because you’re my sister but I see you as my brother still”. Maria appreciated his honesty and felt that he respected her nonetheless.

The Implications for Kinship

What do the effects of gender transition mean for broader, theoretical considerations of transforming personhood and re-imagining the modern family? Are transgender women by virtue of occupying multiple or transitory positions within kinship structures “queering” the family? I never felt that the transgender women and their families that I met had a queering of such at heart; indeed, most tried to fit themselves into the existent kinship structures and make renewed sense of their relationships within, not outside of traditional family structures. And while same-sex couples have had remarkable success, at least in my opinion, in introducing new and creative explanatory models of same-sex parenthood, transgender individuals who transition after having occupied distinctly gendered roles in the family face a much more complex task. This is not say that transgender families cannot benefit from adopting phrases such as “having two moms” or “my other mother”, but family histories remain shared social histories, and the disruption of the intersubjective consciousness of a family history by one family member’s gender transition shows that these phrases cannot accommodate such complexity. The symbolic notion of “losing sons and gaining daughters” suggests that transgender persons uniquely disrupt patterns and positionality of kinship which underscores current anthropological arguments that kinship is temporal, relational, and seductively malleable across time and space. But although anthropologists have noted that in few non-western cultures, individuals whom we might label “transgender” have been incorporated into existing kinship structures, most of these inclusions are “strategies of heirship” as Nancy Levine (2008:377) points out, and Niko Besnier remarks that little is known about how transgender individuals cope with the social tensions pertaining to kinship and their own identities in general (2004).

Legal conundrums add to personal struggles of achieving a sense of cultural intelligibility of one’s position in the family. As Judith Butler (2002) has noted, gay, lesbian, and I might add

transgender individuals, struggle with state recognition of legitimate parental responsibilities and rights because “one’s public and recognizable sense of personhood is fundamentally dependent on the lexicon of that legitimation” (17). Opposite of institutional regulations of kinship, however, Butler, following kinship theorist David Schneider, suggests that “kinship is a kind of doing, one that does not reflect a prior structure but which can be enacted in practice” (34). Butler believes that this would help to “move away from the situation in which a hypostatized structure of relations lurks behind any actual social arrangement and permit us to consider how modes of patterned and performative doing bring kinship categories into operation and become the means by which they undergo transformation and displacement” (34). While kinship as a performative principle rather than static structure makes sense in a post-structural world, this move does not change the notion that kinship remains a distinct site for the reproduction of American family culture. And although some transgender individuals increasingly self-identify against binary notions of gender, binary notions of kinship can serve as a resource to lay claim to gendered positions within these as my examples above have shown. American kinship terminology thus reproduces not only gendered individuals, roles, and relationships but also enduring cultural values and practices which are not so easily transformed by post-structural ideas of the individual, the self, and gendered personhood.

“To Be Seen As A Woman”: The Social Perception of Transsexual Women’s Gender

For the last section of this chapter, I will now focus on how mainstream culture perceives trans women whose socially gendered history may become known and how the knowledge of a person’s differently gendered past can affect the ways in which people construct cognitive composites of gender. In their introductory chapter on the primacy of gender attribution,

psychologists Suzanne Kessler and Wendy McKenna (1978) liken the cognitive process of perceiving whether a person is male or female to a “heads” or “tails” result of a coin toss. Suppose that the insignia of the coin were unreadable, perceptual ideas about a coin as an object with two sides still suffices to assume that one or the other side will turn up. Kessler and McKenna’s binary gender attribution as the underlying cognitive principle of perceiving even ambiguously gendered persons as male or female explicates how cognitive schemas of gender “fill in the blanks”.

However, in this section I problematize their notion of gender attribution based on gendered markers which are visible and can be read. Although perceiving and seeing are often used interchangeably, within psychological anthropology ‘perceiving’ refers to the contextual processing of external stimuli, hence allowing for a selective and culturally shaped interpretation of such. Based on this assumption, I argue that one does not have to actually “see” temporal or permanent gendered markers to perceive them and gender persons accordingly; implicit or explicit knowledge about a person’s transsexualism suffices to project gendered images onto bodies, identities, and lived experiences. Rather than focusing, as so many other scholars do, on the social construction of gender, I am more interested in exploring the social construction of perceiving gendered personhood based on cognitive and cultural processes. I ask what does it mean to “see” persons as gendered individuals when implicit or explicit knowledge about their past gendered embodiment is incongruent with their present one? I argue that, based on perception being shaped by cultural schemas, cultural ideas about transsexuals permit us to read them as such, which is not unlike the idea that culture shapes the way we see color and spatial arrangements, or interpret phonemes into meaningful language. Drawing on my data, I attempt to analyze perceptions of gendered personhood within theoretical paradigms of phenomenology,

narration, embodiment, and previous research on transsexual identity construction. I contend that without the introduction of medicalized discourse about transsexual identities and the medical gaze “discovering” or “perceiving” transsexual bodies, the social gaze would simply adhere to ordering persons into male or female categories as Kessler and McKenna suggest.

Throughout my fieldwork, I noticed a recurrent phrase in transsexual women’s narratives which invariably states “I just want to be seen as a woman”. On the surface, this desire to be perceived in accordance to everyday social conventions of gender seems unremarkable, and as a request for societal acceptance of transsexuals, even more so. However, the implication that one could be seen as something other than, or not “just a woman” suggests at least one other perceptive possibility. In this context, wanting to be seen as “just a woman” connotes as a disassociation from, or a dis-preference for being seen as a “just a man in a dress” as I have suggested earlier. Prioritizing the phenomenological experience of the subjective self as the “true self”, trans man Henry Rubin, building on Merleau-Ponty, notes that “phenomenology returns legitimacy to the knowledge generated by the experiencing ‘I’...” (2003:25). However, Vincent Crapanzano argues that there is “an invisible split between the narrating I(s) and the narrated I(s) that is conventionally ignored where there is a presumption of continuity, but the split cannot be ignored where that presumption is questioned...” (1996:109). It is precisely the idea of narrative and corporeal continuity, the view that a person’s embodied and lived history is linear and dynamic, which is disturbed by ideas about transcending gendered boundaries in order to find or reveal one’s true self. What actually constitutes selves that can be experienced, delineated from, articulated, and seen by others, has of course long been debated by anthropologists (Hollan 2010, Crapanzano 1996, Bruner 1986). Furthermore, ideas about the self as something singular, authentic, and “true”, assumes that it exists and deserves primacy in the first place (Lindholm

2001). This is quite evident in the vocal authority of autobiographical accounts where transsexual narratives often appear as closed narratives leaving no room for interpretation, as if to say “I really am this person because I say so”. But as Edward Bruner remarks “As social scientists we have long given too much weight to verbalizations at the expense of visualizations, to language at the expense of images” (5). And while narratives and language are primary vehicles to communicate one’s identity, there are social, situational, and linguistic limits to narration. “Transsexual stories are hard to tell”, noted Lisa, because “disclosure is not always convenient or possible”.

When such narrative limitations occur, it becomes obvious that bodies are also telling stories about the self. A major and primary communication partner in how visualization and imagery inform the perceiving I and the I that is perceived, is one’s mirror image. Trans man Jay Prosser’s writing on transsexual “mirror stages” emphasizes the cognitive processes of seeing one’s “true” self emerge in the mirror as the physical transition of gender progresses. But for many participants in my sample, the mirror also represents a social proxy for perceptive feedback. Reece noted “As a guy, I always hated looking at myself in the mirror, but now I’m like ‘who’s that pretty girl?’” Others recalled seeing their subjective, previously “invisible” selves projected outward for the first time after hormones took effect or after undergoing feminizing surgeries, but in particular just after undergoing GRS.

Like most of my participants, Gill could now look in the mirror and “see” herself. Carly felt that post GRS, for the first time in her life, she looked at herself up and down in the mirror and was so happy that she saw nothing which contradicted her inner experience. She noted that her “soul self” had been waiting for this moment for so long. Vicky now felt content when she looked in the mirror and find a completed sense of self. Peggy felt “cured” (from GID)

the first time she saw herself in the mirror after GRS; “it’s a woman” she noted. Audrey noted that “I used to look in the mirror and not like what I saw... ‘I hate you, I really don’t like you, I don’t know what’s wrong with you’ ...[]...now I see someone else in the mirror...I see myself”. This, she said, was the biggest change in her life.

GRS affected Elsa in that she could “look in the mirror and see myself and be really happy...it’s kind of like the final note, the final piece of me...this is the last thing”. Elsa, now felt “proper and natural”. She added “having a penis is like that part of the mirror was like shattered to me...that was like a broken part of the mirror down there in that spot...and I couldn’t fit it in and I couldn’t look at it and not avoid it with my eyes and not feel uncomfortable or sad...now I can comfortably look in the mirror and say ‘that’s me’ and that’s correct...[]...before, the very first piece of me that I found in the mirror, the only piece of me I had was my eyes...I’d just look at my eyes because there was nowhere else that I could relate to, that I could see myself”.

Similarly, GRS gave Mia “the body that she has always not seen in the mirror looking back at her”. The mirror thus represents how “true selves” can gradually emerge, enabling a slow but dynamic sense of personhood externalized; nonetheless, gendered persons do not gradually appear or disappear into or out of collective cognition, and it is the explicit or implicit knowledge of a transsexual history which allows for more than one vantage point on such emerging imagery.

But since identities are inextricably tied to social, interactive contexts, the shared notion of being seen as a woman is also critically dependent on its intersubjective reiteration. Prosser sees transsexual narratives as a “kind of second skin: the story the transsexual must weave around the body in order that this body may be ‘read’” (1998:101). The body as gendered social text is thus subject to social readings based on shared understanding, ideally prompting an

affirmation of what the author of such texts has intended to project. However, an affirmative reiteration of “I see you as a woman” appears to imply something quite different, namely that other options are possible. Although it confirms the declaration, it really seems to say “I see you as a woman but I *know* that you are a transsexual/used to be a man”. Indeed, without a shared cognitive awareness of a person’s transsexual status this very statement would have no referential point whatsoever. And it is de facto the cultural reference point of transsexualism which exemplifies the intersubjective disjuncture of both “seeing” and “perceiving” transsexuals “as women”. Cognitive schemas of gender are so sophisticated that we can not only “fill in the blanks” but use female and male gender markers to achieve an unambiguous mental composite. Reading gender into *imaginary* bodies and selves is the same process as reading gender into real bodies and selves, adding or subtracting features which enables us to imagine what a person would look like “as” a man or “as” a woman — in short, we don’t actually need to see it to perceive it. As Robin Conley has poignantly demonstrated in her work on referential discourse concerning transsexuals, explaining that “at the time she was a man” makes sense to interlocuters who can conceive of the idea of transsexualism, and who can therefore perceive the person in question as occupying a differently gendered status in the past (2008).

The Social Capital of Passing vs. Gender-Normative Behavior

Discrepancies in being perceived as “just women” are not just categorical distinctions for transsexuals; in a pragmatic sense, transsexuals quickly become “visible” when they fail to pass in social contexts or are outed involuntarily. Without question, passing constitutes perhaps the most commonly shared desire among trans women as it provides visual credibility to identity claims. Passing also appears to achieves something else for many trans women: the freedom

from having to consciously act in stereotypically feminine ways at all times. This notion made me wonder whether passing alone would constitute acceptance or whether, and how much, gendered behavior contributed to social acceptance of transsexuals as women. In short, I wanted to know whether participants thought passing or gender-normative behavior of trans women was more accepting to general society so I illustrated my question with a hypothetical vignette. I told participants to imagine a man walking into a bar or restaurant. He sees two women both of whom he knows to be transsexual. One woman, who passes effortlessly, behaves in stereotypically masculine ways, standing at the bar, drinking beer with a group of people. The other woman, who does not pass at all, behaves in stereotypically feminine ways, sitting quietly at a table with group of people, sipping wine. My question was: which of these two would the man invite to his house for a social event and why? Although most participants felt that both passing and behavior were important in social acceptance, perhaps unsurprisingly, most participants also chose the passing woman as being *more* socially acceptable. What is interesting however, are the underlying rationales justifying this choice.

Donna felt that there was a general consensus among trans women which ran along the lines of “if you can achieve passing, you can achieve a life”. She felt that passing was more important but mannerisms were also important, especially based on her experience; she felt people accepted her because of her proper behavior, not because of passing or not passing. Leah felt that transsexuals only had social disadvantages if people saw them as transsexuals primarily. Lisa thought passing was more acceptable because it was easier for women to be one of the guys, and that for non-passers hyper-femininity could “set off alarms if gender is already in question”. Joanna felt marginalized whenever she was ‘read’ as transsexual, especially in professional or work related contexts. “This one interviewer was like ‘we are a very accepting place and what

we have is very diverse and there's gay people and straight people and all kinds of people here' and it was very clear that I was read in this regard". She found this to be a very condescending experience. "If that does happen [getting read], you can be damn certain that you are gonna be treated absolutely different, even if they don't try to, even if they don't mean to, it's still gonna happen". She added "it's almost like a handicap". Elaine felt that passing was more socially acceptable because people were superficial. Doris felt that neither passing nor behavior was more acceptable because overdoing it can out you regardless; however, she felt that passing transsexuals would be considered more "normal". Carly felt that passing was more acceptable, even if trans women still behaved in stereotypically male ways because men fantasized about an attractive woman who actually shared their male interests. Luna felt that passing was more acceptable than behavior as it delivered a "truer" image of a woman. Carla felt that passing was more important because 'seeing' people as one gender or the other excuses gender-crossing behavior. Maria felt passing was more acceptable than behavior as it made for less questions asked. Emma thought passing was more acceptable, but that gender-normative behavior should constitute the ethic of acceptance.

Reiterating the recurrent 'woman vs. man in a dress' distinction, Joyce felt that passing was more acceptable than behavior because it made people "uncomfortable" to see a man in a dress. Tina thought that passing was more important than behavior because lots of trans women were "still men in dresses" who "can be gruff and act like construction workers". Carly felt people were visual creatures so "a man in a dress" would not be "an object of desire" for either gender. Kacey felt passing was more important than behavior because people viewed non-passers as "a guy pretending to be a woman" which was "offensive". Rose thought that "when people see transsexuals, they see a man in a dress" and that passing was more socially acceptable

because women who do not pass but behave in stereotypically feminine ways were often seen as “caricatures of men trying to be women”. Kelsey felt that passing was more important than gender appropriate behavior because non-passing threatens men more as they would see a “man pretending to be a woman”. Donna felt that mainstream society reacted to what is “different looking” and kept a general distance from transsexuals whom they saw as “a guy in girl’s clothing out in public”.

Some participants had more ambiguous opinions. Jesse thought that passing was a complex “collection of variations from the gender norm” including weight, health, and aesthetics which is why she thought both passing and behavior were essential to social acceptance. Trish thought that passing was more important to social acceptance initially but in the end, behavior was more important because men find women who behave like men threatening. For her it was always important not to “fake femininity” and not to become a character because kids at school would only tease her more if she tried too hard. Felicia felt that a lot of trans women don’t pass because of their behavior, but passing visually was ultimately most important. April thought that “neither is acceptable” — just the fact that someone is trans is socially unacceptable. Susie felt that both passing and behavior were essential in societal acceptance because “if you follow society’s rules, it’s easier each way”. May felt passing may be more acceptable in rural areas whereas behavior mattered more in urban contexts because women in rural areas often behaved less feminine. Audrey felt that passing was more appropriate as a first impression but that behavior mattered more. Zoe felt that people who passed were more accepted but personally, she felt that people were generally friendly to her because she was perceived as non-threatening and unassuming because of the way she acted, avoiding exaggerated behaviors and dress.

For some participants, passing was of utmost importance and posed a persistent and great concern. For Instance, Kelsey said she often felt hurt and angry when people did not accept her as a woman if she fails to pass. “I consider myself a transsexual and I always will be...but I don’t see anything wrong with that. [But] I hide it because I want to make sure I pass”. Here, Kelsey’s point illustrates that passing reaches beyond its primary visual, physical aspect — knowledge alone disables even the most non-detectable aspects of transsexualism and makes a male past “visible”. Kelsey also noted that it would irritate her if people kept referring to her as a transsexual; “don’t announce me as ‘there’s Kelsey, my transgender friend’” she added. Only Dara felt that behavior conforming transsexuals were more accepting to mainstream society because masculine women were perceived as threatening by men, while Deanne felt that those who acted properly had it easier, even if she herself was very focused on passing.

What was perhaps most enlightening about participants’ comments on passing as increasing social acceptability was this: after I presented participants with the vignette and listened to their answers, I simply added that I never said the passing woman at the bar was pretty or attractive. This seemed to momentarily catch most participants off guard, but in a lighthearted way; confirming my notion that their answer was informed by the thought of an attractive woman, I asked them to describe what the imaginary woman at the bar looked like - and most participants indeed described an attractive, feminine woman. Further, Audrey and Trish explicitly noted that the unspoken notion within the trans community was precisely that passing equaled not only feminine, but pretty, and that non-passing equaled not only masculine, but — as Trish put it — “ugly-ness”.

Passing, GRS, and Identity Distinction from Cross-Dressing

As I have already reiterated numerous times throughout this work, and as many of the above comments show, the most anxiety-provoking idea of being “misread”, at least for the participants in my sample, was not the idea of being read as a man, but rather as a *man in a dress*.

Participants not wanting to be seen as “just a man in a dress” often took on playful but crude variations on the theme such as “line backer in a miniskirt” or “lumberjack in lingerie”. These assertions inherently illustrate a disturbance of a cultural aesthetic, as well as an underlying disdain for being mistaken as “just” a cross-dresser. The imagery invoked here suggests a grotesque figure of a stereotypically masculine man wearing hyper-feminine articles of clothing. Although feminine dress is a major medium to communicate a female identity and a shared common denominator of both transsexuals and cross-dressers, cross-dressing alone often occupies a lower, if not the lowest position of incredulity in transgender support groups and communities.

As I have shown in Chapter 5, more than just transsexual lore, the idea that it is easier to be “read” in a group of cross-dressers or transsexuals who do not pass, divides transgender support groups internally and drives many transsexuals to a permanent dissociation with cross-dressers. This dissociation is part of the culturally motivated desire to undergo genital reassignment surgery as it denotes my participants’ often re-iterated “seriousness” of identity against which cross-dressing appears experimental, temporal, and insincere. To be seen as a “real” woman and not just a man in a dress centers thus on the distinction between temporal and permanent embodiment and expression of identity, suggesting that reading identities as permanent equals reading identities as “real” or “authentic”.

The seriousness of identity communicated through surgical modification of the body reveals another recurrent, if not unanimous theme in transgender women’s narratives in that the

surgery provides a sense of wholeness and completion as I have discussed earlier. Both the sense of the self and its holistic integration or disintegration with the body has been explored by many scholars interested in theorizing the connection between the mind and the body. Such theories are either dualistic or Cartesian, but also often tripartite in nature; for example Sartre's three levels of bodily ontology emphasize that the third level is the alienated body one is coerced to perceive as others do (Prosser 1998) while for Scheper-Hughes, one of three bodies is the social body upon which meaning is inscribed (1987). But transsexual bodies, dualistic, tripartite or divided in any other way, are not a-historical bodies. We couldn't "see" transsexuals before medico-technological advancements made physiological changes of the body to resemble the opposite sex conceivable and perceivable. For example, Bernice Hausman argues that the proliferation of such medical developments "created" transsexuals in the first place, in essence claiming that transsexuals are products of the medical establishment (1995). Distinctly Foucauldian in her approach, Hausman suggests that it is the medical discourse and the medical gaze which have introduced ideas about transsexualism into social cognition, thereby transforming the idea that sex could be changed from mythological fiction into a bio-medical, embodied reality. The idea that new concepts of personhood can be introduced via psycho-medical developments in the last half-century appears strongly biased toward medical legitimization of embodiment, rather than discursive construction of identities. But drawing on biomedical intervention to achieve a culturally intelligible and shared sense of personhood is of course merely a means to an end for transsexuals because in order to be seen as a woman, one must first be seen as a transsexual and submit to medical authorities evaluating one's claim to womanhood. Ironically then, a transsexual must be 'seen' in a medical context in order to be 'unseen' in a social context.

This idea of being “seen as a woman” and not as a transsexual has been reiterated by participants in numerous ways. Despite the fact that Reese’s mom still slipped on pronouns, she hoped GRS would eventually help her “see” her as Reese. She also felt that cisgender women made a distinction between trans and non-trans along the lines of “you’re trying to tell me what it’s like to be a woman?” while men “don’t want to have anything to do with you because they think you’re gay” which suggests that women tend to question transsexual gender authenticity while men question transsexual heterosexual authenticity. Generally, Reese felt that people would see her more as a woman without a penis because “you’ve been validated by doctors, surgery” but on the other hand people might say “you want to sleep with men, that’s why you had surgery”. She felt the stereotypes were sexual either way. Reese felt that if people knew someone were trans, they judged their actions/behavior differently, especially doing something feminine or worse, offering a differing opinion on women’s issues: people would then say “how would you know, you’re not really a woman”. Reese would be disappointed if she was not seen as a woman in dating relationships or if her brother would insist that “we still think of you as our brother”.

Annie’s response to people openly inquiring about her was defiance. She asked people “what do you see?” whenever her gender was in question or whenever people asked “are you a girl?”. However, she was aware that some coworkers had heard rumors about her transsexual status and had doubts about her gender identity. Similarly, for Donna, GRS communicated “I am exactly what you see” rather than just being “a boy in a dress”. Deanne felt that if someone witnessed a transsexual person’s transition, it would be harder to see them as a woman. But if a person had only secondary knowledge about her transsexual status, Deanne, like Annie, would confront questions about her past by asking “what do you see?”. Lisa said that she once called a

person and her old caller id showed up on the dial and had mis-gendered her. Since then this person had been stuck on male pronouns; “just one reference” noted Lisa “created a male image immediately”. Although overall Elaine felt accepted, she had no dialogue with her brother who still saw her as a man. Dara felt that sex with her girlfriend was very important to her and that her girlfriend could now (post GRS) see her “how I want her to see me”. Kacey said “if I were truly considered a woman, the conversations wouldn’t be about being transsexual primarily”. For Kacey, those who did not speak about her transsexualism with her, at least not on a frequent basis, saw her as more of a woman. All of these examples speak to the idea that to be seen as a woman is complicated by social histories and not simply a matter of gender attribution or passing.

Gender, Genitals, and the Social Self: The Relational Nature of Identity and Embodiment

This chapter has tried to draw together how participants narrate their socially gendered histories into current social contexts, how they negotiate changing gender positionalities with those who, by way of kinship relations, have the most intimate and extensive knowledge about their pasts, and conversely, how they manage the social perception of their female identities with those who do not. As I have asked at the outset, how much significance does socially shared knowledge about past and present gendered embodiment hold in gendered legitimacy?

While GRS had no direct bearings on either disclosure models of participants’ differently gendered past, nor on the narrative strategies in renegotiating or affirming personal kinship relations, nor on the impersonal social perception of transsexual women’s identities as distinct from cross-dressers or other transgender individuals, the surgery nonetheless remains central to individual participants’ self-identification. Situating themselves socially as “not just a guy in a

dress” by constructing womanhood through narration, relationality, and perception management re-emphasizes that these are distinctly social and cultural processes which operate independently of the surgery; and yet, while the surgery in and of itself does not enable these processes, it enables trans women to articulate these from positions of self-affirmed legitimacy and authenticity. However, socially shared knowledge about differently gendered embodiment also limits transsexual women’s claim to womanhood with or without “trans” prefixes or modifiers; while participants may feel ‘complete’ through the means of surgery, this physical feat of completion also in-completes their social histories, leaving gaps, blanks, and grey areas via a language of exclusion. Moreover, within families where kin-relations anchor trans women’s experiences in shared memories of social histories, such gaps, blanks, or grey areas cannot be inserted to complete images of trans women as “just women”. As I have shown, kinship terms describing familial relations are resistant to gender change, and further, continue to shape just what kinds of gendered positions can be assumed — and by whom — in the most basic form of social organization.

Lastly, I want to reiterate that phenomenological interpretations, narrative accounts, and intersubjective contexts of transsexualism presume that such a concept of personhood is conceivable and perceivable in the first place. For transsexuals, what it means to be seen as a woman then is clearly a question beyond explicatory frameworks of the gender attribution processes ever since medical ideas about transsexualism have informed and transformed social ideas about personhood. As I have tried to argue, such ideas can be always be called into question because gender — and transgendered personhood by extension — is not about what can be known through seeing, but rather what can be known through perceiving. And while new medical technologies undoubtedly constitute an increasingly global impetus for seeing new

forms of embodiment emerge, perceiving new ideas about personhood remains a cognitive process distinctly regulated by changing cultural and social constructs over time.

Conclusion

GRS Past, Present, and Future

GRS as Social Capital

What do transsexual women ultimately expect to gain *socially* from GRS? As I reflected on this question during my last few days in Trinidad, I realized that perhaps I had been too critical in my own initial position on GRS; I was distrustful of the many overtly positive accounts of transsexual women in the past who claimed to live “happy ever after” lives post surgery. I had explained away the high success but low response rate of GRS follow-up studies by reasoning that only those patients who indeed experienced significant life improvements were responding to these surveys, and that many exaggerated these accounts as to avoid cognitive dissonance. As I started to fill my suitcases and bags with clothes, field journals, consent forms, books, and other stuff ethnographers drag to the field and back, I wondered whether questioning what social capital GRS might confer to transsexual women was productive at all in illuminating the cultural meaning of gender, genitalia, and biomedicine. Why would medically modified transsexual bodies produce any kind of social capital — valuable social relations which confer desired gains and benefits on the individual — when this is either already or not at all afforded to persons who live in and through them? What does GRS contribute to transsexual women attaining the social capital of being socially perceived as “just a woman” if their transsexual trajectories to womanhood defy this very claim?

When I asked participants directly whether they would disclose the fact that they had indeed undergone GRS whenever their gender was being put into question, my inquiry was met with a unanimously negative response. Not one participant felt that explicitly telling someone about their post-surgical status who was already doubting their gender identity as women could

be convinced otherwise. This particular consensus on the irrelevance of genitalia in affirming one's gender socially reveals perhaps most strongly what I have been trying to show throughout: gender is not a question of what kind of genitalia a person possesses at one time or another, nor is it simply a socially constructed product of masculine or feminine socialization. As the tropes of transsexual women's life experience show, gender is best thought of as socially gendered embodiment — that totality of corporeal engagement with the social, interactive world, that carnal diary which retains our social inscriptions. Knowledge of genital reassignment thus hardly confers any social capital at all; biological males do not become social women through this process because while medical procedures can change penises into vaginas, they cannot change the social histories which have been achieved with or through sexed bodies.

Yet, to wake up every day, as a transsexual woman had told me once, “feeling always a step behind everybody else”, but to take that step out of bed anyways, is nothing short of remarkable. Perhaps this is why transsexuals are so often praised as being “brave” and “courageous”, even if they don't feel that they have any other choice. But what sort of bravery or courage is wanting to live life as a woman or a man? What kinds of battles must be fought and won to claim a gender identity? And what, I wondered, is the price people pay when this is not a fight everyone — if anyone — can win? But there I was, waving good-bye to the victors who had fought their way through loss, rejection, marginalization, medical gatekeeping, all the way to Trinidad, and who were now returning home, feeling elated, grateful, and definitely happier than before.

As I have tried to show throughout this ethnography, although GRS is highly beneficial to the individual in terms of lessening or eliminating dysphoric feelings about one's body, it is expected to confer few social benefits in and of itself. The primacy of relieving persistent distress

about the body reaffirms the therapeutic potential of GRS in restoring a body-self unification, alignment, and completeness. Without a doubt, GRS accomplishes a profoundly psychological and somatic sense of relief from a life-long tension between the subjective experience of the body-self and the objective reality of gendered embodiment. The surgery thus remains psychologically and medically justifiable, and because of its life-enabling potential, it should by all means be considered a medical necessity for those who suffer life-disabling distress without it.

In only very few incidences was surgery explicitly conditional to increasing social inclusion, but not necessarily the social capital of acceptance or gendered equality: since bathroom use issues are mostly legal, policy-related matters, it cannot be argued that sharing a bathroom with women at work automatically means that transsexual coworkers are thereby more accepted. Especially when the right to shared bathroom use comes about by way of lawsuit or threat of such, social approval in places of employment may actually lessen, rather than increase. Similarly, the hopes that surgery increases possibilities for sexual or romantic relationships have the highest chance of realization when or if trans women are already in relationships or have partners who would accept them either way. For future relationships, however, the necessity of disclosure of one's transsexual status was often expected to prompt dismissal which is not necessarily dependent on the genital status of trans women, but her social history as having lived as a man. Within families, the surgery is expected to communicate seriousness and realness and is thus thought to confer more credibility to trans women, but on the other hand, the finality of the surgery could just as well achieve the opposite if the surgery represents as the ultimate "loss" of person, and moreover, the loss of relationships established within kinship or family structures. Social networks or interest groups which either welcome or reject trans women were thought to

be the least affected, especially since non-sexual or non-physical interaction is the area least affected by gendered embodiment. In short, as long as the resistance to accepting transsexuals as women in society is hindered by the social history they have achieved as men, or hindered by the cognitive ability to imagine the person as having lived as the opposite gender, their genital status is mostly irrelevant, and further, continues to deny transsexuals the claim to being “just women” even if they are no longer “just a guy in a dress”.

While pre- and post-operative statuses of transsexuals tend to retain medical and personal significance, it does not appear that they produce social significance. Not one participant was explicitly certain that GRS would change anything for transsexuals generally, even though most remained hopeful that their self-identification as women would engender their social identification as women. The distinction between the therapeutic effect of GRS for the individual and its social implication reiterate Claudine Griggs’ point that after GRS, transsexuals remain “women trapped in transsexual bodies” even if their self perception may change toward self-identification as women. As most participants did not see their transsexualism as a main aspect of their identity, but rather a medical process which enabled them to live safer, more confident, and more authentic lives, this process nonetheless remained something to be explained. GRS did not significantly contribute to participants’ gender identities which were already transformed via social transition even if it transferred a certain legitimacy of speaking from a medically and legally confirmed position of a woman.

However, throughout my work in Trinidad, many participants had related to me how lucky and grateful they felt when comparing themselves to less fortunate transsexuals; I got a sense of optimism and positivity towards life which seems almost paradoxical given most transsexuals’ life circumstances. I began to think that maybe academics, medical professionals,

or really anybody else who is not transsexual or transgendered, are doing trans people a great disservice by continuously anchoring their experience in pathos, struggle, and resignation. Thus I wish to re-emphasize that individually, many participants lead successful and satisfying lives in their own estimation which speaks strongly to the relativism of evaluating someone's life quality. And while follow-up studies reflect high levels of overall life satisfaction after surgery, it is important to reiterate that if *social* life satisfaction is already relatively high or low, GRS has little impact on changing it. In other words, individuals who either maintain or achieve high or low levels of social acceptance, support, inclusion, and integration during and after transition will benefit the least from GRS socially. This insight evokes the ethical proposition *Cui Bono?* Who benefits the most from GRS beyond statistical probabilities of individual surgical "successes"? This question, as I will discuss below, is not a question of medical justification or efficacy, but rather forces us once more to look — with an eye toward the future — at how transsexualism and its medical treatments are situated within contemporary culture.

The Next Generation: The Social Capital of Transgender Children

As the year 2011 nears its end, media reports on transgender children who are being raised by supportive families are on the rise. Concurrently, new medical treatments centering on puberty blockers for transgendered kids are increasingly finding support within pediatric and adolescent medicine (Zucker et al. 2011). Although the use of puberty blockers intending to ward off the onset of puberty in transgender kids is contested by some medical experts, it gives kids more time to decide whether more permanent treatments such as Hormone Replacement Therapy (HRT) are indeed the desired path into gendered adulthood. These treatments are not without health risks, and yet, medical practitioners are faced with an ethical question as to what would

cause greater harm: while these treatments have physical risks, withholding such treatments is likely to cause much greater psychological stress in children who have to watch themselves grow into biologically distinct males or females — these natural hormonal developments are difficult to “undo” later, should individuals turn out to be “truly” gender dysphoric after all (Ehrensaft 2009, Giordano 2008). To prescribe or not to prescribe is indeed a tricky decision and contains a shared responsibility of physician, parent, and children under the age of medical consent.

But while the medical focus on benefits and costs of puberty blockers rests, not surprisingly, on the individual and the individual’s body, the social benefits of either delaying gendered puberty combined with an early transition should be quite clear: if a transgendered child who expresses gender variant behaviors or a gender variant identity has the opportunity and the social support to live in the gender they feel themselves to be, this child would never achieve or build up a significant social history which will indeed “trap” him or her in it for life. As I have shown in the many examples in this ethnography, this child is likely to escape the problems of having a socially shared memory of gendered rites of passage, kinship roles, sex/love relationships, careers and employment, and gendered embodiment lived out in the “wrong” gender. I would take my hypothesis a step further by arguing that even if it were known that for example, a little girl was born a biological boy, and was raised as such until parents realized that their child was indeed transgendered, the relationships which are primary, at least until the onset of puberty, are based on age differentiation, and not so much gender differentiation. That is not to say that adults do not treat boys and girls differently from the day they are born - they most certainly do. However, gender differentiation tends to matter much more when a) children begin to express distinctly gendered behaviors and b) sexual maturity sets in. In addition, gender-variant behaviors in childhood are easily explained away by the naturalness of children exploring

our gendered world, and transgressions are, at least nowadays, much more easily forgiven in childhood than adulthood. Nonetheless, even if there is now much more tolerance for gender-mixing behaviors of children or even young adolescents, transgender children are still highly aware of gendered identities and behaviors at an early age; something adults often find troubling, especially when children make comments about genitalia or other sexual aspects of bodies. But herein also lies the potential for recognizing the distinction between gender playfulness and gender pain — although transgender children are arguably just as explorative as any other child, an observant parent will eventually realize that transgender children will consistently reject what they can understand as being associated with the gender they don't feel themselves to be.

It is of course both fortunate and unfortunate that both medical professionals as well as parents recognize that all children at some point “play at gender”; while this is considered an important aspect to discovering the gendered world we live in, for transgender children, the notion that they are “just playing” with gender can be detrimental to that very same sense of development. If such children are being denied either sincerity or credibility, or if they are outright denied any such explorations of their own gender identity, the only thing children really learn is to withdraw as to avoid punishment — in the extreme case, so-called “reparative” or gender-role conforming therapy. And although Marci Bowers believes that “genitals tell us who we are every day”, I believe that genitalia alone do not determine who we feel ourselves to be as people — without distinctly social interpretations of genitalia, they simply steer us into sexual preferences, practices, and desires, nothing less, nothing more. Gender on the other hand, is a much more complex human experience, and notions of gendered identities, expressions, roles, and attributes change all the time, and are cross-culturally not always based on natal sex, genitalia, reproductive capabilities, or sexual utilizations of these.

To advance a hypothesis on the future of transsexualism and GRS, I presume that based on current evidence, transgender children who are allowed to transition early and within a supportive environment have the best chances of growing up as socially and psychologically well adjusted adults. Even if surgical or hormonal interventions may not happen until puberty, growing up as boys or girls and building social relationships as such would greatly improve their situations as adult men and women. Further, when people have an opportunity to watch a transgender child grow up socially no different than cisgender children, the social history disjuncture transsexual adults experience is likely to be minimized. This is especially true in adulthood, when sets of social groups are likely to have changed, individuals who have only experienced a differently gendered childhood for a relatively short period of time, have the best chances for normal social lives and relationships. And even if people are conscious that these individuals as children, or perhaps even as young adults, have had or still have differently sexed bodies, the social engagement of these sexed bodies is likely to matter far more than their biological reality to social interactions. For transgender children, being able to grow up in their desired or preferred gender is just as beneficial as for example letting disabled children experience “normal” childhoods by way of minimizing their physical limitations and maximizing their social inclusion because as children build relationships with others, participating in cultural rites of passage into adulthood is important in enabling children to achieve a more secure and socially integrated self image. Most importantly, transgender children would be spared the wistfulness many adults experience as they would not have to “miss out” on life as much if at all.

Nadine, my youngest participant, as well as other younger trans women’s experience strongly confirm this projection. Because Nadine never experienced “male” puberty, and lived in a fully supportive household, she shrugged off most questions about integrating her past and

present as there was little to integrate. She had felt little anxiety about teenage-hood and had practically no idea how to use a razor on her face or what boys did or talked about when no girls were around. Nadine also never questioned herself openly expressing crushes on teen idols or movie heart throbs because as a sexually inexperienced person, she did not worry that such expressions could be interpreted as homosexual desires. She had only vague memories of being a little boy because her family let her explore and find a gender identity which was more comfortable for her. And although Nadine lived an arguably sheltered life, spending most of her time within family contexts by choice, she couldn't recall a single instance of having experienced *interpersonal* stigmatization, even if she and her family did experience at least some instances of *structural* stigmatization such as difficulty finding a school to enroll in, and locating a doctor who would prescribe puberty blocking hormones for her.

Other youngsters like Elsa, Rhonda, Gill, and Sia, although only 4 to 5 years older than Nadine, had similarly received a lot of family and especially parental support after coming out, but they did not transition as young as Nadine did, and had experienced a “normal”, but troubled male puberty which resulted in depression, isolation, and withdrawal from social life. Despite sharing Nadine's early onset of gender dysphoria, these individuals had already begun to establish male social histories as teenagers and young adults, physically as well as socially. And although they had different individual maturity levels, as well as different attitudes toward being “out” or “trans” identified, the fact that their transition occurred within already established social contexts in which they could — arguably — always be read as male and by extension as transsexual, fundamentally distinguished them from Nadine and even younger transsexual children growing up as we speak.

GRS Patients Then and Now: From Christine Jorgensen to Kim Petras

In 2009 16 year old German native Kim Petras became the world's youngest transsexual to have undergone GRS (Davies 2009). Since her surgery in Germany, others have followed suit; in England, for example, two teenagers were able to undergo GRS at the same age and one had her surgery paid for by the British Government (NHS). The media coverage of Jorgensen and Petras reveals similar yet different portrayals beyond the obvious 60 year span between their stories: while Jorgensen's photographs portray a serious, restrained, middle aged woman, Petras' images over-emphasize youthfulness, playfulness, and a distinctly modern teenage attitude. Yet, since both Jorgensen and Petras sought out a rather public life as entertainers (Petras is an aspiring pop star), their portrayals similarly emphasize glamour, style, and hyper-femininity. However, they transitioned in very different times and parts of the world, they had very different sources of support, and quite a different media reception. While Jorgensen was a sensation because she was the first, Petras was a sensation because she was the youngest person to undergo GRS.

Predictably, both media coverages focused the story on the "before-and-after" template I discussed earlier. However, while Jorgensen's template describes a "man to woman" trajectory, Petras' describes a "boy to girl" trajectory. Although the narratives are similarly focused on having been born in the wrong body and having suffered from such embodiment since early childhood, Petras' representation involved her parents recognizing her transsexualism and supporting her plea to live as a girl (she was put on puberty blockers and later hormone replacement therapy). This is a remarkably powerful differentiator because it invokes a great deal of compassion for a case of an innocent little boy who is believed to suffer involuntarily from something he does not quite understand. In Jorgensen's case, however, the internal suffering was mostly overshadowed by her self-recognition and identification as transsexual, and by her

previous adult male achievements, especially after her supposed “intersex” justification for the surgery was revoked and her sex change was declared a “hoax” (Meyerowitz 2002). Jorgensen was quickly reduced to a “male transvestite” and her motives for reassignment surgery were instantly questioned — subsequent stories about Jorgensen focused almost exclusively on her male past, discrediting claims to innate womanhood she had laboriously constructed. Petras stories however, lend a primary credibility to her identity as having “always been a girl” precisely because her feminine behavior and insistence that she was a girl had been *witnessed* since she was little, and furthermore, her story had been given social, medical, and now public media legitimacy early on.

But even more interesting is the differential impact of before-and-after pictures between Jorgensen and Petras: Jorgensen is shown as an adult man and Petras as a little boy. While Jorgensen is shown unambiguously male, in distinctly male clothing such as her GI uniform, Petras looks very gender ambiguous as most small children do. The transformative effect from almost gender neutral to feminine is thus minimized in Petras case while the effect from distinctly masculine to distinctly feminine is maximized in Jorgensen’s case. But while masculinity and femininity are clearly prominent in visuals presented, the real reason why adult transsexual transformations are more focused on before-and-after templates is this: these images are supposed to invoke ideas not just about a gendered person, but a sexual person. In Petras’ case, the viewer sees — or is supposed to imagine — a non-sexual and thus innocent child while in Jorgensen’s portrayals the viewer sees — or is supposed to imagine — a sexual man with deviant (homo)sexual past.

Another interesting aspect about media stories about transgender children is that although most are hyper-feminine or at least are drawn to hyper-femininity and girliness, many do not

appear to deliberately want to hide their transsexualism or go stealth. For example, in almost all “typical” documentaries on transgender children such as Barbara Walter’s *20/20*, especially parents are remarkably “out” and outspoken about having a transgender child and many wish to raise awareness about transgenderism. So here it seems that these kids clearly long to be no different from their natal peers but they are seemingly comfortable with social knowledge about their transgender status. And of course, it would be rather difficult for an 8 year old child to construct a consistent narrative of “stealth”. What is different for transgender children however, and my point here, is that it is not the knowledge of their male genitalia but the social relationships established which determine how well a transgender child adapts to growing up. Indeed, it almost seems that the more gender normative (in their desired gender) transsexual children are allowed to grow up, the more confident and comfortable they may be with sharing or disclosing their transsexualism. Here again it is the participation in gendered every day life and cultural rites of passage which matter more than genitalia to social integration. Although transgender children may be just as uncomfortable with their bodies as adults and may express the same urgency to be rid of their male genitalia, the embodied history which adults have achieved with and through such bodies is mostly absent in children or teenagers’ lives.

One final aspect of transgender children who transition early and who are able to obtain the surgery as soon as they reach the legal age deserves consideration here. In a media analysis of transgender murder cases Schilt and Westbrook (2009) show that “discovery” of trans person’s “true” gender or sex, tends to frame the trans person as a “deceiver” (see also Bettcher 2007) because genitalia which do not match a trans person’s gender presentation are seen as the main culprit to inciting (mostly male) violence, especially if sexual contact had occurred before

genitalia were “discovered”. However, the authors note that between 1990 and 2005, only six post-operative trans women were murdered compared to 232 pre-operative ones:

None of them were said to have been killed because they “deceived” their sexual partner about their “true gender.” Journalists do not use the deception frame to explain the murder of postoperative transwomen, as they possess the “correct” biological credentials to do gender as women in sexual interactions. In contrast, journalists portray transwomen who have not had genital surgery as being truly men and, as such, engaging in a double deception—about both their gender and sexual orientation—if they have sex with heterosexual men (456)

This idea that GRS can provide physical safety upon “discovery” is certainly not a novel idea, however I question whether having “correct” genitalia would actually save a transgender person’s life whose gender is already in question; trans man Brandon Teena’s social history had been “discovered” by his murderers before his genitalia were exposed, and while phalloplasty might have prevented his rape, it probably would not have prevented his murder. In Teena’s case, however, the murder motive was not just transphobia or homophobia, but raging male jealousy as Teena’s last love affair had been with a girl whom one of his murderers coveted. The real “discovery”, in my opinion, which motivated his killing, was that the he was able to sexually engage heterosexual women as a man without possessing male genitalia which posed an ultimate threat to his killers’ own insecure sense of masculinity.

But the point I want to make is not about whether discovery of “correct” genitalia can save a transgender person’s life or not, but rather that violence motivated by discovery is not about genitalia per se, but rather about what they have been “used” for, i.e. the social history of genital and gendered embodiment. Here again we see a major difference between transsexual children and transsexual adults in before-and-after media templates: because transsexual children are presumed to be sexually innocent, genital reassignment is divorced from sexual desire or even sexual deviance whereas transsexual adults already — or presumably — have a socio-

sexual history; children's genitalia are thus "innocent" while adults' genitalia are "guilty". This implicit sexualization of adult transsexuals colors the public perception of genital reassignment surgery as motivated by *sexual* normalcy, whereas the implicit de-sexualization of transsexual children frames the surgery as motivated by *gender* normalcy. Especially pre-pubescent transsexual children are exonerated from sexual motivations and given a "virginal" gloss of innocence. While transsexual adults are thus seen to engage in "double" deception (gender and sexual), transsexual children are never seen as deceivers because they are expressing their "true" gender openly, and do not yet have a sexual history, orientation, or motivation.

This comparison of media portrayals between transsexual children and adults reiterates my hypothesis that if children are given the opportunity and support to grow up in their preferred or desired gender and have thus the opportunity to accrue social capital in the process, they will be spared much of the sociogenic suffering which adult transsexual adults must manage throughout their lives. Transsexual children could possibly circumvent a primary or social identification as transsexuals by never experiencing the trauma of pubertal development into adult males nor would they have to suffer the trauma of forced socialization into adult men. This social potential, I think, is the most convincing scenario medical professionals, child psychologists, and most importantly parents should consider when confronted with the counter-arguments against puberty blockers, hormone intervention, and GRS, based on the probability that gender variant or non-conforming children might "change their minds".

So where does this leave my participants, many of which transitioned well into adulthood? As I have shown, the troubles with social acceptance which predominate the adult transsexual's experience, are rarely just based on physical difference even if in some cases, genitalia are directly responsible from barring transsexuals from gender segregated spaces

involving nudity. But again, the problem is much more about the fact that transsexuals never grew up having had access to these spaces *in the first place*. For most adult transsexuals, the hope for greater social tolerance of transsexuals or gender variance in general remains key. But, as I have asked earlier, what does increased tolerance for gender transgressive expression and behavior mean to gender-conforming transsexuals? Would transsexual women really be happier if nobody cared about any and all types of gender transgression or if gender ambiguity was completely acceptable? My answer would be that a gender queer paradise might have a great appeal for transgender identified individuals who are primarily unsatisfied with not being able to express gender fluidity or androgyny but it would be no paradise for unambiguously gendered transsexuals at all. This is because what most transsexuals suffer from is not *not* being permitted to be gender ambiguous, but rather they are not permitted to be unambiguously gendered as cisgender society keeps demarcating boundaries between cis and trans. What is denied to them socially is corporeal authenticity and gender “normality”, even if biomedicine covertly implies that transsexuals can individually obtain just that.

Many of my own participants rejected acceptance based on “tokenization” as this continues to re-emphasize, not de-emphasize the difference between cis and transgender. Participants also rejected special treatment, special laws, or any other type of special status assigned to them *because* of their transsexualism — their political aims were clearly aimed at civil rights equality and not just inclusion in protective statutes such as the ENDA (Employment Non-Discrimination Act). Their focus throughout transition and presumably after GRS was on negotiating how to divorce themselves from the “liminal” status of transsexualism because it was not part of their core identities. This is also why so many objected to being the subject of sensitivity training. Thus, without explicitly denying their transsexual past and without attempts

to go stealth, participants were overwhelmingly focused on being accepted as women, and not transsexuals. Social acceptance then was not about removing their male clothing, legal document markers, stereotypically male behaviors, masculine body shapes, and ultimately their penises, but rather about removing transsexualism itself as a barrier to social inclusion and equality.

Not Just a Guy in a Dress: Womanhood Redux

What does GRS ultimately contribute to “graduating” to womanhood from having lived the life of a man? At what point in transition is a transsexual woman no longer “just a guy in a dress”? As I have discussed previously, many participants’ self identification as women was not just against identification as men, but against cross-dressers who merely “play” with gender subversion or reversal and who do not adopt permanent identities as women, and against transgender identified individuals who wish to purposefully upset or challenge the gender binary through gender ambiguous embodiment. Although passing as women is commonly thought to evade identification as men, passing as a woman-identified transsexual rather than a male-identified cross-dresser is equally important once or if passing as “just a woman” fails.

Because transsexuals, at least in the beginning of transition, may be visually indistinguishable from cross-dressers, later on in life transsexual women often make a more conscious effort to emulate the casualness of what women wear every day. Women’s clothing as a major identifier of gender is often de-emphasized or loses appeal for transsexuals throughout transition; indeed, some participants mentioned that they are more comfortable now wearing casual, not overtly feminine clothing such as jeans and t-shirts. For cross-dressers, however, clothing remains the key aspect to self and other identification, and because dressing is temporal

and often fantasy inspired, oftentimes clothing tends to be overly dramatic or hyper-feminine - and dresses in particular hold an extremely high appeal in cross-dressing wardrobes.

I have always found it interesting that after the effects of hormones begin to show, some transsexual women begin to read their own bodies as sufficiently feminine, especially developing bust lines, and wear revealing or tight clothing which can have a negating effect if their basic male frames still predominate their overall appearance. Just like cross-dressers can appear as “just a guy in a dress”, hormonally developed breasts can make transsexuals look like “just a guy with breasts”. In the same sense, I have often thought about what actually would happen if, after GRS, participants freely moved around naked in all-women’s environments because they felt that genitalia would hold primacy over their other anatomical features in gendering them. What would happen if post-operative transsexual women were read as “just a guy with a vagina”? While the desire to distinguish oneself as more than just a guy in a dress materializes itself in pervasive attempts made through clothing choices, hormonal body modification, facial feminization surgery, breast enlargements, electrolysis, and ultimately GRS, without explicitly exclaiming one’s identity as distinct from others, such misreadings are always possible.

For some participants, GRS provided the cognitive rationale for justifying their identities as “just” women, but almost all felt obligated to disclose a transsexual status sooner or later, especially to sexual or romantic partners. Interestingly, most were acutely aware of the media frame of transsexuals as “deceivers” although of course, none felt that they were deliberately “deceiving” anyone by identifying as women. However, since the media discourse of deception has found its way into their own narratives, a few also stated they would feel deceived themselves if a transgender person did not disclose to them; participants felt people had a “right to know” which is why they felt morally obligated to disclose, and not purely for safety reasons.

Aside from feeling safer in sexual situations because it is, as Joanna mentioned “harder to be rejected if you have the right parts”, many participants felt confident enough in their new sexual embodiment to pursue their sexual motivations, attractions and desires *as* women. However, the challenge of disclosing one’s embodied physical history is perhaps just as challenging as disclosing one’s social history alone; the fear of “what’s down there”, as Rose noted, is not necessarily alleviated by disclosing one had genital reassignment surgery.

Those who were in existing relationships now had the task of either reintroducing sexuality as a genital females into the relationship, or exploring sexuality in their new bodies or with their new body parts. Although intimate partners are perhaps most understanding of their partners as not “just a guy in a dress”, they may also be the most resistant of seeing them as “just women” now. The shared past imagery and experience of bodies, especially in sexual contexts, is unlikely to not ever enter into the present. On the other hand post-surgical bodies do behave decisively different in practice especially if penises served as physical boundary markers and were thus either ignored or de-emphasized in sexual activity. In this sense, GRS provided the much yearned for sexual freedom of bodily expression. Here perhaps lies the greatest social, or I should say sexual capital in GRS: to engage physical bodies as gendered selves, a possibility often denied to, or uncomfortable for transsexual women pre-operatively. Post-surgery, sexual options not only in partner choice but also in sexual practice tend to open up. For instance, Sonya wanted to experiment with “topping” her girlfriend wearing a strap-on dildo, something she would not have liked to do with her own penis because sexual acts tend to gender, even just temporarily, both partners engaged. However, her desire to top or dominate her female partner sexually with a strap-on did not challenge her own or her partners perception of her as physically female and socially gendered as a woman. The strap-on also rendered the (future) sexual act as

essentially lesbian, while penile penetration would have gendered it as essentially heterosexual. All in all, GRS may have the greatest social capital in rendering social selves as sexual selves, but not so much by what they add to sexual embodiment, but rather what they take away; and because sexuality and sexual acts are commonly subject to and analyzed from a phallogentric perspective, the claim to physical womanhood is perhaps most dramatically amplified by losing the ultimate claim to physical manhood.

The Future of GRS: Post-Modern Constructs of Gendered Personhood

In an increasingly post-modern imagery of the world, fragmentation, hybridization, temporality, and spatial contextuality of identities are quickly becoming the norm rather than the exception. Cyborg identities, medical consumerism, plastic surgery as a life style, and biotechnological bases of body modification are rapidly changing our ideas about our biological limitations of who we are and moreover who we can become through biotechnology. Yet, even as we acknowledge these distinctly modern notions of existence, we give humanistic primacy to what is generated inside ourselves, originated by independent thoughts and feelings, and expressed in idiosyncratic ways. Biotechnologies, especially body-modifying medical advancements aid our human expressions and sometimes they make them possible in the first place. The modern medical practice of genital reassignment is no different in that it enables subjectivities which surely would exist as ideational constructs, but not as material realities; and while the desire to change one's sexed anatomy has most certainly existed before modern medical advancements made this possible, I have to agree with Hausman that the medical possibility of genital reassignment did create the distinctly medicalized subject of the pre- and post-surgical transsexual.

So what about the future? Are there always going to be individuals who want to change their anatomical sex? Or is the modern transsexual subject, like all other historical subjects, just an effect of a temporal world system based on rigid structures around which one must work to fit into? Are transsexuals actually products of the gender binary system rather than antithetical aberrations of them? If the answer to this question is yes, then logically, dismantling the system into total gender freedom or gender chaos would make transsexuals invisible: if there are no gender “poles” to migrate from and to, or if the sex/gender match would no longer hold any significance whatsoever, the yes, transsexuals would not exist. But on the other hand, perhaps the exact opposite would be true: transsexuals would still exist because they feel so strongly about belonging to one or the other gender that they would be the last “gender defenders” even if the whole world turned queer. Any each way, transsexuals by virtue of transformation or transition disturb whichever social convention prevails (gender rigidity/gender chaos) and it is unlikely, I think, that paradigm social changes concerning our current sex/gender system would eradicate transsexualism as a phenomenon.

Future research endeavors on transsexualism and genital reassignment need to consider that since more and more transsexuals are beginning transition at a younger age, they are also likely to undergo surgery much earlier in the future if, as my data suggests, the average time from coming out to GRS stays at the rate of about 5 years. If patient ages would drop on average 20-30 years, I would hypothesize that this would transform our knowledge of transsexualism significantly, both in terms of clinical as well as social science research. This shift would provide researchers with an excellent research incentive to not only study *longer* long term effects of GRS, but more importantly, to compare the effects of social stigmatization of transsexuals past and present. What is ultimately so exciting about this possibility is that it could become a

precedent case in showing just how much sociogenic psychological suffering could be prevented by biomedical intervention. Moreover, we could finally have an empirical basis to estimate how much suffering associated with GID is intrinsic to the condition or induced via social stigma by comparing transsexuals' life history experiences past and present. This notion also reiterates that medical intervention for transsexuals could be at once critical at a certain age, but mostly ineffective at other times; in many cases of my own participants, many would have benefitted from the surgery the most when it was least accessible for them. Of course, I am not advocating to throw all caution to the wind by letting transsexual children transition carelessly; I do recognize that medicine has a primary obligation to protect the individual from harm, and children pose a special concern to medicine always. However, since we have already seen over 6 decades of negative effects of denying transsexuals of all ages medical and social support to live in their desired gender, with suicide ideation estimates nearing 60 percent, the ethical question for medical professionals working with transsexual children must center on taking the risk of early, but closely supervised treatment, in supporting children's self-determined sense of gender.

I would furthermore speculate that the true potential of GRS for transsexuals in the future thus stands to have far less significance than it has today as it will likely be performed on young people who have never known the harsh reality of first living in the "wrong", and then "in between" genders. For those who are permitted to express their gender identities early on, surgery may lose its meaning as a rite of passage to womanhood or manhood. If it may no longer be unusual for a 16 year old teenager to undergo what today is still a relatively rare surgery, GRS might no longer hold the public audience captive as it did in the first few decades of its media entry. If there are no longer "GIs" who "become Blond Beauties" but instead, ordinary 16 year old girls who are medically aligning their genitalia to match the only gender they know

themselves to be, and the only gender they have ever been socially, there is hardly a before-and-after story to be told.

Certainly, some problems would remain for transsexual children and their parents. Transgender children would still have to cope with teasing and ostracism based on their genitalia, in addition to enduring their own discomfort. Parents would still be criticized for supporting what is essentially gender non-conforming behavior for which other kids are routinely, if subtly punished as part of their proper gender enculturation. However, as one child psychologist once asked parents of transsexual children: “would you rather have a dead son or a living daughter”? Sadly, in the past, many parents chose the former by abandoning, shunning, and excommunicating their transsexual offspring, but this attitude is changing: especially now that parents see solutions to what is still, nonetheless, a social problem for adults, but which their children might be able to circumvent if they seek — and get — help early. But today’s parents are also products of a generation who has now grown up with exposure to transsexuals, at least through the media. And just like transsexuals of earlier generations recognized themselves in stories about other transsexuals through media exposure, parents nowadays realize they are not alone — from specialized family therapists to medical experts to support groups, there are lots of resources available to them. Yet, parents are still often at a loss on how to address the socio-cultural issue of having a transgender child in the family, and the metaphorical loss of a son or a daughter is often central to their own suffering, even though they did not literally “lose” a child.

Another problem for parents and transgender children remains the cultural meaning of puberty in young adulthood. What kind of puberty — on puberty blockers — is *no* puberty? As transgender children keep developing mentally and physiologically, but not hormonally, this experience and its effects are still unknown territory for pediatricians and child psychologists

alike. Do children on puberty blockers experience sexual awakenings? Do they experience any significant physical change other than growth and weight gain? How do they relate emotionally to other pubescent teenagers? These are not only questions for medicine, but also for social scientists. And just what kind of relationship do trans kids who grow up in their desired gender have with their genitalia? Surely, the *genital* dysphoria may remain similar to that of adult transsexuals, but what about the absence of *gender* dysphoria? Can we still diagnose these kids with GID if the child is well adjusted in his or her social role and social network? What I am certain of, however, is that there would be no longer a justifiable rationale to deny GRS to a person who has no social history as or in the other gender. Indeed, denying vaginas to girls with penises who have never been boys seems to work against the hippocratic oath of “do no harm”.

These and many other questions remain open for discussion. Although the numbers of GRS surgeries are rising, the numbers of transgender individuals are rising at even greater rates, and of those, many chose not to have GRS or any other kind of surgery. While some might interpret this as a loosening of gender norms or increased genito-sexual flexibility, I do not believe this is the case because increased tolerance for gender non-conformity does not alleviate the strong and persistent desire to become or live as the other gender, nor does it make transsexuals more comfortable with their natal bodies, at least for now. For them, genitals continue to matter, individually as well as socially — and there is no indication that GRS will cease in frequency of surgeries performed, nor in the intensity of its demand no matter what the current notion of gender flexibility or rigidity is.

The research horizon on the future of GRS is vast. I would predict that if the number of transsexual adolescents as primary GRS candidates predominates its surgical demographic, GRS may one day no longer be performed on transsexuals, but rather on ordinary young women who

happened to be born with penises. Because transsexualism remains an inherently social problem based on changing social relations while maintaining a socially shared history, changing the emphasis on having lived as *two genders in one sexed body* to having lived as *one gender in two sexed bodies* would drastically transform modern day notions of transsexualism, GID and its treatment. As I have argued, a person who has experienced the social trajectory of a girl and a woman can only be considered a transsexual if she changes both, her gender and her genitalia, and in the process, has to re-gender her entire social relationality. Even if it were known that she has male genitalia, but no male history, neither a social marker of transsexualism nor a medical diagnosis of GID would be warranted unless the diagnosis *only* centers on distress about one's genitalia and the desire to change these. Finally, a person who simply wishes to reassign their genitalia but not their gender would hardly have to go through the "real life test" — transgender children don't have to "prove" that they can "function" as the opposite gender if they never "functioned" in their gender assigned at birth in the first place. Considering the future of GRS then, leaves me to conclude that there will always be GRS patients, but they may not all be transsexuals who seek distinction as women over being "just a guy in a dress".

APPENDIX I

Patient Profiles

For the brief profiles below, I have chosen the following ethnic identity abbreviations:

C = Caucasian, B= African American, A = Asian American, L= Latina, M = Mixed

Race/Ethnicity:

Annie: A, 28, Nurse, Texas. Full time: 5 yrs. Annie came alone

April: A, 26, Software engineer, Colorado. Full time: 1 yr. Came with parents, uncle

Audrey: C, 28, Computer programmer, Texas. Full time: 2 yrs. Came with Mother

Betty: C, 67, Computer technician, Texas. Full time: 2.5 yrs. Parent. Came with wife

Carla: C, 29, Student (current), Florida. Full time: 3 yrs. Came with girlfriend

Carly: C, 55, Physician Assistant, Oregon. Full time: 5 yrs. Parent. Came with partner

Dara: C, 59, Bus Driver/Musician, Minnesota. Full time: 5 yrs. Came with girlfriend

Deanne: B, 37, Restaurant Manager, West Virginia. Full time: 20 yrs. Parent (ad.) Came alone

Donna: C, 65, Insurance Sales, Florida. Parent. Full time: 5 yrs. Came with wife

Doris: M, 29, Computer Tech, Texas. Full time: 2 yrs. Came with friend

Elaine: C, 56, Business Marketing, Hawaii. Full time: 3 yrs. Parent. Came alone

Elsa: C, 20, Student, California. Full time: 1 yr. Came with mother and boyfriend

Emma: C, 45, Security Officer, Texas. Full time: 15 yrs. Came alone, had friend pick her up

Felicia: M, 59, Engineer/Sales, Colorado. Full time: 15 yrs. Parent. Came with friend

Gill: C, 22, Student, Colorado. Full time: 2 yrs. Came with mother and sister

Haley: C, 45, Hair/Make up Artist, Minnesota. Full time: 12 yrs. Came alone, had friend visit

Jane: C, 57, Real Estate Broker, Minnesota. Full time: 2 yrs. Parent. Came with friend

Jean: C, 45, VA disability, Washington. Full time: 4 yrs. Came alone

Jenna: C, 62, Computer programmer, Texas. Full time: 3 yrs. Parent. Came alone

Jesse: C, 29, Student/Programmer, Tennessee. Full time: 3yrs. Came with wife

Joanna: C, 27, Administrator, California. Full time: 2 yrs. Came with mother

Joyce: C, 47, Retired, Colorado. Full time: 3 yrs. Parent. Came with husband

Kacey: C., 55, Teacher, Massachusetts. Full time: 1 yr. Parent. Came with sister

Kellie: C, 43, Mortgage Specialist, Missouri. Full time: 2.5 yrs. Came alone

Kelsey: C, 57, Nurse. California. Full time: 1 yr. Came alone

Lana: C, 55, Art Dealer, Georgia. Full time: 2.5 yrs. Parent. Came alone

Leah: C, 51, University Professor, Idaho. Full time: 2 yrs. Came alone

Lisa: C, 52, Computer Tech, Colorado. Full time: 3 yrs. Parent. Came with wife

Luna: L, 44, Researcher, Kansas. Full time: 1 yr. Came with sister and mom who left after GRS

Maria: C, 37, Realty/disability, Colorado. Full time: 9 yrs. Came alone

Mary: C, 58, Bank Customer Service, Chicago. Full time: 2 yrs. Came alone

May: C, 27, Student, Mental health Clinic, Alaska. Full time: 5 yrs. Parent. Came with friend

Mia: C, 34, Snow Groomer, California. Full time: 2 yrs. Came with parents

Nadine: B, 18, Student, Connecticut. Full time: 3 yrs. Came with her father

Nancy: C, 55, Law Enforcement, Colorado, Full time: 2 yrs. Parent. Came with wife.

Pam: C, 52, Medical Aid, Washington. Full time: 2 yrs. Came alone

Peggy: C, 57, Oilfield Worker, Wyoming. Full time: 1.5 yrs. Parent. Came alone, picked up by friends

Reese: C, 29, Teacher, Massachusetts. Full time: 4 yrs. Came alone

Rhonda: C, 23. Student. Texas. Full time: 4 yrs. Came with mother

Rose: C, 44, Attorney, Texas. Full time: 2 yrs. Parent. Came with friends

Ruby: M, 63, University Professor, Texas. Full time: 1 yr. Parent. Came with partner

Sia: M, 22, Student, Minnesota. Full time: 2 yrs. Dropped off/picked up by parents

Sonya: C, 34, Art teacher, New York. Full time: 3 yrs., Parent. Came with her girlfriend

Susie: C, 65, Retired/disability, Washington. Full time: 13 yrs. Parent. Came alone

Tina: L, 57, Maintenance Tech, California. Full time: 16 yrs. Parent. Came with wife

Tracy: C, 28, Solar Panel Manufacturing, Colorado. full time: 1.5 yrs. Came with boyfriend,
parents visited, friend visited

Trish: C, 41, Teacher, Minnesota. Full time: 1.5 yrs. Parent. Came with girlfriend

Vicky: C, 58, Unemployed, Washington. Full time: 2.5 yrs. Parent. Came alone

Violet: C, 65, retired Military, Wyoming. Full time: 1 yr. Parent. Came with brother.

Zoe: C, 64, Retired, Colorado. Full time: 3 yrs. Parent. Wife dropped her off /picked her up.

APPENDIX II

Interview Questions

Interview 1

1. Theme: Getting to know the Patient. Obtain general patient views about meanings of GRS, expectations of effects on various areas of life.

2. Central research questions:

- a) What does undergoing GRS mean to transsexual patients?
- b) How would undergoing GRS affect patient's future lives?

A) Please tell me a little bit about yourself.

Prompts:

- Where are you from? How long have you lived at your current residence?
- What do you do for living?
- Are you married? Do you have children?
- What are your personal interests/hobbies/passions?

B) I am interested to learn more about your thoughts on genital reassignment surgery. What does undergoing genital reassignment surgery (GRS) mean to you?

Prompts:

- Do you see undergoing GRS as a significant physical or mental change in your life?
- What kinds of hopes and dreams have you invested in undergoing this surgery?
- What other kinds of life changes would you compare GRS to?
- How long have you wanted to have GRS?
- What does GRS symbolize for you in terms of your transition?
- How important is undergoing GRS to you?

C) How would you say will undergoing GRS affect different areas your life?

Prompts:

- Do you feel it will have an impact on all areas of life?
- Your family including children, parents, siblings, other relatives?
- Your spouse/lover/partner?
- Your friends/social environment?
- Your work/career?
- What areas, if any, would be most or least affected and why?

Interview 2

1. Theme: Conceptions of, and experiences with social stigma.

2. Central Research Question: How do transsexuals experience social stigma?

A) Most of my questions today deal with the relationship between transsexualism and stigma. To start off, I'd like to ask a really broad question, namely what comes to mind when you think about the relationship between transsexualism and stigma.

Prompts:

- How would you define stigma?
- What does stigma mean to you?

B) How would you say does stigma affect transsexual or transgendered persons?

Prompts:

- Are some of the ways that stigma affects transsexual persons more problematic than others?
- What would you say are some of the more problematic ways that stigma affects transsexual persons?
- The most problematic way?

C) Are there different types of stigma, for example institutional and interpersonal stigma which affect transsexual or transgendered persons?

Prompts:

- Can you describe some instances of institutional stigma, for example being denied health care services, financial services, educational or economic opportunities, etc?
- Can you describe some instances of interpersonal stigma, for example public ridicule, embarrassment, social distance, avoidance, overt or covert prejudice, discrimination, etc.?

D) Do you think, in comparison to other transsexual or transgendered individuals, that you experience more or less stigma than they do?

Prompts:

- Why/Why not?

E) Do you feel that undergoing GRS could lessen the degree of stigma experienced?

Prompts:

- Why/Why not?

F) What, if anything, do you think could mediate stigmatizing experiences of transsexuals or transgender individuals?

Prompts:

- For example, Sensitivity Training? Public Education? Positive Media Exposure?

G) Do you feel that transsexual or transgendered persons stigmatize other transsexual or transgendered persons?

Prompts:

- Do you feel that there exists a “hierarchy” among transsexual or transgender persons in terms of being further along in transition?

Interview 3

1. Theme: What are the benefits of GRS?

2. Central Research questions:

- a) The benefits and disadvantages of GRS
- b) Does GRS resolves/treat/cure Gender Identity Disorder (GID)?
- c) Are transsexuals or transgendered persons still transsexual or transgendered after GRS?

A) I am interested in learning more about the benefits of GRS. Could you please tell me any and all benefits or advantages of GRS, as well as disadvantages if you perceive any.

Prompts:

- Broadly: legal, medical, financial/economic, functional, aesthetic, reproductive, etc.

B) What are your thoughts on GID?

Prompts:

- How do you feel about the GID diagnosis?
- Does GID describe how you feel about yourself?

C) Do you think that GRS resolves or treats or cures GID?

Prompts:

- Generally speaking, do you think that GRS is the best/only/most appropriate “cure” or treatment for GID?
- How much of GID would you say is attributable to feeling dysphoric about your body/not having a female body?
- How much of GID would you say is attributable to feeling dysphoric about not being able to live socially in your gender of choice?

D) How would you define “transsexual” or “transgendered”?

Prompts:

- How does GRS inform a person’s transsexual status?
- Why would/wouldn’t GRS eliminate one’s social or medical status as a transsexual?

- How would you feel if people would refer to you as a transsexual before and after GRS, even though you may not see yourself as a transsexual after surgery?
- How would you communicate/express your change in status and your desire not to be called a transsexual to others?
- Would you identify/agree with the statement “I was a transsexual before surgery but I am a woman now”?
- Why/Why not?
- Do you feel that GRS makes someone no longer transsexual or transgendered?
- Do you think there is such a thing as an “ex” transsexual?

E) What does GRS contribute to your chosen/new gender identity?

Prompts:

- What role does GRS play in affirming/confirming/creating/establishing in who (first name) is?
- How would not being able to have GRS affect how you feel about your chosen gender identity?
- Would you still undergo GRS even if you knew that it would not change anything about your gender identity in the eyes of others?
- Would you undergo GRS even if you had a supportive partner/spouse/family to whom your genital status would not matter and who accepted you as you are?

F) How would GRS affect your sexuality and sex life?

Prompts:

- How important is your sexuality/being able to have sex in your chosen gender identity to you?
- What difference, in terms of sexual activity and or partner choice, would undergoing GRS make in your case?
- How much would GRS contribute to affirming your sexual orientation/preference/identity?

Interview 4

1. Theme: Transsexualism/Transgenderism in the context of mainstream society

2. Central Research Question: Do you think GRS changes the views of mainstream society on transsexuals and transgendered persons?

A) I’m interested in learning more about the relationship between transsexuals and mainstream society. Generally speaking, how do you think mainstream society views transsexuals or transgendered persons?

Prompts:

- Do you feel that society in general sees transsexuals or transgendered persons as different in any way from non-transsexuals?
- (If yes) In what ways?

B) How do you feel about being labeled as someone different in some ways from the social norm?

Prompts:

- Do you feel socially marginalized because of your transsexual or transgendered status?
- Do you feel that your transsexual or transgendered status has significant social disadvantages? If so, could you give me some examples of these?
- Do you feel that people stereotype you or hold stereotypical attitudes about you?
- What kinds of stereotypical views do you feel people hold against you?

C) Do you think that undergoing GRS makes any kind of difference in how mainstream society views and treats transsexuals or transgendered persons?

Prompts:

- If so, how, why?
- Do you think members of mainstream society would be more accepting of post-surgical transsexuals or transgendered individuals?
- Why? How so?
- How much of social acceptability of transsexuals or transgendered persons has to do with passing and/or gender-appropriate behavior?

E) What would happen if generally, people would treat you no different after undergoing GRS than they do now, meaning no better or worse than before?

Prompts:

- Would you be disappointed? Why? Why not?

Interview 5

1. Theme: Impact of GRS on disclosure of past life, and integration of former and current self.

2. Central Research questions:

- a) How do GRS patients strategize to integrate their past and present social histories?
- b) How will GRS patients handle voluntary disclosures about their transsexual status?
- c) How will GRS patients handle involuntary disclosures about their transsexual status?
- d) What is the social capital patients expect to gain from disclosing their post-surgical status?

A) I would like to learn more about your past and present social life. How many people currently involved in your life know that you are a transsexual or transgendered person?

Prompts:

- Who knows and who does not?
- Why did you choose to disclose your status to some and not others?
- How did you disclose to them that you are a transsexual or transgendered person?
- How did they react?
- How did you feel about their reactions?

B) How many people currently involved in your life know that you are undergoing GRS?

Prompts:

- Who knows and who does not?
- Why did you choose to disclose your GRS to some and not others?
- How did you disclose to them that you are planning to undergo GRS?
- How did they react?
- How did you feel about their reactions?

C) What role does GRS play in your strategy to integrate your current and former gender identity?

Prompts:

- How does GRS affect your current and former sense of your gender identity?
- How “out” were you/are you about your transsexual or transgendered status?
- Are you considering going “stealth”, or “blending in”, meaning dis-associating with any one or thing which could tie you to your former life after GRS?
- Are you worried about someone finding out about your past life?
- What consequences do you think would involuntary disclosure about your transsexual or transgendered status bring about?
- Are you planning on disclosing your transsexual or transgendered status to future sexual/romantic partners or spouses?
- If yes, what is your strategy/plan to disclose?

D) Have you thought about how you will talk about your differently gendered past?

Prompts:

- For example, when talking about your childhood to people who assume that you have always been female, would you omit gender-specific details?
- Would you replace pronouns with gender appropriate pronouns?
- Would you say “when I was a little girl” instead of saying “when I was a little boy”?
- Would you talk about your “ex” instead of “ex wife/husband” or “ex girlfriend/boyfriend”?
- What other kinds of situations or contexts can you think of where you would adjust a story or narrative?

- What kinds of details about your past would you purposefully omit and why?
- Is it or has it been difficult for you to compartmentalize who knows what about your past?
- Do you feel that you are being somewhat dishonest when you do not disclose your past history to new acquaintances?

E) Do you feel that GRS will be helpful to you in validating your gender identity to others?

Prompts:

- Would you tell someone who does not acknowledge you in your current gender that you have undergone GRS?
- What kinds of interactions or situations would make you talk about or even show people your newly created genitalia?
- Do you think you would feel more comfortable talking with other women about female-only related topics after GRS?
- Would you feel more confident in drawing attention to your body even though your genitalia are generally concealed?

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