The *True Transsexual* and Transnormativity: A Critical Discourse Analysis of the Wrong-Body Discourse

by

Kimi Dominic

Graduate Certificate in Learning and Teaching in Higher Education, University of Victoria, 2016
Bachelor of Arts (Honours), University of British Columbia, 2007

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We acknowledge and respect the lək̓ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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Abstract

How did the wrong-body discourse (WBD) become the dominant medicalised discourse in Canada and the United States? What ideological effects did this dominance have? To address these questions, I conducted a critical discourse analysis informed by Foucauldian genealogy. I analysed texts written in, or translated into, English for a medical-expert audience from the earliest mentions of wrong bodies in 1864 to the institutionalisation of the WBD in the *DSM-III* diagnosis of transsexualism in 1980. I argue that through the medicalisation of gender variance, the three tenets of the WBD—wrongness of the body; disjuncture between sex and gender; surgical and hormonal solution—developed individually and were brought together by medical experts into a coherent discourse in the mid-1960s. Two main factors likely contributed to the dominance of the WBD: the lack of dependence on any particular etiology that made the WBD compatible with a wide variety of explanations, and the very small number of medical experts responsible for the majority of publications on gender variance all using the WBD. I further argue that medical experts, faced with challenges to their treatment of gender-variant people, turned to the idea of *true transsexualism* to stabilise the newly-formed WBD and legitimate their treatment of gender variance. In addition to the three tenets of the WBD, *true transsexualism* also included characteristics and assumptions that medical experts expected gender-variant people to embody if they wanted access to treatment. Through these expectations, medical experts produced a set of norms against which all gender-variant people were judged as legitimate or not, namely, one of the first iterations of transnormativity.

Key words: wrong-body discourse; transsexualism; true transsexualism; transnormativity

Table of Contents

List of Tables

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Dedication

For John.

1 Introduction

"…being trapped in the wrong body is simply what transsexuality feels like." (Prosser, 1998, p. 69)

"If I have the wrong body, whose body do I have and where is my body?" (Cromwell, 1999, p. 25)

For many people, both gender-variant and not, "being born in the wrong body" is just what transsexualism is (Cromwell, 1998).[1] It is a self-evident truth, repeated in medical handbooks (Latham, 2019) and in popular media (Siebler, 2012), biographies (Docter, 2007) and autobiographies (Morris, 1974/2005). As the quotation from Prosser above reflects, it has been a discourse that has spoken to gender-variant people for as long as it has been circulating. It has been the dominant conceptualisation of gender variance in American and Canadian medicine for most of the last century (Meyerowitz, 2002), and it was certainly the first discourse I came across when I first learned that transsexualism was, for lack of a better phrase, *a thing*. For a long time, however, it was also the only discourse I ever encountered, and so it was the discourse that prevented me—and many people like me—from recognising myself as gender variant. I am uncomfortable in the gender I was assigned at birth, but I do not feel like I was born in the wrong body, so I guess I must not be "this trans thing." It was many years before I discovered that there were other ways to conceptualise gender variance, ways that did not centralise the experience of a body wrongness that I did not have. Cromwell's (1999) quotation above is on point: the idea of

[1] In this dissertation, I discuss "transsexualism," a particular, historically-contingent conceptualisation of the phenomena of gender variance. Many contemporary researchers use the terms "transgender," "trans," "trans*" or even "trans-" in order to be more inclusive and less dependent on medical definitions that are widely seen as pathologising (Stryker et al., 2008). However, in this case, I am using "transsexualism" precisely to invoke that medicalised definition that was not only predominant during the period this dissertation covers, but also the model that I personally encountered when I first became aware of gender variance.

the body being wrong does not resonate for every gender-variant person. The question, then, is how did the idea of the wrong body become so ubiquitous as to eclipse [all] other ways of conceptualising gender variance?

The wrong-body discourse (WBD) explains gender variance, specifically the phenomenon termed "transsexualism," by presenting a person's sexed embodiment as wrong for their gender identity, with the implied solution being changing the person's body to match their gender identity. According to this discourse, a "transsexual woman"[2] person feels like a woman, but has a male body, which is wrong; the right body would be a female body. Similarly, a "transsexual man" person feels like a man but has a female body and the right body would be a male body. The WBD can appear in different ways, such as being "born in the wrong body" or "trapped in the wrong body" (as in the first quotation of the epigraph of this chapter), but the underlying theme is the same: the body is wrong. The WBD is pithy and, in a way, catchy. It contains within a short phrase not only the problem (having the wrong body) but also an innocence (being born or trapped through no fault of one's own) and a struggle (one is *trapped*, the body is *wrong*, neither of which is comfortable). It can engender sympathy, or at least a level of kindness or pity. It resonates with many gender-variant people. It is no surprise, then, that it should be so widely used.

Despite its overriding dominance, the WBD is not the only way to conceptualise or articulate gender variance. Beyond this Western-society model, other cultures have had, and continue to have, diverse genders that do not fit neatly (or at all) into the "born in the wrong body" model. One of the most famous gender identities outside of Western society is *hijra*, who are people in India most commonly assigned male at birth, identify as feminine, are culturally

[2] "Transsexual woman" and "transsexual man" are the appropriate terms in the context of the WBD and "transsexualism." The contemporary terms are "trans feminine" and "trans masculine."

recognised as a third gender and increasingly legally recognised as well, and have had a distinct role in society despite colonial attempts to eliminate them (Hossain, 2017; Hinchy, 2019). In Thailand, the term *kathoey* is used to refer to "all third gender categories, theoretically referencing all non-normative gender presentations and sexualities beyond heterosexual male and female" (Käng, 2012, 477). And in Canada and the United States, the English-language term Two-Spirit refers to "all gender and sexual variance among people of Indigenous North American descent: including lesbian, gay, bisexual, transgender and/or queer identities" (Ristock et al., 2019, p. 769). It is important to note that although "Two-Spirit" is a single term, there is no pan-Indigenous concept to which it refers. Rather, it is intended as a generalisation, to point to the numerous different Indigenous identities that cannot be subsumed under the Western notions of sexuality or binary gender (Hunt, 2015).

These examples demonstrate not only discursive attempts to normalise the existence of only two genders by commonly referring to non-Western gender categories as "third genders" (Towle & Morgan, 2002), but also the fact that the Western separation between gender and sexuality is not universal but rather historical and contingent. Moreover, there is great variability and diversity in other ways of conceptualising gender and sexuality (Towle & Morgan). *Hijras*, who not only have many different ways of conceptualising themselves depending on which local Indian culture they belong to, are also defined by various sexualities (Hossain, 2017; Kalra & Shah, 2013). *Kathoey*, similarly, are one of at least five gender/sexuality categories, though some researchers have identified as many as ten (Käng, 2012; Jackson, 2000). And, as Ristock et al. (2019) note, the Two-Spirit identity explicitly involves a rejection of not only "Eurocentric binary categories of sex and gender" (p. 769) but also of the distinction between gender and sexuality.

Given this context, the question of how the WBD, a single discourse among many, became *the* dominant discourse of gender variance in Canada and the United States, is particularly pertinent. It is not only dominant, but it is *normalised*, unquestioned, and for many people, a given. How did this occur? What factors made this possible? What factors contributed to the process? And what issues could come up should this be challenged?

1.1 Research purpose and questions

In this dissertation, I endeavour to explore the overarching question of how the idea that gender-variant people had the "wrong" body became the legitimate and authoritative way of understanding gender variance in Canadian and American institutionalised medicine. To do so, I ask the following four research questions:

1. How did the wrong-body discourse develop?
2. How did the wrong-body discourse become the dominant discourse?
3. How was the wrong-body discourse used by medical experts?
4. What ideological effects did the wrong-body discourse have?

To answer these questions, I use critical discourse analysis (Fairclough, 1995) informed by Foucauldian (Foucault, 1981) genealogy to analyse texts on gender variance written for medical-expert audiences between 1860 and 1979. Because of the intended audience and the power relationships involved in knowledge production, the majority of these texts were written by cisgender medical experts. Nevertheless, a small number of them were written by gender-variant people themselves. Through this research, I hope to contribute to the understandings not only of what the WBD is *as a discourse*, but also of what has made it so ubiquitous and persistent. Moreover, I hope to contribute to a more thorough understanding of what is at stake when

challenging the centrality of the WBD to Western institutionalised medicine's conceptualisations of gender variance as well as any ideologies that may be based on the WBD.

1.2 Dissertation outline

I have organised this dissertation into seven chapters. Following this introductory chapter in which I outline my research questions and provide an overview of my key concepts and key terms, I provide an extensive analysis of the literature that has been published to date on the WBD. This body of literature is small, because identification of the WBD *as a discourse* only began in the late 2000s. Nevertheless, I demonstrate that other researchers have delved into mapping out what the discourse is and how it plays out in various situations such as in news and popular media, in books, and in relationships between gender-variant people and their communities. Drawing on this literature, I develop a model of the WBD that I then use throughout this dissertation.

In the third chapter, I discuss my methodology, critical discourse analysis (CDA). I draw most heavily on the work of Fairclough (1989; 1992; 1995) and Weiss and Wodak (2003), to which I add four genealogical principles from Foucault's (1979; 1981) genealogical method. I outline the main tenets of CDA, the most common criticisms of this methodology, as well as its roots in the work of Foucault, and then explain how Foucault's genealogical principles strengthen this methodology. I close the chapter with a description of the methods I used to conduct the research, including how I selected and analysed the primary sources.

The fourth chapter represents the first task of CDA: the historical contextualisation of the discourse being analysed. In the case of the WBD, this is the history of the medicalisation of gender variance. I use the concept of medicalisation to structure this chapter. In particular, I focus on the "engines of medicalisation" (Conrad, 2005), which I identify as: self-interested

agents, social institutions and socioeconomic forces, technological use and development, and related discourses. The bulk of this chapter focuses on the role of medical experts and gender-variant people, both of whom comprise self-interested agents in the context of the WBD and the medicalisation of gender variance. I also consider the role of institutionalised medicine, especially gender identity clinics as well as the formal documents *Diagnostic and Statistical Manual III* (*DSM-III*) (American Psychiatric Association [APA], 1980) and the *Standards of Care version 1* (*SoC ver. 1*) (Berger et al., 1979), as well as popular media and social movements taking place at the time. I then look at the development of technology such as sex hormones and surgical techniques. Following this, I consider different discourses operating at the time when the WBD was developing which likely had an effect on this development. I close the chapter with a discussion of the limitations of my historical contextualisation, and a recognition that there is no way to ever produce a complete picture of a historical context.

In chapters 5 and 6, I present the results of my analysis of primary sources on gender variance that were written for a medical-expert audience between 1860 and 1979. Chapter 5 addresses the first two research questions: how did the discourse develop and what factors contributed to it becoming dominant. In that chapter, I trace the development of each of the three tenets of the WBD that I developed from the literature review. I then consider how the discourse itself, as a discourse without an etiology, and its relationship to key figures in the development of the discourse contributed to the central position occupied by the discourse in institutionalised medicine in the United States and Canada. In chapter 6, I address the third and fourth questions: how the WBD was used by medical experts, and what ideological effects this had. I consider that the actual use of the WBD, like in the case of any discourse, was significantly more complicated and messy than the three-tenet model would suggest. I show how the messiness was implicated

in medical-expert anxieties that the WBD alone could not assuage, and I argue that the development of the *true transsexual* was a way to stabilise the WBD and defend against challenges to the hormonal and surgical treatment of transsexualism. I close chapter 6 by arguing that the primary sources demonstrate the development of one of the first iterations of transnormativity through this process of trying to stabilise the WBD through the use of the *true transsexual*.

In chapter 5 I demonstrate that the WBD developed slowly through the end of the nineteenth century and into the first half of the twentieth century. In the mid-twentieth century, however, attention to gender variance drastically escalated in the United States and Canada, speeding up the process of discursive development, as a result of, among other things, Christine Jorgensen becoming the first transsexual celebrity (Gill-Peterson, 2018). Medical experts were inundated with requests for treatment similar to that which the requesters had heard that Jorgensen had received, and publications began to reflect a growing need to make sense of gender variance and how to treat it. By the publication of Harry Benjamin's (1966) famous book, *The Transsexual Phenomenon*, the WBD was solidified as being made up of three tenets: (1) there is a wrongness in the body; (2) there is a disjuncture between sex and gender; and (3) the solution is hormonal and surgical treatment. These three tenets continued to operate with little variation for the next decade, and were institutionalised in 1980 in the *DSM-III* diagnosis of transsexualism (APA, 1980).

Despite the existence of other ways of conceptualising gender variance, medical-expert texts exclusively used the WBD, raising the question of what made it so robust so as to overtake all other ways of understanding gender variance. One of the most notable characteristics of the WBD is that it contains no etiology, making it compatible with any etiology a medical expert

might have. It is also rooted in medical and scientific discourses, especially that of diagnosis, such that it *made sense* to medical experts who already operated within those discourses. Additionally, the number of people involved in the development of the WBD was extremely limited. This is all the more notable because only four medical experts wrote or were in discursive control of over half of all of the texts that met the criteria for this research project: Harry Benjamin, Richard Green, John Money, and Robert Stoller.

In chapter 6, I delve into the messiness that was part of both the development and the use of the WBD. First, I look at how despite being used to understand, conceptualise and diagnose all gender-variant people, the WBD was based only on the experiences of gender-variant people assigned male at birth (AMAB) who sought out medical experts, and thus reflected only their experiences, particularly in relation to their bodies and genitals. This already set the WBD up as a problematic discourse. I then argue that the WBD was not as stable as medical experts might have wanted it to be, and that to try to stabilise the WBD, many medical experts began to use the concept of *true transsexualism* instead of just transsexualism. *True transsexualism* was defined not only by the three tenets of the WBD but also by the presence of appropriate binary-gender presentation and identification, lifelong and stable gender identity, asexuality prior to treatment and a desire to be heterosexual after treatment, and a persistent misery and distress due to their condition. Because it drew on additional, already-stable discourses, *true transsexualism* was a way for medical experts to defend their hormonal and surgical treatment of gender-variant people by demonstrating careful consideration of which disorders should and should not be treated with hormones and surgery, as well as which patients who could be treated that way would do best with such a treatment, thereby stabilising the WBD. Despite this messiness, the ideology of *true transsexualism* and its subject position, the *true transsexual*, was treated as the

ideal that gender-variant people were expected to embody, against which their gender variance was judged as legitimate or not, and formed the basis of gatekeeping access to treatment. As a result, it was one of the first iterations of an ideology that has since been termed transnormativity (Johnson, 2015; 2016; Matte, 2014).

I begin the last chapter by revisiting my four research questions and providing summary answers to each one. I then consider two implications of my research. The first implication lies in the material interests that might come into play in challenges to the WBD as made evident by using the concepts of ideology and transnormativity. The second implication lies in how the predominance of AMAB gender-variant people among those interacting with medical experts, that led to the WBD being based on AMAB gender-variant experiences, might affect gender-variant people assigned female at birth (AFAB) beyond what is evident in the primary sources. Following this, I discuss the limitations of my research, and I close this last chapter with some ideas for future research based on the research I have presented here.

A final note on the outline of this dissertation. Following the body of the dissertation are two lists: references and Appendix A. All of the secondary sources used for the key concepts (chapter 1), the literature review (chapter 2), methodology (chapter 3), and historical contextualisation (chapter 4) are listed in the references. These are the sources I am referring to when I use the phrases “secondary sources” and “secondary literature.” All of the primary sources that comprise the data analysed in chapters 5 and 6 are listed in Appendix A. These are the sources I am referring to when I use the phrase “primary sources.” This allows for a clear demarcation between publications analysed for the presence, development and use of the WBD, and those that form the structure of the research through the literature review, methodology, and historical conceptualisation but were not analysed as data.

1.3 Conceptual Framework

As a CDA, this dissertation is structured around a number of key concepts. In addition to the three concepts of the methodology, discourse, text and ideology, two other concepts from the foundation of this analysis: medicalisation and transnormativity. I begin this section with an outline of my definitions of these three CDA concepts. I then outline each analytical concept, defining and explaining how it makes a distinct contribution to my analysis. I close with a discussion of language use in this dissertation, in which I explain the key terms used throughout this work.

In this dissertation, I use the term **discourse** to mean a historically-contingent social practice of using language in speech or in writing that has a dialectical relationship with its context and is structured by rules of what can and cannot be said about a topic, as well as by whom. In being structured by these rules, discourses produce the very objects that they purport to describe, which includes the production of subjects and subject positions. Nothing operates outside of discourse, including researchers. I use the term **text** to refer to the product of discourse use, either spoken or written, that contains traces of the social structures within which they were produced and cues for how it is expected to be interpreted. This includes the products of research such as this dissertation. And finally, I use the term **ideology** to mean a set of ideas that "arise[s] from a given set of material interests" (Fairclough, 1989, p. 94) that is present in discourses such that ideologies both form a part of social structure and are reproduced in social practices. Ideologies are not, by definition, dominant, but rather are tied to material interests regardless of the standing of those interests vis-à-vis other material interests in a particular social context. However, because they arise from material interests, they are one of the ways in which unequal power relations are reproduced. Ideologies can become *naturalised* such that they no longer

appear tied to specific material interests but are seen as common-sense knowledge about the world.

1.3.1 Medicalisation

The first analytical concept I use in this dissertation is medicalisation. Medicalisation covers not only who is involved in the process and how it often takes place, but also the possible effects of the process. As such, I use it primarily to structure the historical contextualisation of the WBD (chapter 4) and the development of the WBD into a dominant discourse (chapter 5). In this section, I outline the key elements of the concept of medicalisation and discuss how this concept strengthens my research.

There are a number of different approaches to defining medicalisation, but what these definitions have in common is the idea that medicalisation is the process by which a human phenomenon that was hitherto not seen as medical comes to be seen as a medical phenomenon. This involves using medical terminology and language, understanding a phenomenon through established medical concepts, and conceiving of solutions from a medical perspective (Conrad, 1992). In this way, medicalisation structures how a problem is seen and understood, who should deal with it, how and when it should be addressed, what solutions are considered possible, and what constitutes it being solved (Conrad; Lupton, 2012; Zola, 1976). Conrad and Schneider (1992) articulated a five-stage model of the process by which this takes place. As with any model of a social process, though, there is often uneven progress through the stages and significant overlap of stages present.

According to Conrad and Schneider (1992, p. 266-271), the first stage of the model, "deviance," involves a behaviour being socially defined as deviant. In the second stage, medical experts begin to explore the phenomenon, trying out different ways to make sense of it using

medical perspectives. Conrad and Schneider call this stage "prospecting." The third stage, claims-making competitions, involves various medical experts and other interested non-medical parties starting to make claims that they have the best explanation of what the phenomenon is and how it should be addressed. At this stage, explanations and debates proliferate. In the fourth stage, "claiming ownership," a subset of the competing medical experts "wins" the claims-making competitions by convincing other medical experts that their explanation is the most legitimate. The "winning" medical experts claim discursive authority over how the phenomenon is explained and how it is addressed and treated, and the phenomenon comes to be defined by their model. As other medical experts cite and reference the "winning" medical experts, the phenomenon comes to be seen as belonging to them, as "theirs." They have thus successfully "claimed ownership" of the phenomenon. The fifth and final stage, institutionalisation, involves the production of an official definition of the phenomenon in medical terms, based on the authoritative explanation of the medical experts who claimed ownership, often through the development of an official diagnosis.

In addition to this, Jutel's (2009) work helps elaborate upon the fifth stage, institutionalisation, through a model of how a personal experience becomes a diagnosis. According to Jutel, there are three steps to this: (1) illness: articulation of a personal experience; (2) disease: biological retelling of illness by a qualified professional; (3) diagnosis: medical retelling of the disease, conceptualised in terms of what is not working right and needs to be fixed. Jutel's model not only outlines the discursive shift from personal experience to medical diagnosis, but also includes in it an implicit power relationship, whereby one party (the patient) must submit to another party's (doctor's) retelling of the narrative.

Medicalisation, however, is not solely a top-down process, imposed on laypeople by medical experts. Rather, it is a "complex, ambiguous, and contested process" (Ballard & Elston, 2005, abstract), one that is interactive and involves numerous actors and social forces to varying degrees (Conrad, 1992; Fainzang, 2013; Bell, 2016). Conrad (2005) refers to these various forces that drive the process of medicalisation as "engines of medicalisation" (p. 5). Broadly speaking, medicalisation involves people who have an interest in the problem (whom I term "self-interested agents"), social institutions, economic forces, technology, and discourses and ideologies (Conrad; Williams et al., 2017). Medicalisation is also not unidirectional: medical involvement can be decreased or outright eliminated (demedicalisation) and subsequently increased or re-introduced (remedicalisation) (Conrad, 2007; 1992). Indeed, the various forces do not all push in the same direction at the same time. Medicalisation, then, is not a binary of medicalised or not medicalised, and the degree of medicalisation can differ significantly between phenomena (Conrad, 1992).

Medicalisation has a number of effects, both positive and negative. There is significant consensus in the literature that overall, medicalisation has the (negative) effect of social control (Conrad, 1992; Zola, 1976). Drawing together discussions from the literature, most especially Conrad (1992; 1979), Conrad and Schneider (1992), Lupton (2012), Bell (2016) and Waitzkin (1989),[3] it is evident that this social control takes three primary forms that I have termed structural authority, regulatory effects, and technological tools. Structural authority involves the discursive and ideological control of (medical) knowledge and is an overt way of maintaining a power difference between medical experts and lay people. Regulatory effects involve direct,

[3] The model I have outlined here represents my own understanding of the various ways in which medicalisation effects social control according to the authors listed. As such, it differs slightly from each of the authors individually.

indirect, and even covert, actions of medical experts in their interactions with laypeople that serve specific social values, beliefs and relations. Regulatory effects are the way that social hierarchies such as those based on race or gender are reproduced through medicalised interactions. And finally, technological tools cover the use of specific technologies such as medications, surgical procedures and medical confinement to manage groups of people that are defined as problems for society. Nevertheless, medicalisation can also have positive effects, such as providing legitimacy for an experience or phenomenon, and changing the attribution of responsibility for a condition, particularly in cases where a person's morality is questioned (Conrad & Schneider). Medicalisation, then, is significantly more complex than simply a tool of social control, even though the negative effects of medicalisation have been more widely researched.

The concept of medicalisation is particularly useful in my research for several reasons. The first is that the process of medicalisation is still occurring, not only in general (Busfield, 2017), but also in the context of gender variance specifically. There are numerous debates taking place about whether gender variance should be a mental illness or not (Bockting, 2009; Ross, 2009; Lev, 2005), whether it should be medicalised at all (Wilson et al., 2002; see also: Bockting), and how this medicalisation relates to other discourses such as health and productivity (Lev; Irving, 2008). Analysing how medicalisation developed over time can help produce a more thorough understanding of what is at stake in contemporary debates. Secondly, the concept of medicalisation is already oriented toward an analysis of discourse. As Lupton (2012) stated, medicalisation as a concept helps analyse "the role of language in constituting and maintaining social order and notions of reality" (p. 2). This means that using medicalisation as an analytical concept can help develop a more comprehensive picture of what can affect the development of a

discourse and, more specifically, what factors can be seen to have affected the development of the WBD. It can also help reveal how certain discourses were more likely to become dominant than others, and what factors specific to the WBD and its development contributed to its dominance.

Third, the literature on the various forces involved in medicalisation as well as the nature of the process as interactive and always in flux directs attention to what historical context is relevant to my research questions. Specifically, it helps structure my identification of who has an interest in the medicalisation of gender variance and why, including specific self-interested agents and social institutions, as well as technological and discursive developments that shaped how medical experts and gender-variant people understood both gender variance and its medicalisation. In short, the concept of medicalisation provides a model to follow for answering my questions about how the WBD developed and became dominant, including how the discourse was used, who used it, in what contexts, and alongside what other ways of making sense of gender variance. And finally, medicalisation as a concept already involves issues of power relationships (Busfield, 2017). As Conrad (1992) himself noted, the process of medicalisation produces medical phenomena in ways that obscure the power relationships involved. Thus, using the concept of medicalisation can reveal those power relationships, including those involving race, class, sex, imperialism, colonialism, or citizenship. Conrad's point here ties the concept of medicalisation directly to questions of ideology and the ways in which medical knowledge and "truths" contribute to specific power relations that privilege some people while disadvantaging others.

1.3.2 Transnormativity

The second analytical concept I use in my research is transnormativity. Transnormativity is a way of conceptualising the patterns and outcomes of practices that, because they are based in particular articulations of gender variance, reproduce and reify that articulation as dominant, superior and even more "true" or "real" than others. As such, I use this concept primarily to structure my analysis of how medical experts used the WBD in practice, and the ideological effects this use had (chapter 6). In this section, I outline the key elements of the concept of transnormativity and discuss how it strengthens my research.

According to Johnson (2016),[4] whose definition is cited widely in the transnormativity literature, transnormativity is "a hegemonic ideology that structures transgender experience, identification, and narratives into a hierarchy of legitimacy" (p. 466). What this means is that whether a gender-variant person decides to engage with institutionalised medicine or not, they are judged against the norms produced by this medicalisation. Moreover, it means that those who conform to specific expectations, discussed further below, are seen as more legitimately gender variant than those who do not. This makes transnormativity a "regulatory normative ideology" (p. 466).

Drawing on the work of other researchers, not all of whom used Johnson's (2016) definition, it is possible to produce a more thorough understanding of transnormativity as a concept. At its most basic level, transnormativity is about identifying who is gender variant and what that actually means about who they are (Matte, 2014). To do so, transnormativity defines gender variance by a specific set of characteristics. However, in doing so, transnormativity also presents all gender-variant people as having the same experiences and plans for treatment

[4] The first person to have published on transnormativity seems to have been Matte (2014). Unfortunately, Matte did not provide an explicit definition of the concept. As such, throughout this dissertation, I use Johnson (2016) as the main source of my understanding of transnormativity, although I want to acknowledge here that he was not the first to publish on it.

(Richie, 2016). It also presents “passing” as the ultimate goal of treatment for all gender-variant people (Riggs et al., 2019; Thomas, 2019). According to some researchers, transnormativity is thus a way to reduce the threat posed by gender variance. Transnormativity makes gender variance intelligible not only by constraining all gender variance to certain characteristics (Ruin, 2016), but also by defining gender as unchanging, in accordance with prevailing beliefs about gender and gender identity (Sumerau et al., 2020). In doing so, transnormativity has the effect of validating only some gender-variant people at the expense of others (Lampe et al., 2019: Matte; Miller, 2019).

Transnormativity, however, is not a singular concept. Rather, there are numerous historically-contingent and culturally-specific transnormativities (Matte, 2014), although not all researchers who have published on transnormativity have recognised this. In general, transnormativities are rooted in adherence to the gender binary (Bradford & Syed, 2019). They also are racialised and classed, with many researchers identifying white middle-class heterosexual norms as underpinning the characteristics identified as defining of gender variance (Mocarski et al., 2019; Glover, 2016). There are, nevertheless, more specific transnormativities. Matte, for example, demonstrated that in the 1950s, a specifically liberal American transnormativity operated and in the 1960s was promoted by the Erickson Educational Foundation. This articulation of transnormativity, in addition to having the elements identified by other authors above, was rooted in the liberal American values of individualism, freedom and equality. Similarly, Miller (2019) showed that in the contemporary United States, transnormativity has become intertwined with patriotism to form “transpatriotism,” which carries with it the political ideals of assimilation and exclusion.

While the concept of medicalisation helps structure my analysis of the WBD, the concept of transnormativity is useful in that it helps articulate the relationship between the WBD model of transsexualism and how it was actually used by medical experts. Transnormativity offers two analytical angles. The first uses the analyses of transnormativity as an ideology to reveal the material interests that are served by specific iterations of transnormativity. As noted above, the most common transnormativity in Canadian and American contexts is that based on white middle-class binary gender and heteronormativity. This means that gender variance is medicalised in the context of specific race, class, gender and sexuality ideologies, and suggests avenues for analysis of the reasons for enforcing transnormativity in various contexts. The second uses transnormativity as a concept and thus brings attention to the processes by which hierarchies of validity and legitimacy were produced in the context of gender variance. It helps identify those patterns in a variety of situations, such as in the historical development of the WBD. Transnormativity as a concept, then, helps elucidate the actual process by which medical experts produced a hierarchy of gender-variant people, some who were deemed "valid" and were granted access to surgical and hormonal treatment, and others who were excluded from legitimacy and from treatment, when putting the WBD into practice. Together, the two ways of using transnormativity help reveal how the context within which medical experts operated and made treatment decisions affected gender-variant people. It connects the material interests of the medical experts to specific effects on gender-variant people through the decisions medical experts made about who would and would not get treatment. It also helps explain how the production of a hierarchy of legitimacy serves material interests related to race, class, gender and sexuality on which the particular transnormativity being used is based.

1.3.3 Language use in this dissertation

Language is of particular importance in this dissertation and comes up in three ways. The first way is in the set of key terms that are relevant to my research question. These I define by their common use in society today. Where this differs from their use during the historical period that this dissertation covers, I make note of it in the body of the dissertation by using one of the terms I developed and outline in the following subsection. I chose this way of defining the key terms because each of these terms is also a discourse in itself and as such, it is important to identify the form of it that operates in the context of the research being conducted. I further elaborate on this in the section on discourses in chapter 4. Second, I have created two terms to articulate specific conflations of the key terms, to represent how the historical use of a term reflects a conflation of contemporary usage. Finally, many of the terms used in the literature I have analysed in this dissertation are outdated and some are even considered offensive. As a result, I close this section with a short explanation of when and how I use historical terms versus contemporary terminology.

1.3.3.1 Key Terms

Sex is a category assigned at birth, usually by a doctor, via a visual inspection of the genitals. In Western society, the two sex categories are "male" and "female," and because sex is part of the discourse of biology, sex is seen as a biological truth about a person, outside the realm of the social (Dreger, 2000). Despite sex being conceptualised as binary, there are numerous presentations of intersex bodies. Intersex infants are often first identified by having ambiguous genitals, although there are other types of intersex conditions that do not involve ambiguous genitals (Dreger). However, because sex is expected to be a binary category, intersex infants have historically been surgically and socially forced to conform to one of the two sex categories, most often female (Dreger; Kessler, 1998). The terminology used to describe this third category

has varied over time, and is still subject to debate (Meier & Labuski, 2013). Previous terms have been hermaphroditism and intersex, with the most contemporary medical term being "disorders of sex development" (Davis, 2014) and community term being "differences of sex development" (Alkazemi et al., 2020).

Gender is a social category, generally understood in Western society as binary (often termed the **gender binary** or **binary gender**) and comprising boys/men and girls/women. In this conceptualization, gender is expected, and even often believed, to follow from a person's assigned sex such that males are boys/men and females are girls/women (Dozier, 2005). This expectation/belief is so strong that many people treat sex and gender as interchangeable. Related is a person's **gender identity**, which is the gendered sense of self a person has, their identification with a social category. Gender identity may match what is expected of the person as a result of the sex they were assigned at birth or not, and it may match what the person presents to others or not. Although sometimes gender identity is referred to as simply "gender," this conflation is problematic in the context of discussions where the development of "gender" as a concept in the 1950s is relevant to how the WBD developed and changed over time. As a result, I maintain this distinction in order to avoid potentially obscuring the contributions of different ways of thinking and conceptualising sex and gender.

Sexuality refers to "patterns of both romantic and erotic interests which may, or may not, involve the presence of other people in actuality, in fantasy, or virtually" (Devor & Dominic, 2015, p. 183). It is often seen as a binary of heterosexuality and homosexuality, with bisexuality occupying the middle ground between the two but depending on the binary to make sense. In Western society, like sex, sexuality is based in biological discourses and thus it is frequently conceptualised as an innate characteristic of a person, although historically this has not always

been the case (Foucault, 1990). Moreover, the binary of heterosexuality and homosexuality is inextricably linked with gender in that both presuppose the gender binary and without it, neither heterosexuality nor homosexuality make sense.

Cisgender refers to a person who identifies with the gender that is expected of the sex they were assigned at birth, such as people who were assigned female at birth and who identify as girls/women. The concept of cisgender is the basis of cis-centrism, a hegemonic ideology that presents the assumption that most people are cisgender, i.e., not gender variant, and produces a binary made up of "trans and non-trans" (Matte, 2014, p. 3).

Gender variant is a term that refers to "anyone who has a gender identity which differs from the gender [sex] they were assigned at birth and who chooses, or prefers, to present themselves differently than what is expected for the gender [sex] they were assigned at birth" (GATE-Global Action for Trans* Equality, n.d.).[5] This includes people who want to present themselves differently but by virtue of life circumstance, do not feel they can do so. "Gender variant" is in contrast to **gender non-conforming**, which refers to anyone who identifies or presents themselves in ways that are not expected of the gender they are assumed to be. When it is important to make the distinction, I use "assigned male at birth" (AMAB) and "assigned female at birth" (AFAB) to describe the gender-variant people about whom I am writing.

I have chosen to use "gender variant" as the umbrella term in this dissertation instead of the commonly-used umbrella term "transgender" for several reasons. First, I see "gender variant" as the most encompassing term I could find to cover people whose gender identity differs from their assigned sex, without including people who are gender non-conforming but whose gender

[5] I have placed "sex" in brackets to indicate that the phrasing of the GATE definition—assigning gender—corresponds to my discussion of assigning sex above, and to direct the reader's attention to the fact that the relationship between the concepts of sex and gender is a complicated one.

identity aligns with their assigned sex. Second, I did not want to evoke a relationship to discourses of transsexualism before the term was used and institutionalised, which I argue terms that use "trans" necessarily do, either directly or by defining themselves in opposition to them. I want to maintain a clear distinction between the population of people who could potentially be medicalised (gender-variant people) and medical discourses (transsexualism, transsexual, *true transsexual*). Third, I wanted to avoid inadvertently excluding people who do not identify with "transgender" or any "trans"-related term such as trans, trans+, trans-, or trans*.[6] And finally, related to the previous point, I wanted to avoid the historicity and contingency of the various, more specific terms based on the prefix "trans."

"Gender variant," however, is not an unproblematic term. It depends on the particular distinctions between "sex," "gender" and "sexuality" as I outlined the terms above, and these distinctions are not universal. For example, the term Two-Spirit refers to "all gender and sexual variance among people of Indigenous North American descent: including lesbian, gay, bisexual, transgender and/or queer identities" (Ristock et al., 2019, p. 769). According to Ristock et al., this concept draws on, among other things, a rejection of "Eurocentric binary categories of sex and gender" (p. 769) as well as the distinction between gender and sexuality. "Gender variant," however, draws on those binary categories of sex and gender, as well as presupposing an internal gender identity which is an essentialist conceptualisation. As a result, my use of "gender variance" imposes not only an assumed similarity of experience or identity on the group I am trying to describe, but also presumes particular ontological conceptualisations that may exclude some people and include others who would not categorise themselves as "gender variant."

[6] This decision came from my personal experience of struggling with the idea of "trans-anything" in my own identification. Because I had rejected the possibility of being trans*sexual* specifically, I necessarily assumed I could not be "trans-anything" because of the prefix "trans." Although anecdotal, I have met others who have articulated their difficulties in similar terms, and I wanted to avoid this pitfall.

Moreover, the term "gender variance" also brings with it a racialised history, discussed in chapter 4, of the concept of gender, and the use of "gender" as a tool of colonialism. And finally, the term "gender variance" reproduces the cisgender/gender-variant binary identified by Matte (2014). Despite these issues, however, I believe this is the best term I could find to be able to refer to the vast group of people who could be medicalised through the diagnosis of "transsexualism."

A **medical expert** is a person who, through experience or study, has acquired medical knowledge and skill. How this experience or study is understood, and what constitutes medical knowledge and skill, have changed over the course of history, and so that who might be seen as a medical expert is historically specific. **Medical authority** is the epistemic status of the medical expert as defined by privileged access to, and use of, medical knowledge, practices and technology. That access is privileged because of how it is acquired (namely, the scientific method, institutional degrees, examinations, licensing) and is in comparison to the lay person, the patient, who does not have that same access to, and use of, medical knowledge, practices or technology. Moreover, those methods of acquiring access are governed by a rational system of rules and regulations, making medical authority an example of rational-legal authority (Royce, 2015). Like "medical expert," medical authority is also historically contingent.

1.3.3.2 New terms

The term **sex/gender/sexuality** refers to the conflation of sex, gender and sexuality into one single concept. Prior to articulation of sexual behaviours as a distinct aspect of a person in the late 19th century (Foucault, 1990), the term "sex" referred to a combination of everything that was later separated out as sex, gender and sexuality. Not only did the term "sex" refer to biological category as well as personality characteristics and preferences, it also referred to erotic

desire. According to this understanding, males, for example, were masculine, identified as boys/men, and were sexually attracted to females. Referring to a person as "male" encompassed all of these assumptions. The corollary was true for females: they were feminine, identified as girls/women, and were sexually attracted to males. At this point, gender variance and homosexuality were understood to be one condition: inversion (Hovey, 2007). Because sex, gender and sexuality were all conflated, variance in what we now call gender (whether it be gender identity, or gender presentation) were seen as evidence of homosexuality (Taylor, 1998). The opposite was true as well: homosexuality was seen as an expression of variance in gender.

The term **sex/gender** represents the conflation of what we now call sex and gender that existed before the development of the term "gender" which started as "gender role" in the 1950s by Money et al. (1955a; 1955b). Prior to the development of the concept of gender but after the articulation of sexuality, the term "sex" referred to not only the biological category to which one was assigned, but also the characteristics, traits, preferences, aptitudes, and behaviours associated with that sex, what in Western society is now associated with the term "gender" (Meyerowitz, 2002), though even after the discursive separation of "gender" from "sex," the two were often considered to be the same thing until the early 1990s (Cromwell, 1999). This historical conflation is tied to the continued belief that males are naturally boys/men and that females are naturally girls/women, and that knowing what gender a person appears to be gives information about their biological category. It is thus also related to the contemporary treatment of "sex" and "gender" as interchangeable.

1.3.3.3 Historical terms

There are a number of terms that I use throughout this dissertation that are no longer in use and, in some cases, are offensive. However, in those cases where their meaning is relevant to

the discussion, or in direct quotations, I use the terms of the time rather than replace them with contemporary terminology. The reason for this is that, I contend, using a contemporary term loses some of the context and meaning that is relevant for understanding discussions of the time. As Devor (1997) stated,

> although we may be tempted to retrospectively name behaviours by today's standards, if we wish to begin to understand their meanings for those who lived them, we must peer at them through the lenses of their times as best as we are able. (p. 4)

However, where my discussion is *not* intended to explicitly evoke connections between bodies of literature or histories of particular terms, I use the contemporary terms.

The term "hermaphroditism" is a good example of where historical context matters. The current terms in use are "intersex," "disorders of sex development," and "differences of sex development." However, these two terms reflect contemporary understandings of not only how sex develops but also the ontological meaning of "sex" as a biological category but *not* a social category (gender) nor a sexual attraction (sexuality). "Hermaphroditism," on the other hand, carries with it not only the conceptual conflations discussed above, but also a focus on ambiguous body morphology (specifically genitals), struggles to define (or diagnose) "true" sex and the restabilisation of binary sex through the category of "pseudo-hermaphroditism" (Dreger, 2000; Kessler, 1998), as well as early attempts to conceptualise gender variance as "psychic hermaphroditism" (see: Westphal, 1869/2006). By choosing to use the term "hermaphroditism" when discussing particular texts that used that term and engaged with that body of literature, I want to make clear the connection between that text and the history of the term. Using any of the contemporary terms, particularly in an analysis of discourse, would obscure those connections and that history.

Similarly, when discussing previously-published literature, I use the terminology used by the authors I am citing. Because terms can change quickly, and the meanings of new terms may not map exactly onto older terms, I have chosen to make use of the terms found in the article or book I am discussing. For example, the term "FTM" is no longer considered appropriate. Instead, "trans man" or "trans masculine" are the currently preferred terms. However, some of the literature I cite refers to research in which people who identify as "FTM" were interviewed. Because that term was relevant to participation in the study, I use the term when discussing the findings rather than refer to participants as "trans men," as that term may not even have been in use at the time the study was conducted. Using "trans men," I contend, would thus rewrite the self-identification of participants without their consent. I believe in the context of a dissertation that is concerned with discourse, language and meaning, this means using the terminology of each publication.

Finally, I use the terms **transsexual** and **transsexualism** throughout the dissertation in accordance with the literature I analyse. Medical experts used the term "transsexual" to refer to all gender-variant people who came to see them and who met certain criteria, namely those outlined by the WBD. When discussing gender variance as a whole, medical experts used the term "transsexualism." In 1980, the term "transsexualism" became the diagnosis in the *DSM-III* (APA). Therefore, when it is important to the discussion, I also use the terms "transsexual" and "transsexualism." It is important to note that I often use "transsexual" in opposition to "gender variant" when highlighting the distinction between those who did engage with institutionalised medicine (and were thus given the label of "transsexual" by medical experts), and those who did not engage with institutionalised medicine and whose ways of conceptualising the self and their gender identities cannot be known (whom I refer to as "gender variant"). I acknowledge that for

many, the term “transsexual” is offensive and comes with a history of pathologisation and mistreatment, while for others it is central to their self-identification and still very much in use today. In this dissertation, however, its meaning is limited to those labelled “transsexual” by medical experts during the time period I am analysing, and those who self-identify as such in the literature I have reviewed.

2 Literature Review

Although the link between the dominant narrative of gender variance in the United States and Canada and medical discourses was identified early in discussions of transsexualism (see, for example, Meyerowitz, 2002), the discourse was not characterised by the idea of the wrong body until the 1990s. As such, critical examinations of the wrong-body discourse (WBD) *as a discourse* did not emerge until the late 2000s and into the 2010s. With very few exceptions, these have been written in English and have taken place in Canada and the United States.[7] It was at this point that theorists started to delve into the discursivity of what had thus far been mostly referred to as "medical narratives of transsexuality" and sometimes "the wrong-body narrative." As such, analytical work on the WBD is significantly limited and there remain many unanswered questions.

The body of literature has, thus far, focused on developing a deeper understanding of the WBD: what does it look like, what does it do, and of what elements is it made? In questions of discourse, these questions are inextricable from one another. These effects have been supported by theorists who have taken a closer look at how the WBD plays out in different contexts. Together, these authors have begun to create a map of the discursive terrain within which the WBD operates. However, many questions remain, and the literature conducted thus far raises further questions as well.

To locate my research in this literature, I begin with a detailed overview of the WBD literature. First, I look at how the literature has mapped the terrain of the discourse, along with

[7] I have found only two non-English sources that may be relevant to the discussion of the WBD: Missé (2018), written in Spanish, and Koh (2012), written in Japanese. According to Gonzalez (2019), Missé's book is about the "myth" of the wrong body. Koh's article, on the other hand, is about the history of gender identity disorder. However, due to language limitations, I could not read either work, and for the same reason, I cannot ascertain if similar work has been conducted elsewhere. Additionally, the fact that I did not find any other references in the citation lists of other authors may also have been limited by language and their possible dependence on English.

how this map has been strengthened by work focusing on the ways in which the WBD plays out in more specific contexts and the possible reasons authors have identified for its discursive dominance. I then outline the understandings of the WBD that the literature provides. I look more closely at what the literature actually says about what the WBD looks like, distilling three tenets that authors seem to agree on, as well as five assumptions that different authors have recognised as underpinning the discourse. This three-tenet model, while drawn from agreements I found in the literature, is my own. I conclude the chapter with an evaluation of the literature, identifying questions that remain unanswered and explaining how my research is intended to address some of these questions.

2.1 Mapping the terrain

Under names such as "medical narrative of transsexuality" and often just "medical narrative," the WBD was identified by the gender-variant community as essential to how medical experts defined transsexualism early in the medicalisation of transsexualism (Bolin, 1988; Meyerowitz, 2002). According to the literature, this was the narrative of selfhood and experience that centralised the experience of the body as wrong that had to be told to medical experts in order to be intelligible as transsexual and be granted access to hormonal and surgical transition (Bolin, 1984; Denny, 1992). Moreover, it came to be expected by those medical experts (Denny, 1996). Until the late 1990s, however, this discourse was not examined *as a discourse*, though it did appear in literature on other topics. Exploration of the WBD *as a discourse* began with the work of Prosser (1998), and it is with his work that I begin this section, moving then to other work that has looked at what the WBD is and what it does. I then consider research on how the WBD plays out in different contexts, and close the section with a look at ideas several authors have had on why the WBD became dominant.

2.1.1 Contemporary WBD literature

Beginning with Prosser (1998), theorists writing about the WBD set out to articulate what the WBD *actually was*. Using post-structural theory and psychoanalysis, Prosser conceptualised the relationship between transsexual subjectivity and transsexual embodiment as being manifested through the skin, where the skin was the surface on which subjectivity could be represented and embodiment felt. A subjectivity that could not accurately be represented through the skin was one whose embodiment was thus experienced as wrong. As such, according to Prosser, the WBD is a succinct articulation of transsexual embodiment and is widely used because "being trapped in the wrong body is simply what transsexuality feels like" (p. 69). Moreover, it is inextricable from questions of selfhood because, as Prosser argues, being trapped in the wrong body means one's true self is obscured.

Publishing just a year later, Cromwell (1999) took the opposite position on the WBD. As part of his exploration of the lived experiences, realities and identities of trans masculine people, Cromwell argued that the idea of the wrong body not only did not reflect the majority of gender-variant people's experiences, but also was one imposed on gender-variant people by medical experts. Although Cromwell's book did not focus on the WBD nor his participants' relationship to the discourse, most of his participants did not express any kind of resonance with the idea of the wrong body. As Cromwell noted, "many female-bodied people do not and have never felt like 'a man trapped in a woman's body' or as though they have 'the wrong body'" (p. 25).

Prosser's (1998) conceptualisation of the WBD as dependent on subjectivity and inextricable from embodiment remained the only substantial account of the discourse until the second half of the 2000s, when other theorists began to critique the way the WBD produced a coherent and limited subject. The first of these was Crawford (2008). Using the work of Deleuze

and Guattari (1983), Crawford took explicit issue with what he saw as Prosser's defense of a modernist discourse, and argued that the WBD excludes other ways of being gender variant. According to Crawford, Prosser's conceptualisation of the WBD as "simply what transsexuality feels like" (p. 69) was modernist because it depended on a core internal self that was either expressed through the skin or obscured by a wrong skin (body). However, Crawford concluded that Prosser was not entirely wrong. Given that in Deleuzo-Guattarian theory, "feeling" [8] is associated with imposed regularity, coherence and unity, and the WBD is a form of imposed coherence and unity on gender-variant bodies and senses of self, Prosser's statement makes sense. Through this work, Crawford added a level of complexity to the discussions of the WBD, moving the literature towards examining the role of the WBD in the production of contained and constrained subjectivities.

Following this same line of critical examination, both Bettcher (2014) and McQueen (2014) argued that the model of transsexualism presented by the WBD is fundamentally flawed in that it is based on the very assumptions that are problematic to gender-variant people. For Bettcher, this was due to the fact that the WBD recentralises binary gender and gender essentialism as crucial elements of gender-variant subjectivity. In doing so, Bettcher argued that not only does the WBD constitute an erasure of other ways of being gender variant, but it also reifies the very assumptions on which violence against gender-variant people is based, namely binary gender and gender essentialism (p. 387). According to Bettcher, in order to make sense, the WBD must necessarily undermine its own political potential. McQueen made a strikingly

[8] According to Deleuze and Guattari (1983), "affect" is the molecular counterpart to the molar "feeling." In their work, Deleuze and Guattari use the terms "molar" and "molecular," which they drew from chemistry, to articulate the difference between their conceptions of wholes (the molar) and parts (the molecular). For Deleuze and Guattari, the molar is associated with unity, organisation, regularity, coherence and being static. The molecular, on the other hand, is associated with multiplicity, partiality, becoming and movement. As such, feeling is associated with the same limitations on movement and possibility as anything molar. Affect, on the other hand, is not only fluid, but also not entirely able to be contained in language and so it is full of possibilities.

similar argument: because the WBD is generated, and maintained, by gender norms, it has the effect of limiting the political subjectivity of those to whom the discourse applies by constraining those subjectivities to possibilities delimited by gender norms. McQueen's argument, however, is deeper than that of Bettcher. McQueen recognised that these limits are not only limits on political or cultural intelligibility, but also on subjectivity itself: the ways to make sense of the self and of one's embodiment that the WBD makes available for gender-variant people are limited to experiencing the body as wrong (p. 540). For McQueen, then, having the right body is inextricable from political subjectivity and citizenship, not having the right body excludes gender-variant people from recognition and validation, and having the wrong body requires certain actions to "right" it so that recognition and validation can be granted (p. 541).

One of the most important contributions to mapping the terrain of the WBD is that of Nirta (2017), who takes this critical examination in a slightly different direction. Looking at the discursive context of the WBD, Nirta identified a set of binaries on which the WBD depends: right/wrong, male/female, inside/outside, and body/mind (p. 134). The author looked to Shildrick's (2002) theory of monstrous bodies as a way to think about how the WBD redefines bodies considered disturbing into ones that have a solution that brings them back into sameness. According to Nirta, by defining binary gender as something to be embraced and enacted, the WBD presents its solution—transition—as a way to achieve freedom. In doing so, rather than freeing the subject, the WBD negates its ability to be disruptive or disturbing by rendering it no longer monstrous or "disobedien[t] to institutionalised thought" (p. 134).

Perhaps the most notable contribution to the mapping of the WBD domain, discerning what it is and what it does, is the work of Latham (2019). Latham outlined the assumptions and propositions that he argued comprise the WBD, and then demonstrated that the WBD does, in

fact, underpin contemporary medical understandings of transsexualism. According to Latham, the WBD is made up of four axioms:

1) Transsexuality is a disjuncture between mind and body;

2) Transsexuality is hating having the wrong genitals;

3) Transsexuality is painful and debilitating;

4) Transsexuality is treatable with surgical and hormonal body modifications. (p. 14)

Through his analysis of Benjamin's (1966) *The Transsexual Phenomenon* alongside contemporary medical guidebooks on the treatment of transsexualism, Latham demonstrated that the WBD does, in fact, underpin contemporary medical understandings. In doing so, he also empirically demonstrated the continued dominance of the WBD and produced the most nuanced model of the discourse to date.

2.1.1.1 What does the literature say about the use of the WBD?

A significant portion of the literature on the WBD is made up of research into how the WBD plays out in different contexts, such as news media coverage of transphobic violence (Barker-Plummer, 2013), YouTube vlogs (Psihopaidas, 2017), and relationships among undergraduate trans men (Catalano, 2015). This set of literature can be most broadly divided into two groups: that which focuses on media use of the WBD, and that which focuses on how gender-variant people use the WBD. Because this section of the literature focuses on specific situations rather than on theoretical considerations, much of what it contributes lies in the conclusions drawn from the data. The greatest contributions lie in how these works demonstrate the ubiquity of the WBD. It is evident in the literature that the WBD is widely used in the media, though it is beginning to be replaced by more nuanced representations of gender variance. It is also used by gender-variant people themselves, where it is often done so strategically and even

sometimes ironically. It appears, then, that the WBD continues to have cultural currency, but that its use is more complicated than simply using it or rejecting it.

A number of authors have focused on the ways in which the WBD plays out in the media, especially in television programmes. According to Siebler (2012), television programmes in the United States centralise wanting to pass and equate being transsexual with wanting surgery. Although Siebler did not use the term "WBD" in his research, he focused on a key element of the WBD, surgery as the solution, and found that representations were limited to just this one trope. Capuzza and Spencer (2017) extended Siebler's work by looking at scripted television programmes in the United States between 2008 and 2014. They found that indeed, the WBD remained dominant, which they saw as confirming Siebler's findings. However, they also found that genderqueer presentations that did not focus on only surgical transition and passing, or moving to a stable gender identity, were beginning to proliferate. Nevertheless, Capuzza and Spencer argued that because gender variance appeared in these programmes as an individual problem with an individual solution, it was effectively depoliticised, despite the shifts into more complex and nuanced representations. By presenting these characters as passing, seeking and accessing hormonal and surgical transition, and "moving from genderqueer to gender stable identities" (p. 216), these television programmes used the WBD to present gender variance as a personal struggle that can be individually solved in a specific way without challenging any social assumptions around gender or sex.

Putzi (2017) also found that the WBD is the dominant way of presenting gender variance in young adult novels. Putzi's research showed that, much like television programmes, many of the most popular novels in this genre in the United States centralised desiring surgery as well as fitting into the gender binary. However, Putzi argued that there are inroads being made into more

unfixed and fluid presentations of gender variance, To that end, she analysed two novels, one published in 2013 and the other in 2014, to demonstrate that the discursive space in young adult novels is beginning to include other ways of understanding gender variance, ways that are not rooted in the WBD.

In contrast to the shifts away from the WBD, Barker-Plummer (2013) demonstrated that the WBD not only is still being used, but that there are situations in which the shift *to* the WBD can be beneficial. In her discursive analysis of news stories about Gwen Araujo's murder, Barker-Plummer found that as descriptions of Araujo shifted from characterising her as a deceitful cross-dresser to using the WBD to secure her status as a young woman, so did the framing of the situation shift from provoked attack to hate crime. Barker-Plummer concluded that this was most likely related to the legitimacy offered by the WBD, setting Araujo apart from ideas of perversion and dishonesty associated with cross-dressing and presenting her as the legitimate victim of a crime.

Gender-variant people themselves also make use of the WBD, both in relationships with others and in the production of their own media. When gender-variant people do use the WBD, however, it is in ways that are more complex than simple acceptance. In her work with Taiwanese trans people, Ho (2006) found that her participants frequently used the WBD as a short-hand way to explain their existence to people. However, their actual relationship to the discourse was significantly more complex due to the limitations on access to hormonal and surgical transition services which then also limited their abilities to act on the expectations of identity and transition that the WBD outlined. Thus, according to Ho, the WBD offered many Taiwanese trans people a sense of empowerment in being able to articulate their experiences not only to others but also to themselves, but did not account for the entirety of their experiences.

What is also evident in Ho's work, though not explicitly articulated by Ho herself, is that the WBD obscured experiences that did not align with the discourse itself, leaving them unarticulated and potentially even unarticulatable using the available discourses. Similarly, in their study of the ways in which Polish trans men conceptualised their gender, Kłonkowska and Bonvissuto (2019) found that the WBD and culturally-specific myths were integrated together in personal stories and hopes and dreams. This appeared in, for example, wishes for alchemists to change "wrong" bodies into "right" bodies, drawing on both cultural stories about alchemy and the basic premises of the WBD.

Catalano's (2015) work delved into this limitation of the WBD more significantly. Catalano explored the ways in which undergraduate trans men used the WBD both among themselves and in situations with cisgender peers, and found that his participants struggled with the hierarchy of legitimacy that this created. Many of his participants struggled with being perceived as "trans enough" when they did not fulfill the expectations of the WBD, specifically in regard to experiencing their bodies as wrong or desiring access to hormonal and surgical transition. Catalano's research demonstrated that the WBD was used as a way to legitimate certain ways of being gender variant, forcing gender-variant people to choose between being authentic to themselves and being recognisably trans to others, including people they expected to be more accepting, namely other trans men.

The WBD can be used in a multitude of ways, however. In addition to being both empowering and limiting, it can also be a starting point for new articulations of gender variance. Psihopaidas (2017) found exactly this in his research exploring the ways in which the WBD is used in communicating the self and self-making. Although YouTube users often policed each other on whether they aligned with the WBD, many used such policing as an opportunity to

redefine what it means to be gender variant by using the WBD in what Psihopaidas considered to be playful and ironic ways (p. 418). They used the "language and logic of the wrong-body" discourse (p. 419) to question the role of surgery in defining the gendered self (p. 418), to challenge essentialist binary gender assumptions of what it means to be a man or woman—and at what point they were a man or woman (p. 420)—and to undermine the privileged position of medical knowledge over self-knowledge by positioning their knowledge of themselves as having equal if not more authority (p. 421). These challenges, asserted Psihopaidas, were made possible by the WBD itself, rather than them being made in spite of it.

2.1.1.2 Possible reasons for discursive dominance

While most authors have focused on what the WBD is and how it plays out in different situations, three authors have also examined factors that have contributed to the dominance of the WBD. These authors represent the beginning of a closer analysis of how the discourse came to be dominant, connecting it to other discourses as well as to power relationships that may affect the stability of the discourse. The first of these three authors, Sullivan (2008), compared discursive attempts to claim validity made by gender-variant people and people requesting limb-removal surgery. Sullivan found that by using the WBD, gender-variant people could access the legitimacy granted by the already-valid discourse of bodily integrity. However, people requesting limb-removal surgery could not make the same claims, despite also defining their own bodies as "wrong," because removing a limb considered healthy by medical experts conflicts with the discourse of the body as a unified whole. Sullivan's work demonstrates that the idea of alienation from the body present in the WBD, and the centrality of the discourse of body and self integrity in Western societies, have been significant factors in the legitimacy and dominance of the WBD.

Lovelock's (2017) research corroborated that of Sullivan (2008). Lovelock argued that one of the biggest contributors to the dominance of the WBD is not the resonance the discourse has for gender-variant people, as Prosser (1998) suggested, but its connections with other, already established discourses in Western society. According to Lovelock, the WBD depends on essentialist gender, discourses of inner self-truth and working on one's body, discourses already widely used and accepted in Western society. Because of these connections, the WBD always already carries with it a degree of legitimacy that other discourses may not receive. The works of both Lovelock and Sullivan reveal, then, that the WBD may be dominant partly because of its compatibility with discourses of neoliberal selfhood which focus on discovering and embodying an authentic, core "true" self and self-actualisation (Lovelock).

Approaching the question from a different angle, Fink (2018) explored how the main character of Charlie Anders' novel *Choir Boy* navigated and resisted the WBD as they tried to access hormone treatment. In doing so, however, Fink demonstrated that the WBD is not only demanded by medical experts, but it is actually reinforced by the necessity to participate in the discourse in order to access treatment. Although Fink did not set out to make this specific argument—his research focuses on how disability studies could reimagine the relationship between patients and medical experts—his work nevertheless illustrates the feedback loop between medical experts and the patients over whom they have power and authority, suggesting that this feedback loop serves to strengthen the central role the WBD has had in medicalising gender variance.

2.1.2 WBD literature overview

It is evident from this overview that although the body of literature on the WBD is still relatively small, a significant amount of work had been done in the 2010s to map out just what

this discourse is, and answer some of the most important questions: where can we find it, and what does it do? The WBD appears to be a widely-used discourse that describes transsexualism both within institutionalised medicine as well as in Western society. Moreover, it is often used by gender-variant people themselves, both to articulate and make sense of their own experiences, as well as to challenge the authority of institutionalised medicine over their subjectivities. The work reviewed here demonstrates that the use of the WBD is not straightforward nor unproblematic, but that it continues to be used because of other discourses that support it and in the context of which the WBD makes sense.

However, with the exception of Latham (2019), no author has set up an explicit model that would help answer these questions in more detail. Such a model would allow for more concerted analyses of specific texts, but also for understanding better how it is used and taken up by gender-variant people, in the media, and how to challenge it by discovering the various ways in which it is stabilised and reified. And yet, this body of literature does provide a lot of information towards developing such a model. The following section outlines a model of the WBD that is drawn from the literature by looking at aspects of the discourse on which authors seem to have developed a consensus, and what aspects are still being considered and added. From this information, it is evident that the WBD is widely treated as having three tenets, and the assumptions that underpin it are still being discussed.

2.2 Understandings derived from the literature

Although the majority of the literature does not delve into the aspects that make up the WBD—namely its tenets and the assumptions that underpin it—they are nevertheless evident in the descriptions and operationalisations of the WBD that the authors present in their research. The exception to this is Latham (2019) who, as discussed above, divided the WBD into four

axioms in order to demonstrate that the discourse continues to be evident in contemporary treatment guides and handbooks on transsexualism aimed at a medical expert audience. Although Latham's work is quite recent, and thus one cannot expect that other researchers will have already taken up his model, it is also evident that the literature does not reflect his model. Rather, the literature demonstrates three key tenets and includes a discussion of five assumptions, although due to the very limited extent of this literature, it is highly likely that there are numerous other assumptions that underpin the WBD, or even have a mutually reinforcing relationship with it, that have yet to be explored. In this section, I outline of the tenets and assumptions of the WBD that are evident in the literature.

2.2.1 What does the WBD look like in the literature?

The most important contribution this body of literature has to offer is an overall understanding of what the WBD actually looks like. Because most of the authors writing about the WBD did not explicitly map out the discourse in detail, the following understanding comes from drawing together the different ways in which these authors operationalised the WBD during the course of their research, and the conclusions they presented. Regardless of whether they explicitly stated their entire understandings of the discourse or they were implicit in how the research was conducted, it is evident that all authors analysed here considered the WBD to be the overarching medical discourse explaining transsexuality (Barker-Plummer, 2013; Psihopaidas, 2017; Sullivan, 2008). It is especially notable that none of these authors disagreed with one another or proposed meanings or assumptions for the discourse that conflicted with those of any other author.

The researchers reviewed here all concurred that the WBD was the idea that transsexualism was the experience of having been born, or being trapped, in the wrong body.

Underpinning this general statement are three tenets that can be distilled from the literature: 1) the body of a transsexual person feels wrong; 2) this is because there is a disjuncture between the person's gender and sex assigned at birth; and 3) the solution to this is hormonal and surgical transition in order to align the person's sex and gender and relieve the feeling of body wrongness. Most, though not all, authors make some reference to each of these three tenets, though none explicitly call them tenets. The closest model can be found in the work of Latham (2019) who, as discussed above, divided the discourse into four axioms.

Tenet 1: The body feels wrong

This first tenet is drawn from the most recognisable aspect of the WBD, namely that in transsexualism, the body is experienced as somehow "wrong." All of the authors reviewed here with one exception[9] identified the feeling of wrongness in the body as iconic and definitive of the discourse. Sullivan (2008) articulated this as "the self trapped in a body that is alien and alienating" (p. 106), though this wrongness is also identifiable in such phrasing as "false embodiment" (McQueen, 2014, p. 533), "wrong body entrapment" (Fink, 2018, p. 22), "being born in the wrong body" (Prosser, 1998, p. 69), and even "hating having the wrong genitals" (Latham, 2019, p. 26). All of these articulations centralise the body as being somehow *wrong* for the self, and it is around this articulation that the WBD is then built as a way to explain not only what the problem is (tenet 2), but how to solve it (tenet 3), as is evident below.

Tenet 2: Disjuncture between sex and gender

Many of the authors reviewed here extended their descriptions of the WBD by including how the discourse explains the feeling of body wrongness that defines it. Sullivan (2008) noted

[9] The only exception to this is Siebler (2012) who does not make any reference to wrong bodies, but has an extensive discussion of tenets 2 and 3 and as such, does discuss much of what is part of the WBD without naming it explicitly.

that the feeling of wrongness is caused by a "split between body and self, sex and gender" (p. 106), while Catalano (2015), drawing on the work of Cromwell (1999), expanded on this explanation by adding that the "misalignment [was] between body and cultural meanings of gender ascribed to specific parts of body" (p. 413). However, it is Barker-Plummer's (2013) articulation that has been cited by other authors in this body of literature. Barker-Plummer argued that the WBD explained gender variance as "the (accidental, biological) result of an individuals' brain or psyche being misaligned with their anatomy, so that an individual may identify as being one gender while living in the body of the "other," thus being in the "wrong body" (p. 711). Barker-Plummer's articulation most clearly explains *how* a person might come to experience their body as wrong for them.

In contrast to works that explicitly name sex and gender, Sullivan (2008), McQueen (2014), and Latham (2019) all conceptualised the disconnect as being between a self (mind) and the body that is inhabited by that self. This is not a significant step away from gender/sex-based descriptions, though, as is evident in the work of Bettcher (2014) who brings these two together in her articulation of the WBD as being about "a misalignment between gender identity and the sexed body" (p. 383). Bettcher's articulation makes evident the conceptual basis of sex as a characteristic of the body and gender or gender identity as located in the mind, connecting these two forms of articulation. Although authors like Latham and McQueen explain these relationships (sex/body and gender/mind) in the course of their publications, that explicit link is not as evident in their articulations as it is in Bettcher's. It is, however, evident in all of these explanations that the core problem that the WBD presents as the cause of feeling one's body as wrong is a misalignment or disjuncture between one's gender and one's sex.

Tenet 3: Hormonal and surgical treatment is the solution

Many authors writing on the WBD have focused on the way the discourse centralises hormonal and surgical treatment as the solution to the problem of feeling body wrongness. Bettcher (2014) argued that "in the wrong-body model, to become a woman or a man requires genital reconstruction or surgery as the correction of wrongness" (p. 390). This articulation explicitly positions genital surgery as the solution, correcting the feeling found in tenet 1 that defines the discourse in the first place. Other authors concurred, such as Psihopaidas (2017) who noted that "through medical gender transition the body is understood as having been healed or corrected" (p. 422), and Barker-Plummer (2013) who argued that the feeling of wrongness was "potentially fixable through changing the bodies of individuals" (p. 713). McQueen (2014) stated the relationship between experience and solution that is posited by the WBD most succinctly, writing that "the 'cure' for being in the wrong body is enacted through hormonal and surgical treatment" (p. 536). Latham (2019), then, expanded this. He argued that the WBD's use of the concept of incongruence acts "to justify and enable medical treatment" (p. 18), connecting the feeling of wrongness specifically to the solution of changing the body via explanations that centralise incongruence between body and mind. This body of literature, then, reveals that there is a consensus on the idea of the WBD including a presupposed solution as part of the discourse itself.

2.2.2 What assumptions does the literature reveal that the WBD depends on?

The literature also reveals that there are a number of assumptions identified by different authors that form a foundational lattice on which the WBD depends. Although it is likely that there are numerous assumptions that support the WBD as well as are reified by it, there are five that have been identified in the literature thus far. These are: 1) the mind and body are separate; 2) gender and sex are not the same thing; 3) gender and sex are both binary and exist in a

predictable relationship; 4) the "right" body (sex) exists for each of the two genders; and 5) bodily integrity is necessary for human well-being. The literature unfortunately does not yet include any works that consider the relationships between these assumptions. As such, I have listed them here in order of frequency with which they appeared in the literature.

Assumption 1: The mind and body are separate

A number of authors identified that the WBD presupposes a separate mind and body. Most, such as Nirta (2017), simply mentioned it without much discussion. Latham (2019), however, considered this assumption so important to the discourse that he counted it as one of his four axioms that make up the WBD. In fact, Latham argued that "the fundamental way transsexuality is constituted is through understanding a distinction between mind and body" (p. 17). Sullivan (2008) went further, explaining that in modernist understandings, the body is the property of a subject, and the subject inhabits it akin to operating a machine (p. 107). This, Sullivan argued, allows for an explanation of gender variance in which someone's self can be at odds with, and feel alienated from, their own body since the body is completely separate from the self/mind. Other authors have identified the presence of Cartesian dualism in the WBD and connected it to other discourses with which the WBD can thus develop a mutually reifying relationship. McQueen (2014), for example, connected the WBD to issues of citizenship and political agency through the way both were dependent on Cartesian dualism in compatible ways. Lovelock (2017), on the other hand, used the mind/body split to demonstrate that the WBD is tied to "self-realisation-via-body-alteration" (p. 677) such that transition can be articulated as becoming one's authentic self. The distinction between mind and body appears to be the most widely recognised underpinning assumption for the WBD in the literature.

Assumption 2: Gender and sex are not the same thing

It is evident from the literature that the WBD is also based on an understanding of sex and gender in which the two are not the same "thing," but each is an essential truth of a person. However, this assumption is not as easy to recognise as the first. Rather, the idea that sex and gender are separate is evident in such articulations as "transgender people possess an authentic gendered core, which is located within an initially mismatched corporeality" (Lovelock, 2017, p. 676) and "the problem for the transgender individual … is that the body and gender do not correspond" (Putzi, 2017, p. 424). In both of these quotations, gender and body are presented as being in opposition, necessitating the understanding that the two are not the same thing. Bettcher's (2014) articulation provides more detail, as she noted that in the WBD, it is "the body (genitalia, gonads, etc.) [that] is defective" (p. 386). These are characteristics that are, in contemporary biological discourse, aspects of "sex" (Devor & Dominic, 2015). Together, these examples demonstrate that the WBD is based on an opposition between sex and gender, where sex is a characteristic of the body, and gender is a characteristic of the mind/self.

Assumption 3: Sex and gender are both binary

Much like the second assumption, sex and gender both being binary is evident in the literature but rarely explicitly stated. Two notable exceptions to this are Lovelock (2017), who argued that the WBD "re-inscrib[es] a man/woman binary logic as the sole means of making sense of gender and the self" (p. 686), and Latham (2019), who noted that "the notion of binary, 'biological sex' underpins" the WBD (p. 18). Additionally, Psihopaidas (2017) noted that "binary and essentialist expectations … are associated with the wrong-body" discourse (p. 422), though his analysis focused on how some gender-variant people challenged these expectations rather than on how the expectations were part of the WBD. Other authors in this body of literature have made reference to binary gender in their discussions, and even though they did not

explain how it relates to the WBD (for example, Putzi, 2017; Catalano, 2015; Barker-Plummer, 2013), their identification of binary gender and binary sex reinforces the ideal that the WBD makes sense specifically in the context of those binaries.

Assumption 4: A right body exists

The assumption that a right body exists for each person, though rarer in the literature, has been identified as key to the production of the wrong-body. Indeed, there are only four references to the idea of a right body, but this nevertheless demonstrates that authors are beginning to grapple with the question of, if this body is wrong, what is a right body? Firstly, Barker-Plummer (2013) identified that the WBD "problematically pre-supposes a 'right' body" (p. 713). Capuzza and Spencer (2017) added to this idea that "transition [is] from a 'wrong body' to a right one" (p. 216) and Latham (2019), although not using the word "right" explained that "the very terminology used to describe trans surgeries, 'sex reassignment surgery' or even 'gender realignment surgery' for example, cite this concept of normative alignment" (p. 23), namely, a normative body for a particular gender. And finally, McQueen (2014)'s work demonstrated the most in-depth consideration of the idea of a "right" body. McQueen argued that "to feel in the 'right' body, one requires social recognition/validation of this, and this can only be offered if the body in question meets particular norms of what a 'right' body actually is" (p. 542). McQueen's work hints at links to binary sex and binary gender, though he does not explore those possible links in his research. Nevertheless, the question has been identified: what makes a body wrong or right?

Assumption 5: Body integrity is necessary for human well-being

The last assumption that the literature suggests underpins the WBD is the idea of integrity, though only three authors make note of it. According to Sullivan (2008), "a sense of

integrity is essential to human well-being" and thus the goal of treatment as outlined in the WBD is integration (p. 107). McQueen (2014) concurred, noting that "the idea of unity is … pervasive" and that there is an "assumed coherence of one's self that will be brought about by the correct alignment of mind and body" (p. 536). Latham's (2019) argument supports this assertion as he noted that treatment based on the WBD "reinforces the concept of congruence" (p. 23). Each of these terms—integration, unity, coherence, congruence—refers to the idea of everything fitting together the right way. Moreover, these examples suggest, in the least, a relationship to the first assumption, that mind and body are separate. Though that is not explored by these authors, Latham does also identify the mind/body split as relevant to the WBD, as does Sullivan, so a relationship between those assumptions can at least be inferred to exist.

2.2.3 So, what is the WBD?

The WBD, as described in the literature, is a three-tenet discourse that depends on a number of assumptions. These three tenets are: 1) the body feels wrong; 2) there is a disjuncture between sex and gender; and 3) hormonal and surgical treatment is the solution. Although this model is not explicitly stated by any author, the ways in which authors in this body of literature operationalise the WBD reveals these three tenets as the key propositions of the discourse. In addition to these tenets, the literature reveals a number of assumptions on which the WBD depends. These assumptions demonstrate that the WBD does not function in a vacuum, but rather as part of a broader network of discourses that together depend on and reify one another. It is likely, however, that there are additional assumptions on which the WBD depends that have not yet been identified in the literature. There are also noticeable gaps in the kinds of assumptions that have been identified as well as hints to other assumptions, such as the discourse of distress or the relationship between medical discourses and scientific discourses more generally.

Additionally, a number of authors have made reference to the notion of authenticity, and though one can theorise possible relationships between that theme and some of the assumptions present in the literature, the relationship has not been made explicit.

2.3 Evaluation of the literature

The literature explicitly analysing the WBD is very recent, and in it there have been significant contributions made by numerous authors to the understanding of what the WBD is and how and where it operates. This literature also shows that researchers are asking critical questions of how gender-variant people relate to the discourse, how they use it, and why, but also what other discourses have played a role in the development and the dominance of the WBD. However, there are a number of limitations to this literature and areas that need further research, demonstrated by the following questions.

First and foremost, what exactly *is* the WBD? The literature is missing an empirically-validated model of the WBD *as a discourse*. Although I have distilled a model based on the characteristics treated by researchers as defining of the discourse, no one has provided a set of characteristics by which one can identify the WBD. The closest to this task is the work of Latham (2019), whose work demonstrated that the same self-evident truths about transsexualism underpinning the work of Benjamin (1966) continue to appear in contemporary medical handbooks on the treatment of gender variance. This leaves every researcher interested in the WBD having to decide for themselves how to operationalise the discourse and how to identify it in data, which can be problematic as not all researchers clearly outline how they understand the WBD. This creates possibilities for data that is disparate and difficult to compare.

Second, how did the WBD actually develop into the contemporary dominant medical discourse of gender variance? Despite Stone's (1992) contention that the WBD became dominant

simply by default (p. 174) and several authors whose works demonstrate preliminary consideration of this question (Fink, 2018; Lovelock, 2017; Sullivan, 2008), the literature to date does not include a direct examination of this question. It does, however, suggest that a number of factors were possibly at play, such as the connections between the WBD and other discourses used within medicine and in society, which offers a starting point for more direct analyses.

Third, how have gender-variant people themselves related to the WBD? Thus far, only Ho (2006), Catalano (2015) and Psihopaidas (2017) have explicitly explored how gender-variant people make use of the WBD. Similarly, research into how gender-variant people contributed to the production and development of the discourse is extremely limited. It is highly likely that gender-variant people significantly shaped the development of this discourse, particularly since authors like Bolin (1988) and Denny (1996) have noted that gender-variant people, having read Benjamin's (1966) book, repeated his diagnostic criteria when speaking to medical experts. What little is included about gender-variant people themselves in the history of the medicalisation of gender variance is limited to white gender-variant people: Christine Jorgensen, Reed Erickson, Virginia Prince (Gill-Peterson, 2018). The exception to this is the work of Matte (2014) who looked at how Reed Erickson and the Erickson Educational Foundation (EEF) explicitly pushed medicalisation in general, and liberal American transnormativity in particular, as central to the conceptualisation of gender variance in the United States. Although Matte does not specifically discuss the WBD, the relevance of his work to the development of the WBD is demonstrated in this dissertation, particularly in chapter 6.

Fourth, how does the WBD relate to race and whiteness? In asking questions like how the WBD has been represented in books or television shows, or how it relates to other discourses like political subjectivity or the monstrous, the question of race is conspicuously absent in the

literature. Some literature, such as Snorton (2017) and Gill-Peterson (2018), has demonstrated that gender-variant people of colour not only had a rich history not recorded by medical experts, but their engagement with medicalised discourse differed from that of white gender-variant people. More specifically, gender-variant people of colour were less likely to be granted access to hormonal and surgical treatment, and more likely to be diagnosed with other mental illnesses and incarcerated (Gill-Peterson). Moreover, gender-variant people of colour were often used in experiments in the course of developing techniques and technologies that would benefit white people, gender-variant and not (Snorton). How much of the WBD, then, was shaped by interactions between white medical experts and gender-variant people of colour? How many of these interactions were not recorded anywhere in the medical-expert literature? And, given the links between medical experts like Benjamin and German eugenics movements, discussed in chapter 4, how was the history of the WBD shaped by eugenics?

Fifth, what is the relationship between the WBD and other, especially non-Western, conceptualisations of gender variance? This is an exceptionally important missing aspect, particularly in the Canadian and American contexts, because the development of the WBD, and the medicalisation of gender variance, occurred in the context of colonisation in Canada and the United States and the use of medicine as a tool of colonialism. As noted in the introduction, Indigenous ways of conceptualising gender variance do not necessarily share the WBD's ontological premises. For example, the term "Two-Spirit" includes not only identities similar to Western ideas of gender variance but also lesbian, gay, bisexual and queer identities (Ristock et al., 2019, p. 769), rejecting the same Western ontological separation between sexuality and sex/gender that forms the basis of the WBD. The lack of such an analysis is not only problematic for the lack of acknowledgement of other ways of conceptualising gender variance, but also

potentially reflects a Eurocentric bias in the kinds of work being conducted. Moreover, the lack of such research means that the ontological underpinnings of the WBD remain underchallenged.

Lastly, what is the relationship between the WBD and transnormativity? While the concept of medicalisation is evident throughout the WBD literature, there is no research that explicitly articulates any relationship between the WBD and transnormativity. Although it is possible to find similar themes both in work on the WBD and on transnormativity, I found no publication that makes explicit reference to both. Nevertheless, a link between the two seems possible, because Johnson (2016) links transnormativity to "the medical model of transgender identity" (p. 803), and institutionalised medicine is widely demonstrated in the WBD literature as the foremost context within which the WBD operates.

2.3.1 How my research fits into the WBD literature

My research aims to address some of the questions discussed above. First and foremost, as a systematic, empirical study of texts written for medical-expert audiences that traces the development of the WBD, I intend to empirically validate the three-tenet model of the WBD that is evident, but never explicitly articulated, in the literature. My research can thus show not only that the three tenets implicit in the literature can be seen in primary documents, but that this model helps answer other questions about the WBD.

Using this model, my dissertation is intended to then also address some of the other questions raised by the literature. It aims to start developing an understanding of how the WBD became dominant by identifying, exploring and tracing some of the contributing discursive factors. Although this question cannot be definitively answered, the purpose of this research is to extend the work of such researchers as Sullivan (2008), Lovelock (2017), and Fink (2018), who have thus far connected the WBD to other, more established discourses. My research also aims

to address the significant lack of work on the relationship between the WBD and race. In examining the ways in which the WBD was put into practice as was evident in texts intended for a medical-expert audience, my research can begin to articulate the connection between the WBD and whiteness. Finally, my research aims to connect the WBD literature to the concept of—and thus body of literature on—transnormativity. In doing so, my research can demonstrate that the WBD should be considered by researchers interested in the various transnormativities that operate today and the effects they have on gender-variant people.

3 Methodology

To answer the questions raised by the literature as outlined in the previous chapter, I turn to critical discourse analysis (CDA), especially the work of Fairclough (1989; 1992; 1995) and Weiss and Wodak (2003). I supplement this with four principles from Foucault's (1979; 1981) genealogical method as a way to address some of the critiques that have been brought against critical discourse analysis. I begin this chapter with an overview of CDA, followed by an explanation of how I integrate Foucauldian genealogy and how this enriched CDA methodology is appropriate for my research questions. I then explain how I conducted the research including an overview of how I selected my texts, and close with an explanation of how I conducted the analysis.

3.1 Critical Discourse Analysis

Critical discourse analysis is a methodology that is defined not by a unified way of doing research but by the goals of that research and what is considered important for addressing research questions, namely, language and power. Indeed, according to Weiss and Wodak (2003), there is no guiding theoretical viewpoint that is consistently used in CDA research (see also: Breeze, 2011). Rather, what underpins all CDA research is the question of "how discourse cumulatively contributes to the reproduction" of power relationships in society (Fairclough, 1985, p. 753; see also Meyer, 2001; van Dijk, 1993). Thus, the primary goal of CDA is to "denaturalise," or reveal, ideologies when they appear as common-sense knowledge about the world to actually be relations of power (Fairclough, 1989). What differentiates CDA from other, similar linguistic research methodologies, such as discourse-historical method and critical linguistics, though, is an explicitly emancipatory goal (Fairclough et al., 2011): the purpose of revealing ideologies is to better be able to challenge them. Additionally, because of this

emancipatory goal, CDA researchers make no claims to, nor do they have any desire for, objectivity (Meyer).

Although there are a number of researchers who have made significant contributions to CDA methodology, including van Dijk (1993; 2006), Wodak (2001), and van Leeuwen (1993, 2008), and CDA has roots in Halliday's (1973; 1978) linguistic methodology, the beginning of CDA can be traced back to the early works of Fairclough, particularly his 1989 book, *Language and Power* (Rogers et al., 2005; Blommaert & Bulcaen, 2000). In this book, Fairclough (1989) aimed to articulate the relationship language had to the "production, maintenance, and change of social relations of power" (p. 1). He did this by outlining a discourse analysis methodology—which he alternately called "critical language study" and "critical discourse analysis"—that he argued researchers could use to reveal and challenge power relationships in society. By the publication of his second book in 1995, *Critical Discourse Analysis: The Critical Study of Language*, Fairclough had settled on the name "critical discourse analysis," or "CDA," and had shifted his focus to developing a more explicit analytical framework for his methodology. According to Breeze (2011), this second book marked the consolidation of CDA as a methodology.

Fairclough's (1989; 1995) CDA methodology represents an attempt to bring together several ideas that he found useful in his analysis of the relationship between language and power: Gramsci's (1971) conceptualisation of hegemony, Althusser's (1971) ideological formation, Pêcheux's (1982) discursive formation, and Foucault's (1981) order of discourse. Fairclough's methodology begins with Gramsci's conceptualisation of hegemony as 'common sense' and the idea of consent to power. For Fairclough, this raised the question of how this consent was obtained, how something came to be seen as 'common sense,' for which Fairclough looked to

the concept of language. In order to explain how language was used to make something appear common-sense and obtain the consent to power, Fairclough drew together the concepts of an ideological formation (Althusser) and a discursive formation (Pêcheux)—neither of which in Fairclough's estimation explained the process enough on its own—to form the ideological-discursive formation: "a particular set of discursive conventions [that] implicitly embodies certain ideologies" (Fairclough, 1995, p. 94). In simpler terms, Fairclough conceptualised "ways of seeing" (ideological formations) and "ways of talking" (discursive formations) not only as inseparable but as mutually co-constitutive (p. 40). To this, Fairclough added the concept of order of discourse (Foucault), which he defined as "the ordered set of discursive practices associated with a particular social domain or institution" (p. 12). This was a way for Fairclough to articulate the relationship between institutions, and ways of seeing and talking.

CDA research centers on three key concepts: discourse, text, and ideology. These concepts have specific definitions within CDA, though not all CDA researchers are as clear in their definitions. Fairclough (1995) defines *discourse* as "language use conceived as social practice" (p. 135). It is important to note that in defining discourse as a social practice, the definition encompasses what Fairclough et al. (2011) argued is a "dialectical relationship" between the instance of the discourse and its context: they constitute and reinforce one another. This makes discourses historically contingent (Carvalho, 2008; Fairclough et al.). El-Sharkawy (2017) elaborated on this, explaining that the definition of discourse in CDA, "a group of statements which provide a language for talking about … a particular topic at a particular historical moment" (p. 10), draws on Foucauldian (Foucault, 1972) conceptions of discourse as historically situated. Discourse, then, is not just what is said, but also the rules about what can be said, and as noted earlier, this is inextricable from sociocultural and institutional contexts and it

is historically contingent. Instances of a discourse being used are called "articulations" (Horner, 2014), and can be identified by such things as explicit wording, assumptions, and chains of equivalence, a term referring to words and phrases being treated as related in meaning or drawing on the same meaning of a concept (Horner; Howarth, 2013). Each time a discourse is articulated, the context within which this occurs shapes the articulation and that articulation then becomes part of the context for the next articulation (Horner).

Articulations of discourses can be found in *texts* which, according to Fairclough (1995), are "the written or spoken language produced in a discursive event" (p. 135; see also Leitch & Palmer, 2010). Another way of understanding texts in CDA is seeing them as "representations of social actions, of social productions, or makings of meanings, understandings, knowledge, beliefs, attitudes, feelings, social relations, social and personal identities" (El-Sharkawy, 2017, p. 16). Additionally, texts contain two implicit sources of information for the analyst: traces of the process and context of production, and cues for how it is expected to be interpreted (Fairclough, 1989). An analysis of texts, then, must take into account all of these facets. Thus, according to the literature, a text is anything written or spoken that has some sort of meaning.

The final key concept in CDA is *ideology*. According to Fairclough (1989), ideology is the set of "ideas which arise from a given set of material interests in the course of the struggle for power" (p. 94). He elaborated on this, arguing that ideology is "located in both structures … and events" (Fairclough, 1995, p. 25), meaning that ideology both exists as part of the structure within which social practices, such as discourses, take place, and is reproduced through social practices. For Fairclough, nothing is free of ideology, including critical discourse analysis itself. Other critical discourse analysis researchers, however, are not as explicit in their definitions. For example, Weiss and Wodak (2003) stated that ideology is "an important means of establishing

and maintaining unequal power relations" (p. 14), a definition which focuses on what ideology does rather than explaining what it is. Wodak (2001) added to this definition, explaining that discourse is a key instrument of ideology (p. 9), though again, the definition does not have an explicit statement of what ideology is, although in this case, Wodak connects it to one of the other two key concepts, discourse. In this project, I use Fairclough's conceptualisation of ideology. I discuss this further in this chapter in the section on how Foucault's (1972) work is integrated into CDA, as well as in the section on key concepts in this project in the introductory chapter.

In CDA, context is crucial. According to Wodak (2001), in order to adequately analyse a text, researchers must look at the "social processes and structures" that not only led to the production of the texts, but also within which the texts are used and interpreted. These "institutional and sociocultural contexts" (Carvalho, 2008, p. 161) are important because, as Wodak argues, researchers conducting CDA recognise that texts are not just produced by one person. Rather, numerous factors and influences play parts in shaping the text, and many of these leave traces within the text, and as such, are relevant to the meaning and use of the text. The more of these influences a researcher can discern, the more robust the analysis. Indeed, as laid out in Fairclough (1992), CDA has three levels of analysis that allow the researcher to connect the texts and discourses to their context: discourse-as-text, discourse-as-discursive-practice, and discourse-as-social-practice. While these three levels of analysis will be discussed in more detail in the section on how to conduct CDA, it is sufficient to say here that these three levels broadly map onto micro-, meso- and macro-level analyses, respectively, and help the researcher move back and forth between these levels.

Although Fairclough (1989; 1992; 1995) made very few explicit references to Foucault, preferring instead to identify his influences as primarily Gramsci (1971), Althusser (1971), and Pêcheux (1982), it is quite evident that CDA owes an intellectual debt to Foucault and his analyses of power and discourse. CDA is often described as a methodology for "demystifying ideologies and power" (Wodak, 2004, p. 185) and thus does not sound particularly Foucauldian in light of Foucault's rejection of the concept of ideology (Bielskis, 2018). However, the ways in which "discourse" is conceptualised in the CDA literature and by Fairclough himself suggests that Foucault was more influential than it might at first appear. As already noted above, the prevailing definition of "discourse" in the CDA literature draws on Foucault's (1972) understanding of discourse as historically situated. Looking more closely, though, there are two further similarities: discourse as a productive process in the context of power relationships, and the inclusion of Foucault's (1981) "order of discourse" in the general definition of "discourse" within CDA.

Firstly, there are significant similarities between Foucault's conceptualisation of "discourse" and Fairclough's. For Foucault, "discourse" is productive. Foucault (1972) defines discourses as "[social] practices that systematically form the objects of which they speak" (p. 49). In other words, discourses produce the objects that they purport to simply describe. Although Fairclough does not state so as clearly, his conceptualisation of "discourse" also posits it as productive. According to Fairclough (1995), discourse is "language use conceived as social practice" (p. 135). To this definition he subsequently added the premise that there is a dialectical relationship between language use and the context in which it is used: every instance of discourse use adds to the structure which shapes future use (Fairclough et al., 2011). This means that Fairclough's "discourse" produces its own context on an ongoing basis. In a similar fashion,

Foucault's "discourse" produces objects, and these objects can structure further discourse, especially if, as Foucault noted, discourses provide ways to talk about something and so can be seen as the context of further discourse use.

Secondly, the CDA concept of "discourse" includes within it Foucault's concept of "order of discourse." As already mentioned above, "discourse" in CDA includes not just what is said, but also the rules about what can be said. Rules about what can be said and, indeed, about who can say things and what can and cannot be added to a discourse, are what Foucault (1981) referred to as the "order of discourse." While that particular phrase does not widely appear in the CDA literature, it can actually be found in Fairclough (1989) where he both uses it and acknowledges its source as being Foucault. However, it appears that Fairclough chose not to continue to use this specific phrase and, instead, subsumed the concept under the general term "discourse." Nevertheless, this along with the similarity in conceptualising discourse as productive suggests that Foucault's influence on CDA was perhaps stronger than is widely acknowledged.

3.1.1 How to conduct CDA

Because CDA is not unified by a set of steps but rather by an approach and an understanding of the key concepts, there is no detailed step-by-step guide to CDA methods for a researcher to follow. In developing his methodology, Fairclough (1989; 1992; 1995) outlined a framework to guide researchers in conducting the analysis portion of a CDA research project. There are also four key tasks important to the preparation of CDA research that are evident in the literature. These tasks are: the definition of key CDA terms (discourse, text, ideology), the development of analytical concepts, the writing of the historical context within which the discourse exists, and the development of criteria for the selection of texts. Although these four

tasks do not appear in the literature in any specific order, I have presented them here in the order that I find to be most logical in preparing to conduct research. Additionally, because setting up research comes before analysing the data, I present the guiding discussions first, and follow this with Fairclough's framework for analysis.

The first task of CDA research is an articulation of one's position on the three key concepts that underpin CDA: discourse, text, and ideology (Meyer, 2001; Weiss & Wodak, 2003). This serves as the theoretical foundation for conducting a CDA. The second task is the development of one's own analytical concepts that are specific to the research questions being asked (Meyer; Weiss & Wodak). These concepts must be "capable of connecting the level of text or discourse analysis with sociological positions on institutions, actions and social structures" (Weiss & Wodak, p. 8), and assist the researcher in moving back and forth between micro-, meso-, and macro-level analyses, as well as in identifying what is evident in texts and what is missing. The third task is the writing of a historical context of the discourse of interest (Fairclough, 1985). In order to decide what texts to include in a CDA, a researcher must first combine "a sociological account of the institution under study" with "an account of the 'order of discourse' of the institution" and "an ethnographic account" of the discourse in question (p. 759; see also Meyer; Carvalho, 2008). The final task is the development of criteria for the selection of texts (Meyer). To do this, the researcher should articulate what constitutes a "typical text" in the context of their research question because, due to the variability in CDA research, each researcher must choose their own units of analysis (Meyer). However, these criteria may change during the research process because, much like Grounded Theory (Glaser & Strauss, 1967), data collection and analysis are not distinct phases of research. This also means that data collection is never "complete" because a "complete" analysis is simply impossible, and that theoretical

saturation—when no new information is gleaned from the data—should be the goal (Jäger, 2001).

In developing CDA methodology, Fairclough (1989) outlined a framework for the analysis of data. In subsequent publications, Fairclough (1992; 1995) elaborated on and rephrased the analytical steps, but the basic three-dimensional framework of CDA has remained throughout. According to Fairclough (1992), CDA has three analytical stages: analysis of discourse-as-text, analysis of discourse-as-discursive-practice, and analysis of discourse-as-social-practice. Although Fairclough does not articulate his method in these terms, this framework moves the researcher back and forth through micro, meso and macro levels of analysis in an effort to provide a more thorough picture of the way a particular discourse appears and operates in society, and how it contributes to specific power relations.

The first stage, analysis of discourse-as-text, involves a close look at each individual text. This stage begins with looking at the vocabulary found in the text, paying close attention to the kinds of words and expressions that are used (Fairclough, 1989, p. 112-120). The researcher then examines the grammar, including modes of speech and structures of sentences (p. 120-132). Finally, according to Fairclough, the researcher considers textual structures, namely formal conventions for interaction and for different types of communication (p. 133-139). This level can be conceptualised as the micro level of analysis.

The second stage is the analysis of discourse-as-discursive-practice, alternatively called analysis of interpretation (Fairclough, 1989) and analysis of discourse practice (Fairclough, 1995). Fairclough (1995) explained this stage as the analysis of the "process[es] of text production, distribution and consumption" (p. 2). To do this, Fairclough (1989) explains that researchers must analyse the interactions between subjects and the interpretations of texts made

by subjects (p. 140-162), since the "relationship between text and social structures is an indirect and mediated one" (p. 140). This is also the stage at which the researcher considers intertextuality, which is the relationship between texts. Fairclough (1992) argued that there are two levels of intertextuality the researcher must consider: manifest (explicit or overt referrals to other texts) and constitutive (conventions, discourse types, etc. that rule a particular group of texts). This level also includes quotations available in the text being analysed, and looks at how those quotations are chosen, changed, and contextualised (Blommaert & Bulcaen, 2000). Together, these form what could be considered a meso-level analysis.

The third and final stage is the analysis of discourse-as-social-practice. Fairclough (1989) referred to this as the analysis of the social context, whereas Fairclough (1995) articulated it as an analysis of "discursive events as instances of sociocultural practice" (p. 2). In this stage, the researcher seeks to explain the relationship between the text and its interpretation by looking at social, institutional and situational factors (Fairclough, 1989, p. 164). This level connects discourse to "ideological effects and hegemonic processes in which [this] discourse is a feature" (Blommaert & Bulcaen, 2000, p. 449). Connecting the discourse to ideology and hegemony would constitute a macro-level of analysis.

3.1.2 Critiques of CDA

As with any methodology, there are a number of critiques levelled against CDA with which researchers aiming to conduct CDA must contend. Some of the critics of CDA take issue with what some proponents of CDA consider to be strengths of CDA, such as its openness to varied methods (Meyer, 2001). Others argue that despite CDA having emancipatory goals, actual CDA research often does not fulfil these methodological expectations (Breeze, 2011). Overall,

however, the underlying message amongst proponents of CDA in response to critiques is for researchers to directly address the critiques in their methods and planning.

One of the most common critiques is the idea CDA has too much methodological variability and inconsistency to be considered a critical paradigm in itself (Breeze, 2011). This methodological variability leads to issues like poorly defined key concepts (Meyer, 2001), including even the term "critical" itself (Breeze), as well as the use of incompatible theoretical concepts (Fowler, 1996). This is made significantly more problematic when, as Meyer demonstrated, CDA researchers often do not explicitly articulate their actual methods, making it difficult, if not impossible, to evaluate the conceptual basis of their research. Thus, according to critics like Verschueren (2001), the absence of methodological rigour significantly undermines the validity of CDA research as a whole.

Another overarching criticism of CDA rests on how researchers put the basic premises of CDA research into practice. According to its proponents, CDA centralises context in the analysis of discourses. However, critics such as Verschueren (2001) have argued that, in practice, context is often simply forgotten. In a similar vein, Widdowson (1998) has noted that this lack of contextualisation can result in CDA researchers falling back on naïve linguistic determinism, assuming that audiences accept discursive and ideological meanings unproblematically and that these messages then shape how these audiences think. Others have suggested that not enough attention is paid to the transformative potential of discourses or to resistances to dominant discourses (Martin, 2004; van Dijk, 1993). Despite, as Breeze (2011) pointed out, many proponents highlighting the need to also analyse how a text is produced and used, the reality is that not every researcher is able to do so, because such research can be very expansive and lengthy.

The last type of criticism that appears in the literature focuses on the question of whether, by arguing that no researcher can be unbiased, CDA researchers actually simply interpret rather than analyse, leading them to find in their data exactly what they expected to find (Widdowson, 1998). This criticism was echoed by Schegloff (1997), who considered CDA to involve too much of the researchers own political biases. Blommaert (2001) considered this question more carefully, and suggested that CDA researchers often begin with political stances and beliefs about key figures in the social issue they are exploring. Rather than dismissing CDA researchers for acknowledging their epistemological stance that no researcher is unbiased, Blommaert looked more closely at how that could manifest in ways that undermine a researcher's intent.

Some of these critics also suggest ways to address specific problematic aspects of CDA, though often this is in the form of a change in ontological or epistemological position. The overarching message, however, is that in order to strengthen CDA, researchers must make themselves aware of, and directly address, these problematic aspects. First and foremost, as both Breeze (2011) and Meyer (2001) recommend, researchers conducting CDA should explicitly define the concepts they are using, as well as the theoretical foundation of these concepts. This does not preclude the variability that many proponents of CDA see as a strength of the methodology, but rather makes it apparent to those reading the results of research how the researchers came to their conclusions. A second recommendation is to explicitly state all steps taken in research, in order to demonstrate methodological rigour even if the CDA as a whole does not have any standards on how to conduct good research (Meyer). A third recommendation is to conduct a "natural history" of a discourse rather than focusing on single genres or instances of discourses (Blommaert, 2001) which, although significantly more involved, can produce a more thorough analysis of how a discourse functions.

It appears, then, that there are ways to mitigate the problems caused by some of the ways in which researchers have conducted CDA thus far. I argue that Foucauldian genealogy is one specific way to address some of the critiques that have been identified in the literature, most notably the need to take context more explicitly into account and the need to clearly define theoretical concepts to make sure that these concepts are compatible.

3.1.3 CDA and Foucauldian Genealogy

As is evident from the discussion of the literature above, CDA centralises social critique (Leitch & Palmer, 2010; Blommaert & Bulcaen, 2000; Wodak, 2001), and is considered by its proponents to be an ideal methodology for questions that involve "ideology, power, hierarchy and gender" (Wodak, p. 3) as well as axes of inequality such as race, class or sexuality. Despite this, the literature that focuses on how to conduct CDA research includes only preliminary discussions on how to ensure that researchers address these issues. Even Fairclough's (1989; 1992; 1995) three-dimensional framework for analysis does not provide examples of the kinds of questions a researcher could ask of their data in order to ensure that social critique is, in fact, centralised in their actual research. I argue that Foucault's (1979) genealogical method, specifically his four principles (1981), can significantly enrich CDA methodology. This is because these four principles provide more structure for researchers to follow when asking questions of their texts. In this section I look first at Foucault's four principles, followed by a discussion of how CDA and Foucauldian genealogy are compatible and I close the section with consideration of the theoretical tensions between these approaches, specifically as it relates to the centralisation of ideology.

Foucault (1981) outlined four principles that he argued governed the questions that researchers should ask during genealogical analysis: reversal, discontinuity, specificity, and

exteriority (p. 67). According to Foucault, each of these four principles directs a researcher to a specific dimension of interrogation of their texts beyond what is immediately noticeable. First, the principle of reversal directs a researcher to look at what is excluded and unsignified. For Foucault, discourses necessarily exclude possibilities in order to appear coherent. Second, the principle of discontinuity directs the researcher's attention to the way discourses have disjunctures and contradictions, both within a discourse and between different discourses. This is, Foucault argued, because discourses are not linear but rather form a web with jumps, schisms, and lateral relationships. Third, the principle of specificity encompasses analyses related to articulation, and involves comparing articulations to one another to identify patterns in how things are said. This principle is rooted in Foucault's argument that regularity is not inherent to an object of a discourse but rather is a characteristic produced by discourses. Last, the principle of exteriority directs the researcher's attention to the conditions of possibility of the discourse, namely its historical and sociocultural context. This fourth principle also includes a consideration of the power relations that surround discursive articulations, such as struggles for power and authority. The specific questions I developed on the basis of these four principles can be found in Table 3 on p. 80.

Foucault's (1981) genealogical methodology, and his four principles in particular, are particularly well-suited to being added to CDA methodology. This is most evident when comparing them to the CDA framework outlined by Fairclough (1989; 1992; 1995), which reveals the two frameworks to be closely aligned. Moreover, the overarching goal of CDA is revealing hidden relationships, as is Foucault's genealogy's. And finally, despite Foucault's avoidance of the concept of ideology (Bielskis, 2018), the genealogical method conceptualises

hidden power relationships in an exceptionally similar way to Fairclough's conception of ideology.

The kinds of questions that Foucault (1981) described when discussing his four genealogical principles are very similar to Fairclough's (1989; 1992; 1995) three-dimensional model of CDA. Foucault's principle of reversal, which considers issues of signification and what is potentially excluded from that signification, is very similar to Fairclough's first level of analysis, discourse-as-text, which looks at such characteristics of texts as vocabulary and grammar. This first level of analysis also includes a consideration of the ways certain words and phrases direct attention towards some things and away from others. Foucault's principles of discontinuity and of specificity roughly align with Fairclough's second level of analysis, discourse-as-discursive-event. This level of analysis, according to Fairclough, looks at how texts are produced, distributed and consumed, as well as the relationships between different texts. In the principle of discontinuity, Foucault looks at disjunctures and contradictions both within a text and between texts, a task that could be accomplished by looking at a text in depth (Fairclough's first level) or by looking at texts in the context of other texts and practices (Fairclough's second level). Similarly, in the principle of regularity, Foucault directs attention to what patterns of regularity emerge across a discourse, which could be seen both within a single text as well as across texts and practices. Finally, Foucault's principle of exteriority refers to a discourse's conditions of possibility. This is the same concern that underpins Fairclough's third level of analysis, discourse-as-social-practice, in which the researcher looks at the social, institutional and situational factors involved in the production, distribution and consumption of a text. The principles that Foucault outlined, then, are compatible with Fairclough's three-dimensional model of analysis in CDA.

Moreover, as is evident in the works that bring these two methodologies together, both CDA and genealogy aim to reveal the ways in which language and discourse can be used to hide unequal power relationships. CDA, and particularly the use of the concept of ideology within this analysis, aims to understand "how discourse cumulatively contributes to the reproduction" of power relationships in society (Fairclough, 1985, p. 753) as well as to "denaturalise," or reveal, ideologies when they appear as common-sense knowledge about the world (Fairclough; Carvalho, 2008). Despite not using the concept of ideology, Foucault (1981) had very similar aims in his genealogical method. Underpinning these four principles is genealogy's focus on what Anaïs (2013) articulated as "the story of how a set of discursive and non-discursive practices come into being and interact to form a set of political, economic, moral, cultural, and social institutions which define the limits of acceptable speaking, knowing and acting" (p. 125). According to Evans (2008), genealogy is "a means of undermining any discourse that tacitly or overtly presents itself as transcending the arena of power and resistance" (p. 371). Similarly, Kirkpatrick (2019) argued that the purpose of genealogy is to figure out "how such knowledge [the topic of research] embodies particular power relations and how these become implemented and normalised over time so that their very existence is no longer questioned" (p. 319). And finally, Valdés Miyares (2019) argued that genealogy is used to "[disturb] … foundational myths" (p. 324). Each of these three statements reflects the same kind of idea that the CDA literature centralises: denaturalising ideologies or, in other words, revealing discourses that present themselves as common-sense to actually be in the service of particular power relations.

Despite this alignment, significant tension remains between Fairclough and Foucault: the problem of ideology. For Fairclough (1989; 1992; 1995), ideology is central to understanding how unequal relationships of power are produced and maintained through the use of language.

Recalling the discussion earlier in this chapter, drawing significantly on the work of Althusser (1971), Fairclough (1989) defined ideology as a set of ideas that "arise[s] from a given set of material interests" (p. 94). Although the Marxist roots of this definition are evident in the focus on material relations, Fairclough explicitly positioned his conception of ideology against the Marxist definition of ideology as a *false* consciousness (Fairclough, 1995, p. 16-17). For Fairclough, *all* material interests can give rise to ideologies, and though ideologies are often used to maintain and reproduce unequal power relations, not every ideology is used in this fashion. The analytical task Fairclough assigns to the concept of ideology, then, is to help the researcher reveal the ways in which common-sense beliefs about the world are, in fact, ideological in nature and as such, tied to specific material interests. Moreover, because for Fairclough ideologies arise from all material interests, and all subjects are always in myriad power relations and have multiple material interests, there is no position outside of ideology. Rather, conducting CDA provides only a partial perspective from one position, with no claims to truth or privileged knowledge.

In contrast to this, Foucault (1979) rejected the concept of ideology (Fairclough, 1995; Bielskis, 2018), although he, like Fairclough, was interested in the ways in which language and discourse are used to reproduce, maintain and even obscure power relations. Foucault considered ideology to be problematic in at least two ways: first, ideology implied the existence of a truth, one that could be obfuscated or distorted by ideology; and second, to study it, a researcher would have to either claim a position outside of ideology from which they could provide critique or privilege one discursive position above all others (Foucault, 1972; 1979; 1980; Fairclough; Martin, 2013). Although some conceptions of ideology do indeed presuppose a truth that is hidden from certain groups, particularly those in the Marxist tradition, it is evident from the

literature that Fairclough's conception of ideology does not. In addition to explicitly stating that he does not agree with the Marxist conception of ideology obscuring true material relations, Fairclough argued that ideology arises from all material interests, not just those that disadvantage other groups. This means that a single truth need not exist—Fairclough's position is compatible with multiple truths existing as well as the possibility that a truth, or many truths, exist that are inaccessible to any subjects, or that indeed, no truth exists. Considering Foucault's second critique of ideology, it is evident in the literature that CDA in general—and Fairclough in particular—do not position the researcher outside of ideology. Instead, they recognise the partiality of every view point and advocate for multiple researchers studying similar things to provide a more comprehensive understanding from multiple viewpoints, thereby also not privileging any discursive position above others. Indeed, for Fairclough (1995), Foucault's critique amounts to "helpless relativism" (p. 16) and he disagrees with the idea that all positions being ideological in some way necessarily makes it impossible to study ideology and its effects.

3.1.4 Justification of Methodology

CDA in general, being a political form of discourse analysis (van Dijk, 1993), is appropriate for this research project because it looks at how language and discourse serve as tools of ideology and power relations, and this is also the approach I take in asking my research questions. My first question, how did the WBD come to be the dominant discourse in institutionalised medicine in Canada and the United States, draws not only on the same understanding of discourse as underpins both CDA and Foucauldian genealogy, but explicitly looks to reveal how the naturalisation of the WBD has occurred in Canadian and American institutionalised medicine. Underpinning my first question is the understanding that at the time of its institutionalisation, the WBD appeared as obvious, a given, common-sense, and that this

appearance was produced by the discourse itself. The second question—what are some of the ideological effects of the WBD—links my research directly to the primary goal of CDA, which is to examine how discourses are tools of ideology. Moreover, my questions specifically address how the WBD came to be the discourse that was institutionalised in the *DSM-III* diagnosis of transsexualism (APA, 1980) and researchers such as van Dijk (1993) and Blommaert and Bulcaen (2000) have explained that CDA explicitly examines the relationship between language and institutional practices. In essence, my research questions are based on the same theoretical understanding as CDA, and CDA is intended to answer the very kinds of questions that I am asking.

3.3 Methods

To conduct this project, I began by following the recommendations found in the CDA literature for setting up my research project, as outlined in the discussion above. I started with a clarification of my key methodological concepts, namely how I define text, discourse, and ideology. These can be found in the introduction (section 1.3). I then identified my key analytical concepts, medicalisation (section 1.3.1) and diagnosis (section 1.3.2). As Weiss and Wodak (2003) stated, these concepts are intended to help the researcher connect discourse with action. I then wrote the historical contextualisation of the social issue, drawing both on the literature covering the history of gender variance and my two analytical concepts (chapter 4). Finally, because there are no explicit rules to follow in selecting units of analysis (Meyer, 2001), I have chosen to be clear and explicit about every decision I made, and to explain why I made the selections I did. This can be found below.

3.3.1 Selection of data

As noted by Meyer (2001), each researcher must identify their own units of analysis in the context of their specific research question(s). This is because typical texts differ depending on the context that is being researched. In this dissertation, I define the typical text as a text on gender variance written for a medical audience. Most often, this appears as a medical text written by a medical expert, but also as treatises from the nineteenth century as well as pamphlets published by gender-variant-run organisations intended to educate medical experts on the topic of gender variance.

The selection of texts was based on the following set of criteria, summarised in Table 1 below. First, the texts had to be written in, or translated into, English. Second, the texts had to be about adult gender variance. Most often this meant a discussion of transsexualism explicitly, but this also included discussions of transgender and even inversion. I chose to only include discussions about adult gender variance because the *DSM* diagnoses for adults and children are separate.[10] Third, the year of publication had to be between 1860 and 1979. According to the analysis of the historical context of the WBD and the literature review, the earliest instance of a discussion that was recognisable as being related to the WBD was published in the 1860s. For this reason, I chose 1860 as the beginning date. The end date reflects the institutionalisation of the WBD in the diagnosis of transsexualism in the *DSM-III* (APA, 1980), because institutionalisation represents a shift in the power relations between medical experts and their patients (Dewey & Gesbeck, 2017; see also: Halpin, 2016).[11] In order to ensure that the project

[10] DSM-III (APA, 1980): Transsexualism, Gender Identity Disorder (GID) in children; DSM-III-TR (APA, 1987): Transsexualism, Gender Identity Disorder (GID) in children, Gender Identity Disorder (GID) in adolescence or adulthood, nontranssexual type; DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000): Gender Identity Disorder in Adolescents and Adults, Gender Identity Disorder in Children; DSM-5 (APA, 2013): Gender Dysphoria in Adolescents and Adults; Gender Dysphoria in Children.

[11] According to Halpin (2016), the *DSM* is a text that not only structures the actions of medical experts but also the relationship between medical experts, patients, insurance companies and the pharmaceutical industry. I argue that this is a significant shift from a context of patients (and many medical experts) pushing for recognition of transsexualism, as discussed in the introduction to this dissertation.

was of a manageable size, the work that such a shift would necessitate in the analysis had to be excluded. Fourth, the texts had to be intended for a medical audience. I ascertained this by looking at where the text was published. Academic and medical journals were obvious places to publish, but I also included texts where the authors explicitly named or addressed medical experts. The fifth criterion is that of author. The first set of texts is defined by authors who were medical experts, defined as a person who, through experience or study, has acquired medical knowledge and skill (for a longer definition, see section 1.3). The second set of texts is differentiated by authors who were gender-variant community members. If an author fell into both categories, they were included in the first group, because the authority associated with medical expertise is not accessible to those without medical expertise.

Table 1

Criteria for text selection

Category	Medical expert authors	Community-based authors
Language	English or translated into English	English or translated into English
Topic	About adult gender variance or transsexualism.	About adult gender variance or transsexualism.
Year of publication	Between 1860 and 1979	Between 1860 and 1979
Intended audience	Other people who qualify as "medical experts"	People who qualify as "medical experts"
Author	A person (or people) who qualifies as a "medical expert"	A person that falls under the category of "gender variant" may identify as transsexual but does not have to
Measure of influence	Citations listed in either Google Scholar (books) or Web of Science (articles)	Not applicable

The final criterion, that of influence, I ascertained by looking at the number of times the text was cited. However, because the position occupied by transsexual and gender-variant people vis-à-vis medical experts is already one of inequality, I argue that any voice that speaks from this subject position is important to consider. Therefore, all texts that met the other criteria and were written by a gender-variant person were included. This resulted in eight texts. In contrast, I developed additional criteria for texts by medical experts based on the decade and the number of citations in comparison to the average citation number for that decade. To find the number of citations, I looked each text up in the Google Scholar search engine as well as the Web of Science database available through the University of Victoria library website. I calculated the average number of citations that texts matching the other criteria (language, topic, year of

publication, intended audience and author) had in each decade using the higher of the two citation numbers from Google Scholar and Web of Science, as well as the median number of citations per decade. Using this information I set minimum citation numbers required for each decade and selected texts that met that minimum. I set this minimum as lower than the average to include texts that were not as influential but nevertheless were read by other medical experts. For some decades, such as all those that preceded 1940, because the topic of gender variance was not widely written about in medical literature, the number of citations was not an adequate reflection of the influence that the texts had. Additionally, I could not calculate averages because the number of texts per decade was so low. However, as the number of publications on the topic of gender variance grew, I selected increasingly higher minimum citation numbers. The averages, medians, minimum citation numbers and number of texts in each category can be found in Table 2 below.

Table 2

Number of citations required for inclusion

Decade	Number of texts in decade	Average number of citations	Median number of citations	Minimum citations required
<1940	n/a	n/a	n/a	Any
1940-1949	7	22.8	27	20
1950-1959	32	65.0	36.5	20
1960-1969	54	70.8	38.5	60
1970-1979	95	108.8	45	80

In order to identify texts that could potentially be part of this research, I began by identifying key people and key texts during the literature review. I then searched for additional texts that potentially fit the topic criterion by using key terms in the University of Victoria's library Summon search. These search terms I entered were:

> transgender OR transgenderism OR transgenderist OR trans OR trans* OR trans-spectrum OR transsexual OR transsexuality OR transsexualism OR transsexual OR transexuality OR transexualism OR transvestite OR transvestism OR crossdresser OR cross-dresser OR "gender non-conforming" OR "gender nonconforming" OR GNC OR TGNC OR "gender variant" OR "gender variance" OR "gender minority" OR FTM OR F2M OR female-to-male OR transmasculine OR "trans masculine" OR transman OR "trans man" OR transmen OR "trans men" OR "feels like a man" OR MTF OR M2F OR male-to-female OR transfeminine OR "trans feminine" OR transwoman OR "trans woman" OR transwomen OR "trans women" OR "feels like a woman" OR genderqueer OR "gender queer" OR non-binary OR Two-Spirit OR "Two Spirit" OR "non-western gender" OR "gender identity" OR "gender identity disorder" OR GID OR "gender dysphoria" OR "gender inversion" OR "gender invert"

I also searched for these terms together with the terms "wrong body" and "discourse." In order to locate texts written by gender-variant authors, I also looked through the finding aids available at the University of Victoria's Transgender Archives.

This resulted in 131 total texts that qualified for this research project. 122 of these were written solely by medical experts, five were written solely by non-medical expert gender-variant authors, 3 were co-authored by medical experts and gender-variant authors, and one was written by a gender-variant medical expert author. However, due to the COVID-19 pandemic, the library

at the University of Victoria closed on April 18, 2020. This prevented me from accessing 12 of the sources I had identified (11 authored by medical experts, and one authored by a gender-variant medical expert). Additionally, it also prevented me from looking in the Transgender Archives, which are part of the library, to follow leads that I found in the Transgender Archives finding aids, limiting the number of gender-variant-authored texts that I found. The effects of this are further discussed in the limitations (chapter 7). All of the texts that were included in this analysis can be found in Appendix A. Additionally, texts that met the criteria but could not be included due to library closures can be found in Appendix B.

In addition to these texts, I also included the *Standards of Care* (Berger et al., 1979) and the *DSM-III* diagnosis of transsexualism (APA, 1980), as both were the culmination of the activist and medical-expert work to have gender variance seen as a legitimate medical condition. In both of these texts, gender variance takes the form of "transsexualism," with specific descriptions and expected characteristics. Both of these are relevant to the analysis of how the WBD developed as they demonstrate the shape it took once it was institutionalised, and this shape can reveal assumptions, intentions and understandings of the authors.

3.3.1.1 Relevance to the Canadian context

The central context of the research on, and medicalisation of, gender variance is undeniably the United States. Although the early publications originated in Germany, the majority of the work shifted to the United States as the Nazis rose to power in the 1920s and into the early 1930s (Meyerowitz, 2002). This is reflected not only in the secondary literature reviewed for both the literature review (chapter 2) and the historical contextualisation (chapter 4) but also in the primary sources chosen for the analysis. Indeed, I could find no explicit texts on the WBD in Canada nor on the history of the medicalisation of gender variance in Canada, nor

any primary sources published in Canada. Nevertheless, this analysis does not exclude Canada, but rather demonstrates the permeability of the national border between Canada and the United States.

The *DSM-III* (APA, 1980), the first *DSM* version that included an explicit diagnosis of gender variance (namely, as noted above, transsexualism), was also the first *DSM* version to be officially used in Canada (Kogan & Paterniti, 2017; Junek, 1983). Since then, the *DSM* has remained the authoritative text on mental disorders in Canada, and is widely used across the country in undergraduate and graduate programs, as well as in residencies as part of medical training (Kogan & Paterniti). It is evident, then, that the history of how the WBD came to be institutionalised in the *DSM-III* is as relevant to Canada as it is to the United States. However, prior to the *DSM-III* being officially adopted in Canada, the way gender variance was being medicalised in the United States was likely having an effect on Canadian medicalisation of gender variance. In addition to newsletters and magazines circulating between the two countries, uniting the two gender-variant communities (Matte, 2014), the Erickson Educational Foundation (EEF), which funded the majority of research into gender variance in the United States (discussed in detail in chapter 4), had the explicit intention of ensuring international acceptance of not only the American model of medicalised gender variance but American authority over it as well (Matte). Moreover, this was significantly successful to the degree that Canadian gender identity clinics, which opened at the same time as those in the United States during the late 1960s and into the 1970s, were explicitly based on the Johns Hopkins University model (Matte). What this demonstrates, then, is that although there are no Canada-specific primary sources included, nor were there any Canada-specific secondary sources found, this research is nevertheless

explicitly relevant to Canada and to the history of the medicalisation of gender variance in Canada.

3.3.2 Analysis

I analysed all of the texts using the three-stage analysis outlined by Fairclough (1992), looking at discourse-as-text, discourse-as-discursive-practice, and discourse-as-social practice. To this I added questions that I developed using Foucault's (1981) genealogical method. At each level of analysis, and as I moved back and forth between the levels, I asked the following five sets of questions, found in Table 3. These questions were printed and placed above my work area as well as in my data analysis notebook, so that they would perpetually remain in my mind as I read and re-read the texts.

Table 3

Analysis questions

Category	Sample questions
General questions:	What words is the author using in this articulation? Is there a phrase that this author uses frequently?
	Who wrote this articulation of the discourse?
	What other discourses is the author drawing on?
	What is the author's relationship to the medicalisation of transsexuality and/or gender variance?
	Who does this text make reference to? Who has the author cited in writing it?
	Who has cited this text?
	What relative level of influence can I see from the citation relationships?
Principle of reversal:	What was cut out/excluded? What is missing?
	What events limited the discursive possibilities to result in this specific discourse coming to be in this way?
	What remains outside of the discourse, unsignified, unintelligible?
	What had to be cut for the remainder to be intelligible?
Principle of discontinuity:	What contradictions can be seen within the discourse?
	What other discourses are necessary for this one to make sense?
	What disjunctures and breaks can be seen that the discourse would have us believe are not there, in order to make the discourse appear smooth and continuous?
Principle of specificity:	What is specific about this discursive articulation right now?
	How does it differ from other articulations?
	What is regular/consistent between articulations? What is not?
Principle of exteriority:	What historical context made it possible for this discourse to look this way now?

Category	Sample questions
	What power/authority struggles occurred around this discourse at different points in time? What are its external conditions of possibility? What relationships have to exist for this discourse to be able to look this way (and at each point in time that an articulation takes place)?

Throughout all three levels of analysis, I coded the data inductively, looking to the data to identify patterns and develop codes.

3.3.2.1 Discourse-as-text: Looking at a text's linguistic features

I began the analysis by looking at each text from the point of view of what words and phrases were repeated. I identified all of the quotations that sounded like they were related to ideas that the literature review demonstrated were part of the WBD. Although a number of them ended up not as closely tied as I had initially thought they would be, the vast majority did, in fact, turn out to be part of the discursive articulations of the WBD. I organised the quotations chronologically and by clearly-marked author, and then repeatedly returned to them, rereading them at intervals to see if I could find new patterns in them.

In doing so, I identified as many potential articulations as I could, creating a number of mind maps for each theme to organise the articulations. I developed codes from the characteristics such as phrasing, tone, position of the author, and relationship to other words or phrases nearby. At this level of the analysis, I paid attention to what other discourses were evident in the texts, in addition to the one I was looking for, the WBD. From this I developed a preliminary map of how the WBD was being used and how it changed over time.

3.3.2.2 Discourse-as-discursive-practice: The relationship between text and context

The second level of analysis involved a careful consideration of the relationships between discourses, and the various discourses with which the WBD engaged in dialogue both explicitly and implicitly. I began by locating each text in the historical contextualisation (chapter 4). I identified the author or authors, their relationships to one another, and their relationship to the developing medicalisation of gender variance. Having located each text in the historical context, I looked at the data I have drawn from the text in terms of the other kinds of discourses that were in operation at the time, especially those related to the definitions of key concepts such as sex and gender.

This level also involved intertextual analysis, both synchronic and diachronic. In the synchronic analysis, I considered how the articulations compared to those in other texts of the same year and, depending on the decade and the number of texts published in that decade on the topic, other texts from within five years and within ten years. In the diachronic analysis, I looked at how the articulations I had identified changed over time, comparing those from the 1940s and 1950s to those in the 1960s and then as well to those in the 1970s. I also considered the kinds of quotations that medical experts chose to include in their own texts, both from other medical experts as well as from their patients (manifest intertextuality), and looked to see if I could find patterns within those decisions, especially if those patterns potentially changed (constitutive intertextuality).

3.3.2.3 Discourse-as-social-practice

The final level of analysis involved looking at the texts and discursive articulations in their historical context, considering what conditions allowed for their emergence in those particular forms. This part of the analysis included looking at the effects of the discourse, meanings produced by texts, trajectories of discourse development, the power/knowledge

networks and relationships that shaped, and were part of, discourse development, and the effects of the discourse especially in terms of ideology and normalisation. At this level, I also considered the possibility of specific subject positions being produced by the discourse, how those related to other discourses operating within Western society, specifically in Canada and the United States, and especially how they may have mutually reinforced one another.

4 Historical contextualisation

The first task of critical discourse analysis is to produce a written account of the historical context of the discourse in question (Fairclough, 1985). Since the history of transsexualism as a medical category is the history of the medicalisation of gender variance (Pearce, 2018), this is a task that requires going beyond the secondary literature on the wrong-body discourse (WBD) discussed in chapter 2 to secondary literature on the history of transsexualism. I especially focus on literature written by gender-variant people themselves because the majority of the accounts of the medicalisation of gender variance focus on the roles of medical experts. This chapter, then, represents a picture of how medical experts, especially sexologists, defined and produced transsexualism as a medical category and as a social phenomenon, how gender-variant people themselves influenced the process of medicalisation, and the sociohistorical context within which this occurred between the years of 1860 and 1979. This account is, however, only partial, as historical contextualisations are always incomplete (Fairclough).

In order to provide as comprehensive a picture of the historical context within which the WBD developed as possible, I have structured the chapter using the concept of medicalisation. I have organised the context by "engines of medicalisation" – sociological factors that contribute to the process of medicalisation (Conrad, 2005; see also section 1.3.1) – self-interested agents, social institutions and socioeconomic forces, technological developments, and discourses. In each of these subsections, I provide a chronological account with a focus on how the factor contributed to the medicalisation of gender variance in terms of Conrad and Schneider's (1992) five-step model. The following table provides a snapshot of the timeline of the medicalisation of gender variance in terms of this model.

Table 4

Stages of the medicalisation of gender variance using Conrad and Schneider's (1992) model

Stage of Medicalisation*	Events in the medicalisation of gender variance
1) Human phenomenon socially defined as deviant	Prior to nineteenth century; gender variance considered a moral and a criminal issue.
2) Medical-expert "prospecting"	Early sexologists exploring inversion and hermaphroditism.
3) Claims-making competitions	1920s to 1960s; increasing numbers of medical experts and gender-variant people trying to produce a coherent understanding of gender variance and, specifically, transsexualism; early experimental hormonal and surgical treatments in Germany and then in the United States.
4) Claiming ownership by medical expert(s)	1966, Benjamin "claims ownership" of transsexualism through the publication of his book, *The Transsexual Phenomenon*, bolstering the authority of all medical experts who used the WBD and supported/provided hormonal and surgical treatment; gender identity clinics based on Benjamin's treatment model open.
5) Institutionalisation	1979 publication of the first version of the *Standards of Care* (*SoC ver. 1*); 1980 inclusion in *Diagnostic and Statistical Manual-III* (*DSM-III*) as diagnosis of transsexualism.

* From Conrad and Schneider (1992, p. 266-271), described in more detail in the introduction chapter, on p. 11-12.

4.1 Self-interested agents

The secondary literature on the medicalisation of gender variance reveals two main groups of self-interested agents: medical experts and gender-variant people. The majority of

information available, however, focuses on the involvement of medical experts, although there is increasingly work being done on the role of gender-variant people themselves in how the process of medicalisation unfolded (see for example: Gill-Peterson, 2018; Stryker, 2008; Devor & Matte, 2004; 2007). Unlike cisgender medical experts, with very few exceptions gender-variant people did not have the same access to knowledge production and publication resources, and thus their contributions have often appeared through medical expert interpretation, if they have been acknowledged at all. Although I have tried to find sources that specifically focus on gender-variant people's contributions, this imbalance is nevertheless reflected in this section.

4.1.1 Medical Experts

Medical expert involvement in the medicalisation of gender variance prior to 1980 can be generally divided into three time periods: the late nineteenth century, the early twentieth century, and the mid-twentieth century. The medicalisation of sex/gender/sexuality had begun in earnest in the mid-to-late nineteenth century, and focused on what was "normal" for different genders, races and classes (Cacchioni, 2015a; 2015b; Cacchioni & Tiefer, 2012), as well as what differentiated or constituted male and female (Dreger, 2000). At this time, the concept of "sex" encompassed everything that is now divided into sex, gender and sexuality, although medical experts were beginning to conceptualise sexuality as separate from, though intimately tied to, sex/gender (Meyerowitz, 2002; Dreger). This gave way to the early twentieth century during which the primary interest was developing a classification of a wide range of gender variance that medical experts in Germany had encountered. This classification work was inextricable from concerted efforts to validate a racial hierarchy with scientific "proof," as this proof was most often conceptualised in terms of sexual differences between the races (Somerville, 1994). Finally, this led to the mid-twentieth century, during which medical experts focused on

developing what they considered appropriate treatments for people they identified as transsexuals. Work during this period was rooted in the development of the concept of gender, which was separate from sex but, like sexuality, still closely tied to it (Gill-Peterson, 2018; Meyerowitz). By the 1970s, medical experts were the authorities on transsexualism. Overall, over the period from 1860s to 1979, medical authority over gender variance, and transsexualism more specifically, increased, coalesced and cemented.

4.1.1.1 Early work of sexologists: The late nineteenth century

Most of the historical overviews of the medicalisation of gender variance trace the history back to the mid-to-late nineteenth century around the 1850s and 1860s. This was a time when medical experts were mostly interested in cataloguing and describing all of the various non-normative sexual practices that they labelled "perversions," including gender variance. These practices of "discovery" (or, in terms of critical discourse analysis, discursive production) were what Conrad and Schneider (1992) termed "prospecting:" looking for human phenomena already socially defined as deviant to potentially define in medical terms and subsume under medical authority. Gender variance was subsumed under the label of inversion, a catch-all term for any kind of sex, gender, or sexual nonconformity, and included everything from homosexuality to intersex conditions to transsexualism (Meyerowitz, 2002; Wolf-Gould, 2016). Together, these were linked to ideas of degeneracy through biological determinism (Savoia, 2010; Cacchioni, 2015b). Much of this early work took place in Germany, which some researchers believe was due to the political and social climate that centralised freedom and individuality (Bauer, 2009; Rudacille, 2005). In contrast, in the United States, research into sex/gender/sexuality was being conducted as part of the development of the field of gynecology, and included experiments conducted on black female-bodied slaves in an effort to prove racial inferiority (Snorton, 2017).

Only three sexologists have been recognised in the literature as having produced notable work related to gender variance during the period of "prospecting" in the second half of the nineteenth century, According to De Block and Adriaens (2013), these "canonical and iconic" authors were not necessarily the only ones writing on gender variance, but because their works resonated with discourses operating at the time, their works became central. These three were: Karl Heinrich Ulrichs, Carl Westphal, and Richard von Krafft-Ebing, all of whom were working in Germany. Ulrichs, a lawyer and not a medical expert, was the first person to publish a statement that is recognisably related to gender variance when in 1864 he described male homosexuality as being caused by a female soul trapped in a male body (Bullough, 1994; Meyerowitz, 2002; Bauer, 2009). However, Westphal was the first medical expert to publish on the topic, having explicitly taken Ulrichs' idea, named it "contrary sexual feeling," and published a medical text on it in 1869 (Bullough). Ulrichs' conceptualisation of homosexuality as a misaligned "mind-sex" and "body-sex" also influenced Krafft-Ebing, who wrote to Ulrichs to tell him of this inspiration (Bullough, 2001; Kennedy, 2002b). Unlike Ulrichs, Krafft-Ebing took a more pathologising stance towards homosexuality, though his views softened over the course of his career writing on a wide collection of sexual perversions in his book *Psychopathia Sexualis*, published in 1886 (Meyerowitz). Although many medical experts rejected the medical validity of the book (Beccalossi, 2012), *Psychopathia Sexualis* became the central source on perversions for other sexologists (Oosterhuis, 2012; Cacchioni, 2015b), albeit not until the early twentieth century for English-speaking sexologists (Bauer, 2003).

4.1.1.2 Sexology continues: First half of the twentieth century

Much of the work begun in the late nineteenth century continued through the early twentieth century, although approaches and understandings were shifting. Biological

determinism, which had formed the foundation of the works of Ulrichs, Westphal, and Krafft-Ebing, gave way at this point to Freudian psychoanalytic theories that privileged human development over biology (Cacchioni, 2015a; 2015b; Hovey, 2007; Rees-Turyn et al., 2008). Understandings of how sexual characteristics developed also shifted as early work on hormones was being conducted in Germany (Meyerowitz, 2002). This work, however, was part of the larger project of scientific racism and the racialisation of sex/gender, with many sexologists conducting their research as part of the search for proof of racial hierarchies and racial difference (Somerville, 1994).

Building upon the work of earlier sexologists, Havelock Ellis and Magnus Hirschfeld began to develop ways to differentiate between different types of gender variance in the early part of the twentieth century. These early attempts to differentiate marked the beginning of the shift from "prospecting" to the third stage of medicalisation, claims-making competitions among medical experts (Conrad & Schneider, 1992). Ellis, who articulated his work explicitly in terms of inversion, identified what he first named "sexo-aesthetic inversion," though he decided on "eonism" to differentiate it from types of inversion that would later become known as homosexuality (King, 1996; Taylor, 1998; Bullough, 2000). Hirschfeld, on the other hand, tried to differentiate between types of "transvestism," which was his general term for gender variance and which spanned a large continuum from people who occasionally wore the clothing of the opposite gender (who today might be labelled cross-dressers) to those who felt they were the opposite gender to that which they appeared to be (whom we might today call transgender or transsexual) (Bullough; Meyerowitz, 2002; Wolf-Gould, 2016). Although he did not popularise the term, it was, in fact, Hirschfeld who first used the term "transsexualism" in 1923 (Pfäfflin, 1997). Both Ellis and Hirschfeld thus contributed to a more nuanced classification system of

gender and sexuality differences. Their contributions, however, were largely ignored in the United States (Gill-Peterson, 2018).

4.1.1.3 Popularisation in the United States: Mid-twentieth century

During the mid-twentieth century, medical experts in the United States continued the claims-making competitions that had begun in Germany in the previous decades, shifting in earnest from differentiating between gender variance phenomena to medical experts trying to claim a "definitional role" in regards to transsexualism (Gill-Peterson, 2018, p. 132). In these claims-making competitions, medical experts proposed various explanations of gender variance, made arguments about "whether transsexualism was a distinct condition with varying degrees of severity or whether there was a number of different [separate] conditions" (Matte, 2014, p. 27), and argued about the difficulties in providing treatment. Although not yet an official diagnosis, by this point medical experts writing about gender variance were consistently using the term "transsexualism."

In 1966, one of the most famous medical experts working with gender-variant people, Harry Benjamin, published a book that secured his claims of ownership over transsexualism as well as medical authority over gender variance. *The Transsexual Phenomenon* was the first comprehensive medical-expert text on transsexualism, both explaining what it was and setting forth what Benjamin believed was the appropriate treatment—hormones and surgery. It also presented the first cohesive model of transsexualism. Publishing this book placed Benjamin in the perfect position to have other medical experts accept his claims of discursive authority over transsexualism: there was no other text yet at the time that was as comprehensive and no other model that was as cohesive. Together with other medical experts' familiarity with Benjamin and his work with gender-variant people, Benjamin's model of transsexualism was accepted by many

other medical experts treating gender-variant people as *the* way to conceptualise transsexualism. Furthermore, the legitimation of Benjamin's claim of ownership over transsexualism can be seen in how widely he was cited by his peers, as well as the development of gender identity clinics based on his conceptualisation of transsexualism (Gill-Peterson, 2018; Meyerowitz, 2002). In 1966, the first gender identity clinic opened at Johns Hopkins University (Gill-Peterson; Meyerowitz), and by the 1970s, medical experts used Benjamin's model of transsexualism to run the clinics and research programs, testified in courts, and held national and international meetings (Meyerowitz; Gill-Peterson). This period ended with the official institutionalisation of transsexualism as a diagnosis in 1980 in the *DSM-III* (APA), and in the 1979 publication of the first version of the *Standards of Care* (*SoC ver. 1*) by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) (Berger et al.). This institutionalisation represents the final step in Conrad and Schneider's model of medicalisation.

In the United States, there were a number of key people involved in the medicalisation of gender variance whose contributions have been extensively explored in the literature, such as: Harry Benjamin, John Money, Robert Stoller, Alfred Kinsey, Richard Green, and Ralph Greenson. According to that literature, however, the most famous of these was Benjamin, not only for publishing *The Transsexual Phenomenon* in 1966 and thus solidifying a name for the phenomenon, but also for taking on transsexualism as his area of expertise, being sympathetic to his patients, and supporting his patients in their transitions, positions that were not widely taken at the time (Ekins, 2005; Person, 1999 [1972/1997]). Benjamin's work on transsexualism began much earlier than his famous publication, however, when in 1948, Kinsey referred a transsexual patient to him (Gill-Peterson, 2018). Benjamin also served as a point of intersection between Europe, specifically Germany, and the United States during the post-World War II era. At a time

when German work was generally shunned by the sexological community in the United States, Benjamin met Hirschfeld and brought back with him not only their sexological ideas but also their eugenic values (Gill-Peterson). As an endocrinologist, Benjamin's interest focused on the biological, and thus also shaped the way he conceptualised transsexualism (Ekins), leading him to solidify the position of hormone treatment as crucial to the treatment of transsexualism (Gill-Peterson). Benjamin also attempted several times to create formal networks of medical experts willing to treat transsexualism with hormones and surgery: in 1964 he founded the Harry Benjamin Foundation, shortly thereafter the Benjamin Gender Identity Research Foundation,[12] and in 1969 the Harry Benjamin Research Project (Meyerowitz, 2002). Benjamin's lasting contribution was in organising research that allowed transsexualism to become a "distinguishable clinical entity" (Ekins, p. 309; Dewey & Gesbeck, 2017; Wolf-Gould, 2016). His centrality to this process was honoured by naming the Harry Benjamin International Gender Dysphoria Association after him in 1979 (Devor, 2013).

4.1.2 Gender-variant people

While medical experts had been the most significant driving force behind the medicalisation of gender variance during the period from 1860 to 1979, gender-variant people themselves nevertheless had a significant impact on the trajectory of this medicalisation, especially during the claims-making competitions and claiming ownership stages. Some did so publicly and explicitly. However, there is a growing acknowledgement in the literature of the ways in which certain kinds of gender-variant people were excluded from influencing medical experts, or were used against their will by medical experts as tools to develop ideas and

[12] The exact year he founded the Benjamin Gender Identity Research Foundation is uncertain. I could not find any specific dates for this foundation, though I did find a letter Benjamin had written in 1967 in which he signed his name and included the name of this particular foundation. For that reason, I have placed it between the Harry Benjamin Foundation and the Harry Benjamin Research Project.

technologies. Many gender-variant people, especially those of colour, did not want to be involved with medical experts in any way (Gill-Peterson, 2018). Other gender-variant people of colour, especially those who were children, were used by medical experts as subjects to study or tools in the development of technologies intended to benefit white cisgender people (Snorton, 2017; Gill-Peterson). In general, the majority of gender-variant people who were able to influence medical experts were white, middle-class and AMAB. Those who could and did decide to engage with medical experts did so in four ways: directly educating medical experts as personally-affected laypeople; funding medical experts and in doing so, shaping the direction of medicalisation; sharing knowledge amongst each other, especially with regards to interactions with medical experts; and becoming medical-experts themselves.

Although many gender-variant people likely attempted to educate individual medical experts about transsexualism during individual interactions, especially in the context of information about it not being widely available, few were known for their education of medical experts. A notable way in which gender-variant people communicated with medical experts was through letters, especially letters asking medical experts for treatment and help, though they were most often denied. These letters began during the early medical "prospecting" stage, with many gender-variant people writing to such sexologists as Krafft-Ebing (Oosterhuis, 2012). During the period of claims-making competitions, a large number of gender-variant people, many of whom were children, sent repeated letters to the same medical experts, hoping that one day the answer would change (Gill-Peterson, 2018; Hill, 2008). In those letters, many gender-variant people took up the discourses of the time—both those of hermaphroditism as well as of transsexualism—in an effort to negotiate the support of medical experts (Gill-Peterson), and thereby contributed to the reification of those discourses as medical experts took this to be

evidence of their accuracy (Meyerowitz, 2002). In attempting to find popular support for their legitimacy, many gender-variant people in the 1950s and 1960s articulated their experiences in terms of hermaphroditism and of hormonal abnormalities. However, medical experts, who could not find physical evidence of these conditions in the gender-variant people who came to them, took issue with such claims, countering them with diagnoses of homosexuality and refusing to provide treatment or support (Gill-Peterson).

During the claims-making competitions and claiming ownership stages of medicalisation, many of the gender-variant people who did educate medical experts did so through the Erickson Educational Foundation (EEF). The EEF organised a network of gender-variant people who represented the EEF's ideals for how transsexualism should be conceptualised and treated (namely, medicalised and treated by specific medical experts who would provide hormones and surgery)[13] and who would be available to deliver workshops and presentations to both medical experts and lay people (Devor, 2003; Devor & Matte, 2007; Matte, 2014).

Perhaps the most famous of the gender-variant people seeking to educate medical experts was Virginia Prince, who considered this to be her mission (Ekins & King, 2005; Matte, 2014), and worked closely with both Benjamin and Stoller (Matte; Pearce, 2018; Green, 2010). Although Prince had some difficulty in actually attaining her goals because she herself was not a medical expert and her work was thus not taken as seriously, she was eventually able to leverage her class privilege through her chemistry doctorate (Matte), and with the assistance of Benjamin, was able to publish her work.[14] One of Prince's most significant contributions to the process of

[13] I would argue that the EEF's ideals were based in the WBD, and perhaps future researchers could follow Matte's (2014) research to find out whether and how the WBD may have been apparent in EEF documents.

[14] It is possible that having claimed ownership, Benjamin's authority over knowledge production about transsexualism increased, allowing him to extend that authority to gender-variant people like Prince whom Benjamin chose to include in this process.

medicalisation was the differentiation between transsexualism, transvestism, and homosexuality (Ekins & King, 1997). This differentiation, in which Prince argued that one could live as the "other" gender without medical involvement, represented one of the only challenges to medical authority by a gender-variant person during the 1960s and 1970s (Matte). Additionally, starting in the 1960s, Prince had a significant role in bringing together gender-variant people in clubs or support groups, creating a space for gender-variant people to connect, share experiences and share knowledge, creating their own culture (Bullough, 1997; Ekins & King).

A lesser known but no less important transsexual person who worked with medical experts was Louise Lawrence. An archivist and bibliographer, she was a former patient of Benjamin's on whom both Benjamin and Kinsey depended for information on transsexualism (Meyerowitz, 2002; Gill-Peterson, 2018). Lawrence also actively challenged medical experts on their knowledge and practices regarding the treatment of transsexualism, thereby exerting a significant influence on the trajectory of medicalisation (Gill-Peterson). Lawrence served as a point of connection between different medical experts. Indeed, it was through Lawrence that Benjamin learned about the work of popular sexologist D.O. Cauldwell who, unlike the medical experts discussed in the previous section, wrote for popular audiences (Ekins & King, 2001).

During the claims-making competitions and claiming ownership stages, one gender-variant person also influenced medical experts through financial support, although the vast majority of gender-variant people did not, and still do not, have access to significant financial or class privilege. This one person stands out for his financial contributions to research and education on transsexualism for medical experts, as well as for gender-variant people themselves, and for the influence he therefore had on the direction of the medicalisation of gender variance: Reed Erickson. Erickson was a patient of Benjamin's in 1963, and afterwards

used his inheritance and income to fund the research of pioneering medical experts like Benjamin (Matte, 2014; Devor & Matte, 2004; 2007). Erickson's foundation, the EEF (discussed above), contributed funding to, or entirely funded, among other things: medical research, conferences, symposia, scholarly publications, the gender identity clinic at Johns Hopkins University Hospital, patient care resources, and education for medical experts (Matte; Devor & Matte, 2007; Wolf-Gould, 2016; Denny, 2002). The two most notable effects that the EEF thus had were centralising the medical model and medicalisation in the conceptualisation of transsexualism in the 1960s (Matte), and the creation of a network of medical experts who not only could refer patients to one another but also could exchange information and support one another in gaining legitimacy for the area of treatment for transsexualism (Matte; Wolf-Gould). At a time when there was almost no financial support for research into transsexualism (Meyerowitz, 2002), the funding provided by Erickson and the EEF was crucial to the trajectory of the medicalisation of gender variance (Matte; Denny; Gill-Peterson). Using its vast network of medical experts and other resources, the EEF also connected gender-variant people with resources, information, and with medical experts themselves through lists of supportive medical experts (Devor & Matte).

The third way in which gender-variant people exercised agency in the context of the medicalisation of gender variance was in creating networks to share information with one another. This information was not only about their personal experiences of identity and gender, but also of their experiences of interacting with medical experts, and what the medical experts expected to hear (Bolin, 1988; 1984; Meyerowitz, 2002; Denny, 1992). While medical experts were competing with one another to define transsexualism, gender-variant people compiled information on how to navigate appointments with medical experts to navigate gatekeepers and

to access transition services, as it became apparent that only certain narratives were seen as evidence of transsexualism (Bolin, 1988; Meyerowitz). Taking up these discourses to navigate medical experts reified the discourses themselves, as many medical experts saw this as evidence that their model of transsexualism was correct (Meyerowitz). In time, however, medical experts realised that this was taking place and responded by labelled gender-variant people as dishonest, unreliable, and manipulative, tightening their grip on gatekeeping and further reifying their own production of transsexualism (Meyerowitz). Although the decision to use medical expert discourses was often done in order to navigate the medical system, it reified those very discourses and gender-variant people therefore played a role in their reification, albeit one of much less power and authority than the medical experts had in shaping those discourses; for gender-variant people, taking up these discourses was a matter of survival.

Although this was extremely rare, the fourth way that gender-variant people influenced medical experts was by becoming medical experts themselves, thereby gaining at least some access to the same knowledge-producing practices that medical experts used. Two gender-variant people stand out in this context: Michael Dillon and Jeanne Hoff. Michael Dillon was an English physician and endocrinologist. In 1946 he published *Self: A Study in Endocrinology and Ethics*, a book that Gill-Peterson (2018) characterised as "a major volume of trans knowledge before transsexuality" (p. 18). One of the intended audiences of this book was other medical experts, and so Dillon's influence was not only through a direct attempt to educate other medical experts but also through having access to the kinds of knowledge production that other medical experts would have considered more legitimate than lay knowledge. Like Dillon, Jeanne Hoff was also a physician. She was one of the subsequent owners of Benjamin's practice after he left in the 1970s, and she was known for providing more empathic, compassionate and self-reflexive care

to her patients (Gill-Peterson). While she did not publish any books on gender variance, her influence came through demonstrating different practices in treating gender-variant people. Specifically, the documentation she produced as part of her medical practice included information about her patients that other medical experts had not considered important, but she as a gender-variant person recognised as relevant to the care of her patients (Gill-Peterson).

4.2 Social institutions and socioeconomic forces

Although it would not be inaccurate to state that the medicalisation of gender variance in the United States and Canada was affected by capitalist ideals, the First and Second World Wars, the Great Depression, and the Cold War along with growing fears of communism, writing how each of these had an effect would necessitate an entire second dissertation, in the least. As such, I focus here only on social institutions and socioeconomic factors that were directly related to the medicalisation of gender variance and the development of the WBD. I begin with a very short overview of developments in institutionalised medicine with a mention of two institutes that were key. I then look at gender identity clinics, along with the development of two formal documents, the first version of the *Standards of Care* (*SoC ver. 1*) (Berger et al., 1979), and the diagnosis of transsexualism in the *Diagnostic and Statistical Manual of Mental Disorders III* (*DSM-III*) (APA, 1980). Following this, I look at popular media and close with a short consideration of some sex/gender/sexuality-based social movements.

4.2.1 Institutionalised medicine

The history of the medicalisation of gender variance is inextricable from the history of how medicine developed as an institution, particularly in terms of how different disciplines vied for authority and control over new phenomena being medicalised. The history of psychiatry and of sexology are especially connected to the development of the WBD. As psychiatrists shifted

from biological explanations to a focus on psychoanalysis and psychopathology in the late nineteenth and early twentieth centuries, they demanded that the discipline be taken seriously, and argued that psychiatrists had a medical answer to social ills (Rimke & Hunt, 2002). Sexology, on the other hand, developed during the same period of time as a more interdisciplinary, scientific study of human sexuality (Barker, 2016; Devor, 1997). Although significantly influenced by psychiatry, it also incorporated knowledge from biology and other areas of medicine (Barker). Indeed, many of the early medical experts writing on gender variance in the late nineteenth century, such as Krafft-Ebing, Ellis and Hirschfeld, are seen as the "fathers" of sexology (Barker). "Turf wars" between disciplines, such as that between psychiatry and sexology, continued including among medical experts working at the gender clinics (Bullough, 2007), extending from the stage of claims-making competitions into the stage of claiming ownership. Certain shifts, though, were made possible by specific medical research institutions and the gender identity clinics that began in the 1960s.

The development of relevant medical technology in the early twentieth century, discussed later in this chapter, was significantly made possible by the involvement of two specific institutions: Hirschfeld's Institut für Sexualwissenschaft (Institute for Sexual Science) in Germany, and the Brady Urological Institute at Johns Hopkins in the United States. Hirschfeld founded the Institut in 1919 in Berlin, and it lasted until the Nazi's destroyed it in 1933 (Bullough, 2003). The Brady Institute, on the other hand, opened in 1915 and continues to this day (Gill-Peterson, 2018). Both of these institutes conducted research on differences of sex development, specifically in an effort to eliminate any challenges posed to binary gender by bodies that did not conform by developing surgical techniques to make them conform to binary expectations (Meyerowitz, 2002; Gill-Peterson). While the literature does not detail the

demographics of patients in Germany, historical data have demonstrated that the majority of patients with differences of sex development at the Brady Institute were children (Gill-Peterson). However, while the Brady Institute continued to focus on differences of sex development, Hirschfeld's Institut also provided treatment for impotence, sexually transmitted infections, fetishes, paraphilias, and gender variance, and it also assisted men who were being prosecuted under Paragraph 175, which criminalised sexual acts between men in Germany until 1994 (Rudacille, 2005). The Institut also publicised their pioneering treatments of gender-variant people (Rudacille).

However, the mid-twentieth century brought with it struggles over power and trust within the realm of institutionalised medicine. Beginning in the 1960s, a number of factors contributed to the erosion of paternalistic trust and patient obedience, changing the relationship between medical experts and their patients (Conrad, 2005). In particular, consumerism encouraged people to shop around in order to get the best deals not only in general, but also in medicine, shifting medical treatments and even doctors into being seen as a commodity that patients could consider and choose (Conrad). This was significantly driven by the growth of pharmaceutical companies, leading to a situation where the question was not whether a pharmaceutical drug would be used, but rather which one (Conrad; Cacchioni, 2015b).

4.2.1.1 Gender identity clinics

Many of the same people identified as key to the medicalisation of gender variance in the United States in the mid-twentieth century—John Money, Richard Green, and Robert Stoller—were involved in the founding of the gender identity clinics in the United States (Stryker, 2008; Gherovici, 2011; Reicherzer, 2008). Gender identity clinics were treatment centres that "combined scientific research into the biology and psychology of gender with the expert

evaluation of transgender individuals for hormone therapy and genital surgery" (Stryker, p. 93). The first such clinic opened at Johns Hopkins Hospital in 1966 and was run by John Money (Gill-Peterson, 2018; Meyerowitz, 2002; Stryker; Gherovici), but over 40 opened across the United States and Canada over the next few years, most of which were associated with university hospitals (Denny, 1992) and based on the Johns Hopkins model (Reicherzer). These clinics represented the professionalisation efforts of numerous medical experts working on gender variance in the face of being seen as controversial (Meyerowitz; Gill-Peterson). They were also crucial to claiming ownership or, in other words, to the consolidation of medical expert authority over the medicalisation of gender variance (Meyerowitz).

Although the gender identity clinics had a significant, lasting positive effect on the legitimation of hormones and surgery as the appropriate treatment for transsexualism (Denny, 1992), one of the most significant problems with the gender identity clinics was the disconnect between patient needs and medical expert intentions. These clinics did not, in fact, provide nearly as many surgeries as patients had hoped (Meyerowitz, 2002). Rather, the primary goal of the clinics from the point of view of medical experts was research and experimentation (Denny; Matte, 2014). This resulted in patients waiting inordinate lengths of time having been promised treatment yet never in the end accessing it, and others were frequently denied outright (Meyerowitz), because as Bullough (2007) articulated it, the clinics were a research project, the structure of which necessarily involved a lot of "red tape and complicated procedures" (p. 8). As a result, there was an increase in private clinics offering hormonal and surgical treatments without the wait, provided the patient could pay (Gill-Peterson, 2018).

Moreover, the clinics used their patients as "data" to prove the original assumptions of medical experts (Denny, 2006). In doing so, clinics helped define transsexualism as a correctable

problem marked by psychopathy, manipulativeness, and stereotypical expressions of femininity (Stone, 1992). They also reified racialised gender hierarchies through their decisions to approve only certain kinds of gender-variant people. Two kinds of gender-variant people were likely to be approved for treatment: those who were able to demonstrate white "proper" femininities (Denny), and those who were of lower classes and unable to hold jobs (Meyerowitz, 2002; Denny). Although these two groups seem dissimilar, they both could serve to validate specific discourses, namely the centrality of white middle-class binary gender norms, and the idea that not having a sex and gender that align "properly" necessarily caused overwhelming dysfunction and distress, respectively (Meyerowitz; Denny). Moreover, many medical experts working in the clinics believed that the clinics had the job of upholding "society's definitions of masculinity, femininity, and heterosexuality as the flagship of sexual normalcy" (Califia, 2003, p. 69), and thus forced patients to adopt stereotypical and even unrealistic presentations of masculinity and femininity (Bolin, 1984; Denny).

The clinics began to shut down in 1979 as a result of the publication of a study by Meyer and Reter that same year. The study, which was fraught with problems and errors, purported to demonstrate that surgery had no particular impact on the happiness or well-being of transsexuals (Bullough, 2007; Denny, 1992). Although there are some differing opinions on which factor contributed the most to the closing of the clinics—Lothstein (1982; cited in Denny, 1992) argued that it was publicity surrounding the publication whereas Bullough argued that John McHugh, who was chair of psychiatry at Johns Hopkins Hospital at the time, had always opposed the clinic and had been looking for a reason to shut it down (see also: Denny, 2002; Meyerowitz, 2002)—the outcome was the same. Once the clinic at Johns Hopkins closed, others quickly followed (Meyerowitz).

4.2.1.2 Formal documents: Standards of Care and the DSM-III

When the gender identity clinics started to close in 1979, the process of creating an official diagnosis and institutionalising transsexualism was already underway in the United States (Gill-Peterson, 2018). While the *International Classification of Diseases* (*ICD 9*; World Health Organisation) was published in 1975 and introduced the diagnosis of transsexualism, in the United States and Canada, the institutionalisation took place through two publications: the *Standards of Care version 1* (*SoC ver. 1*) published by the Harry Benjamin International Gender Dysphoria Association (HBIGDA, now the World Professional Association for Transgender Health, WPATH) in 1979, and the publication of the *Diagnostic and Statistical Manual of Mental Disorders III* (*DSM-III*) in 1980 by the American Psychiatric Association (APA), which included the diagnosis of "transsexualism." The two documents addressed separate parts of the medicalisation process: the *DSM* dealt with diagnosis whereas the *SoC* covered treatment.

Despite the dates of publication on these two documents differing—1979 versus 1980—the contexts of their publications makes them inextricably linked. Specifically, the *SoC ver. 1* included the expected wording of the upcoming *DSM-III* diagnosis of transsexualism, because this was already known to the medical experts involved in the writing and publication of the *SoC ver. 1* (Berger et al., 1979). Moreover, as discussed earlier in the chapter, many of the same pioneers who were involved in early work on transsexualism, as well as with the founding and running of the gender clinics, were also involved in developing the diagnosis for the *DSM-III* and in ensuring its inclusion (Meyerowitz, 2002; Gill-Peterson, 2018). For this reason, many researchers have seen the year 1980 as particularly important to the medicalisation of gender variance.

The *SoC* is a document intended to provide information for medical experts on the minimal standards for treatment of transsexualism (WPATH, 2019; Coleman, 2009; American Psychological Association, 2015). As such, it complements the *DSM*, which outlines the criteria for diagnosis but does not elaborate on how to put treatment into practice. The first version of the *SoC* was approved by a committee made up of members of HBIGDA at the Sixth International Gender Dysphoria Symposium in San Diego in February 1979 (Fraser, 2009), and subsequent versions were published in 1980, 1981, 1990, 1998, 2001 and 2011 (WPATH). While some authors have examined how the *SoC* has changed across the different versions (see, for example: Riggs et al., 2019), the effects of the *SoC* on the process of medicalisation have not been significantly studied. The only exception is Dewey and Gesbeck (2017), who found that the *SoC* strengthened the medicalisation of transsexualism through requiring, originally, a *DSM* diagnosis for treatment.[15]

In 1980, the medicalised model of transsexualism introduced by Benjamin, Money and their contemporaries, and that was based on medical gatekeeping, was institutionalised in the United States in the publication of the *DSM-III* and the diagnosis of transsexualism (Gill-Peterson, 2018; Stryker, 2008). Prior to this, no official diagnostic criteria existed for transsexualism in the United States (Stone, 1992). In contrast to the *SoC ver. 1*, the stated purpose of the diagnosis in the *DSM-III* was to organise treatment as well as to further research on transsexualism (Meyerowitz, 2002). Although the term "transsexualism" had been used to organise and structure treatment for almost thirty years, having originally been introduced in mid-century, as discussed in the previous section of this chapter (Gill-Peterson), the inclusion of

[15] Although the *SoC* no longer states that a *DSM* diagnosis is necessary for a gender-variant person to receive treatment such as hormones or surgery, the document nevertheless outlines a number of medical experts who are qualified to provide treatment, reifying the continued medicalisation of gender variance (Dewey & Gesbeck, 2017)

transsexualism as an official diagnosis marked the first time there was a clear and explicit set of diagnostic criteria in the United States (Beek et al., 2016).

4.2.2 Popular media

In the history of the medicalisation of gender variance, the mid-twentieth century is distinguished by a singular event: in December 1952, Christine Jorgensen's transition story broke in the American news media. Jorgensen's story not only provided a language for gender-variant people to use to describe themselves to others (Pearce, 2018), but also set off a deluge of patients going to medical experts saying that Jorgensen's story was their story, and that they wanted the same treatments that she had had (Bullough, 2007; Wolf-Gould, 2016). At a time when medical experts were engaged in claims-making competitions, Jorgensen's story shifted the landscape for both medical experts and gender-variant people by bringing to a wider awareness the phenomena of gender variance, the term "transsexual," and the possibility of medical treatment (Bullough; Meyerowitz, 2002).

Christine Jorgensen, however, was not the first person to undergo surgical and hormonal treatment for gender variance either in the world or in the United States, but she *was* the first transsexual celebrity (Snorton, 2017). Like the transsexual celebrities that followed, such as Jan Morris and Renee Richards, Jorgensen's story of transition was not exceptional. Indeed, there were many other gender-variant figures who were available for celebrity status. The qualities that made Jorgensen the ideal candidate were the fact that she was white and presented a heteronormative version of femininity that aligned with white middle-class values of propriety and domesticity (Snorton; Skidmore, 2011). While many of the other gender-variant figures who both predated Jorgensen and were her contemporaries were people of colour, appearing in Black media in the United states, but not seen as worthy of mainstream media attention (Skidmore;

Snorton), transsexual celebrities throughout this period all conformed to a particular model: white, middle-class, and AMAB.

4.2.3 Social Movements

The social context within which the medicalisation of gender variance took place in Canada and the United States was complex. It has its roots in the political climate of the late nineteenth-century Germany, but was also affected by two distinct movements in the mid-twentieth century United States: the push to demedicalise homosexuality, and trans activism. Although there were numerous social movements that were likely relevant to the trajectory of the medicalisation of gender variance and the development of the WBD, such as the Civil Rights Movement and the Stonewall Riots, I only focus here on these three social factors, because they were closely related to the issue at hand.

As discussed in the previous section, the earliest medicalisation of gender variance took place in Germany, raising the question of "why Germany?" According to a number of authors, this was likely due to the political and social climate that centralised freedom and individuality, alongside movements for homosexual recognition and rights (Bauer, 2009; Rudacille, 2005; Meyerowitz, 2002). Indeed, Meyerowitz characterised this time as being marked by a "vocal campaign for sexual emancipation" (p. 21), challenging Paragraph 175, a law that "criminalised male homosexuality" (Drescher, 2010a, p. 432). At the same time, German scientists were developing the theory of human bisexuality—that all humans are both sexes before differentiating into male and female—and this created the space for significant medical-expert "prospecting" on, among other things, attempting to find the physical manifestations of sexual deviance (Somerville, 1994; Cacchioni, 2015a). These scientific explorations were supported by

the emerging field of endocrinology, the study of hormones (Meyerowitz), discussed more in the following section.

In the mid-twentieth century United States, two significant social movements took place alongside one another. The first was the push to demedicalise sexuality. In 1973, the diagnosis of homosexuality was removed from the *DSM-II* (Drescher, 2015; Meyerowitz, 2002). Although it remained in the *DSM*, first as "sexual orientation disturbance" in the *DSM-II* and then as "ego dystonic homosexuality" in the *DSM-III*, from 1973 onward, the majority of homosexuality was no longer under medical purview; in 1987, homosexuality was finally removed from the *DSM-III-R* (Drescher, 2010a). The literature suggests this was the result of a combination of factors including shifts in authority within the APA (Drescher, 2015), the development of different etiological theories of homosexuality (Drescher, 2010a), and Alfred Kinsey's famous reports—published in 1948 and 1953—that demonstrated that homosexuality was more wide-spread in the general (non-mentally ill) population than had been believed (Chiang, 2008). The most notable factor, perhaps, was the gay rights movement that was pushing for homosexuality to no longer be considered a mental illness (Meyerowitz). Although many gay rights activists made use of the mental illness model because it offered more legitimacy than the belief that homosexuality was immoral, there was a growing belief that conceptualising homosexuality as a mental illness was contributing to stigma (Drescher, 2015).

The second social movement was trans activism, sometimes called the trans rights movement (Matte, 2014; Stryker, 2008; Currah, 2008). Although discussed in more detail above in the section on gender-variant people as self-interested agents, overall, from the 1950s to the early 1970s gender-variant activism focused on accessing legal changes to sex (Matte; Meyerowitz, 2002). Many secret groups of gender-variant people existed in the 1950s and 1960s,

such as the "Hose and Heels Club" for heterosexual cross-dressers founded by Virginia Prince in 1961 (Denny, 2006), though these groups focused on bringing gender-variant people together for peer support rather than on medicalisation. The exception to this was Reed Erickson's EEF, which explicitly centralised medicalisation in an effort to reduce stigma (Matte). In the late 1970s, this activism shifted towards attempting to achieve social integration as well as accessing legal, economic and social protections (Matte).

4.3 Development of technology

Over the course of the medicalisation of gender variance, technology changed and developed, from the earliest research into hormones—then called "gonadal secretions"—in the late nineteenth century (Bullough, 2007), to animal and then human experiments in the early twentieth century (Meyerowitz, 2002). It is evident from the literature that hormonal and surgical treatments developed in tandem with one another, and numerous researchers have identified the various technological developments that became part of the medicalisation of gender variance (see also: Meyerowitz; Rubin, 2003). The relationship of technological developments to the medicalisation of gender variance, however, has not been widely theorised. The exception is Hausman (1995) who made the argument that the technology that made hormonal and surgical treatment possible also was the reason transsexualism emerged as a phenomenon. Despite the controversial nature of Hausman's argument,[16] her work remains the only analysis that considers the actual role of technology and technological development in the development of medical discourses on gender variance.

[16] Hausman's (1995) work is part of a larger body of anti-trans literature that argues that transsexualism was, as King (1987) characterises it, "invented" by medical experts. This body of literature includes such researchers as Janice Raymond and Sheila Jeffreys.

In the 1910s, Eugen Steinach in Austria began publishing his work on experiments in which he transplanted gonads into neutered guinea pigs thereby demonstrating the role gonads had in the development of secondary sex characteristics (Meyerowitz, 2002). Although Steinach himself did not conduct experiments on human patients, he did push for experiments to be conducted on human patients at Hirschfeld's Institut für Sexualwissenschaft (Meyerowitz; Gill-Peterson, 2018), in order to treat everything from homosexuality to disorders of sex development (Pfäfflin, 1997). These experimental procedures, including the first genital surgery which was done on an AFAB gender-variant person,[17] were done in Germany in the 1920s and 1930s but not officially published until the early 1930s (Bullough, 2007). They were conducted on gender-variant people diagnosed with "transvestism" (a diagnosis that included what later came to be known as transsexualism, as discussed earlier in the chapter) and were in line with not only Steinach's research but also the prevailing theory of human bisexuality (Meyerowitz). The early work in which medical experts solidified the foundation of the new science of endocrinology seemed to be rooted in a quest to find the source of "sex" (sex/gender/sexuality) in the body (Meyerowitz; Dreger, 2000), connecting the development of the field of endrocrinology to sexology.

The hormonal and surgical treatments that are familiar to medical experts today were not possible until the mid-twentieth century. Female hormones were isolated both in Germany and in the United States in the early 1930s, and male hormones were isolated shortly thereafter in 1935 in Holland (Bullough, 2007; Rubin, 2003). These discoveries meant that not only could hormones be prescribed to gender-variant people, but more research could be done on the effects of hormones (Bullough). However, these discoveries also brought with them underpinning

[17] According to Reicherzer (2008), the first genital surgeries were conducted on two AMAB gender-variant people in London, England, in the late 1920s.

beliefs that formed the foundation of the very research that led to their discoveries. In particular, studies into hormones were rooted in research attempting to discover the "fountain of youth" and shaped understandings of how hormones provided "vitality, virility, and fertility" (Rubin, p. 36). They were also inextricable from attempts to map out what was "normal" for each of the two sexes (Rubin). Surgical procedures, on the other hand, were developed in early treatments of cisgender patients: mastectomies and hysterectomies for "disorderly" female bodies (p. 58), and phalloplasties for World War I veterans (p. 59). These treatments also came to be seen as the appropriate treatment for people with differences of sex development when their true sex was not accurately diagnosed in infancy linking discourses of hermaphroditism to gender variance (Dreger, 2000). This, together with the belief that all humans were some combination of male and female, i.e., the human bisexuality theory developed in Germany in the nineteenth century (Rubin; Meyerowitz, 2002), likely made it possible for surgery and hormones to be seen as possible treatments for gender variance.

4.4 Discourses

The secondary sources on the medicalisation of gender variance reveal several discursive areas were particularly relevant to the development of the WBD: the concepts of sex, gender and sexuality; inversion; hermaphroditism; and pathology. It is important to note, however, that these are not as clearly-demarcated shifts as they can appear when being described. Despite changes in understandings and discourses, older discourses continued at the same time new conceptions developed and took hold. As a result, contradictory understandings often existed concurrently.

4.4.1 Sex, gender and sexuality

The medicalisation of sex/gender/sexuality in the second half of the nineteenth century focused on what was "normal" for different genders, races and classes, and what was considered

a sexual perversion (Cacchioni, 2015b), as well as what differentiated or constituted male and female (Dreger, 2000). At the time, there was only one concept, "sex," and it encompassed everything that is now split between "sex," "gender," and "sexuality" (Meyerowitz, 2002; Dreger; Rubin, 2006). This conflated concept, sex/gender/sexuality, was inherently racialised, such that what was defined as "normal" was, in fact, based on white middle-class heterosexual norms (Gill-Peterson, 2018; Snorton, 2017). Moreover, sex/gender/sexuality was based on the theory of human bisexuality—namely, that all humans begin as a mix of male and female before differentiating into their respective sexes (Meyerowitz)—and thus carried with it assumptions of racial evolution: white sex/gender/sexuality was more evolved than non-white, and this was evident in what medical experts argued was a greater degree of sexual dimorphism among white people (Somerville, 1994). Underpinning explorations of gender variance was thus a eugenic project that defined racial superiority biologically through, among other things, sex/gender/sexuality.

Whereas the late nineteenth century conceptualisations of sex/gender/sexuality were rooted in biological determinism, the early-twentieth century saw a shift to Freudian psychoanalytic theories (Cacchioni, 2015a; 2015b). These theories privileged sexuality, now referring specifically to sexual desire, behaviours, and physical functions (Oosterhuis, 2012), over sex/gender in human development from childhood into adulthood (Hovey, 2007; Rees-Turyn et al., 2008). Freud's theories of human development, however, did not challenge the eugenic values that had underpinned earlier biological determinism. Rather, the eugenic explanations shifted to accommodate discourses of development, such that non-white racialised groups were now seen as inferior because they were less developed than those considered white (Wynter, 2003; Gill-Peterson, 2018). During this time, sexuality was being separated from

sex/gender, evidence of which can be found in Freud's work in which he articulated sex/gender as the outcome of sexual development in children (Gill-Peterson), as well as in the more frequent articulation of differences between sexual inversion and sex/gender inversion (Chauncey, 1982-1983). One of the early texts on the difference between gender variance and homosexuality, that of Hirschfeld on transvestism, also demonstrated the growing separation between sex/gender and sexuality (Drescher, 2010b). This took place at the same time as the displacement of gonads as the defining element of sex, challenging the idea that "humans were really sexually dimorphic" (Gill-Peterson, p. 79). Essentially, the concept of sex (sex/gender) was being destabilised.

In the mid-twentieth century, the behaviourist model became central to studies of sex, gender and sexuality (Cacchioni, 2015b). In 1955, Money et al. (1955a; 1955b)—researchers studying disorders of sex development—developed the concept of "gender role" (what later came to be referred to simply as "gender") and defined it as separate from sex (Gill-Peterson, 2018; Repo, 2013). Despite being learned rather than the expression of an internal drive, however, "gender role" still carried with it a very specific, expected relationship to the concept of sex, thus serving to stabilise the concept of "sex" at a time when work on disorders of sex development had made the category of "sex" extremely plastic and malleable (Gill-Peterson). Ontologically speaking, then, sex and gender were now separated: sex was the biological category of male and female, and gender was the learned category of boy/man/masculine, expected of males, and girl/woman/feminine, expected of females. Importantly, both the behaviourist model in general, and "gender" as a concept more specifically, carried with them the very same eugenic principles that had underpinned discussions of sex/gender/sexuality and sex difference in the century before. The racialisation of "gender" was most evident in the

development of gender norms which were based on, and thus judged against, white middle-class norms (Gill-Peterson; Namaste, 2000; Snorton, 2017).

4.4.2 Inversion

In the nineteenth century and into the early twentieth century, the predominant way of understanding gender variance as well as sexual variance was inversion: anything that violated the expectations of sex/gender/sexuality was considered a form of inversion. The earliest examples of the discourse of inversion in medical expert texts can be found in works from the 1860s (Bauer, 2009), though literary examples can be found dating back to the sixteenth century (Asmussen, 2013). However, it was especially in the 1870s to 1890s that it proliferated the most (Bauer; Gottschalk, 2003). This discourse was also inextricable from the development of sexology as a discipline (Rees-Turyn et al., 2008). Indeed, as Oosterhuis (2012) noted, inversion "would gradually be differentiated into homosexuality, bisexuality, androgyny, transvestism and transsexuality" (p. 144).

Inversion was based on the notion of being "upside down" (Hovey, 2007). What was upside down, according to medical experts, was the person vis-à-vis the laws of nature (Hovey), specifically those related to sexual instincts (Taylor, 1998). Sexual instincts, recalling the discussion in the previous subsection, were part of the overarching sex/gender/sexuality conception, and so desiring members of the same sex was as much a symptom of inversion as wearing the clothing of the opposite sex (Prosser, 1998; Chauncey, 1982-1983; Rees-Turyn et al., 2008). One of the most significant discussions amongst medical experts interested in inversion was the question of whether inversion was situational or inborn. Situational inversion was conceptualised as caused by the situation in which a person found themselves. It could be treated by removing the person from that situation and thus was not a threat to the social order

(Chauncey). Inborn inversion, however, was a significant social problem, since it could not be treated in the same way and was thus a potential threat (Chauncey).

4.4.3 Hermaphroditism

According to a number of researchers, the discourse of hermaphroditism is inextricable from both the study of gender variance and the distinction between sex and gender that developed in the 1950s. Along side the beginnings of endocrinology and the discourse of inversion, medical experts raised questions about hermaphroditism and what it meant for binary gender. Indeed, there was significant overlap in who was subjected to the discourses of hermaphroditism and inversion as at the time, sex/gender/sexuality was still one concept, sex, such that gender identity, sexual object choice and body morphology were understood as inextricable from one another (Johnson, 2005). The discourse of hermaphroditism, however, cannot be exactly mapped onto the contemporary terms of intersex or disorders of sex development (Davis, 2014). This is because many of these conditions cause no genital ambiguity whatsoever (Hester, 2004), whereas it was specifically genital ambiguity and the difficulties this posed for binary sex that were the "problem" facing medical experts of the late nineteenth and early twentieth centuries (Dreger, 2000); the other conditions had not yet been discovered.

Medical experts of the late nineteenth and early twentieth centuries were troubled by bodies that they could not easily categorise as "male" or "female."[18] Looking to diagnose a person's "true sex," medical experts of the late nineteenth century examined gonadal tissue and, using this biological information, developed a classification system for hermaphroditism that could reduce the threat hermaphroditism posed to the binary sex model (Hester, 2004). According to this classification system, the only "true hermaphrodites" were those people who

[18] This is not to say that medical experts no longer pathologise genital differences, but rather to limit the discussion to the period covered by the dissertation research.

had both ovarian and testicular tissue; all other cases of hermaphroditism were now "pseudohermaphroditism" as the "true sex" could be accurately diagnosed by examining gonadal tissue (Hester; Dreger, 2000; Green, 2010). However, this was not a perfect classificatory system, and there were cases of "pseudohermaphrodites" who lived their entire lives without having their "true sex" discovered (Dreger). One of the ways in which medical experts attempted to address this was by developing increasingly numerous technologies in an attempt to stabilise the concept of sex by diagnosing a person's "true" sex, including measuring hormone levels and then mapping out chromosomes (Dreger). Rather than stabilise the concept of sex, these technologies further destabilised it as they revealed an increasing number of variables involved in the development of sex (Dreger; Gill-Peterson, 2018; Hester).

As the discourse of hermaphroditism changed, medical expert interest in disorders of sex development shifted from finding ways to diagnose a person's "true sex" to understanding why some people with a disorder of sex development felt they were the gender to which they were not assigned (Dreger, 2000). It is this area of study where John Money began his medical career that would later lead him to become an expert in gender variance and transsexualism. In his research on how hormones related to "psychological states of hermaphroditism" (Rubin, 2012, p. 892), Money developed the concept of gender role in order to articulate a person's social role without having to use their assigned sex category (Gill-Peterson, 2018; Rubin). Although Money's explicit reason for developing the concept of gender role was the difficulty posed in trying to articulate all of the different kinds of sex he was trying to explain, Gill-Peterson argued that underpinning all this was the need to find a way to stabilise the concept of sex that had been destabilised by hermaphroditism specifically, in the late nineteenth and early twentieth centuries (see also: Rubin). As a result, the discourse of hermaphroditism specifically, not just of intersex

or disorders of sex development, is central to the development of gender and sex as separate concepts (Rubin), and without this separation, the wrong-body discourse would not make sense meaning that the discourse of hermaphroditism is central to the development of the wrong-body discourse.

4.4.4 Pathologisation

The final discourse that is relevant to the medicalisation of gender variance is the discourse of pathology. By definition, pathologisation is inextricable from the medicalisation process as pathologisation is the practice of seeing characteristics and phenomena through the lens of pathology, or disease and/or disorder (Oxford University Press, 2020d). Pathology has historically been a key discourse used to define and manage deviance, and this has included sex/gender/sexuality deviance (Dewey & Gesbeck, 2017). In particular, the role of psychiatry in managing and controlling of "unwanted" and "disorderly" populations, such as those based on race, class, gender and sexuality, has been widely analysed (Szasz, 1960; Lupton, 2012; Gill-Peterson, 2018; Raz, 2013).

Considering the definition of pathologisation above, it is evident that the discourse of pathology in relation to gender variance began with the first medical experts who looked at sex/gender/sexuality deviance from a medical perspective. Over the period of 1860 to 1979, in addition to the medical experts (discussed earlier in the chapter) who considered gender variance to be a legitimate disorder, the majority of medical experts considered it to be a delusion or a perversion (Wiggins, 2020; Meyerowitz, 2002; Califia, 2003). As a result, they were opposed to treating gender variance with surgery and hormones, and they argued that it would be best treated with psychotherapy with the intent of having the gender-variant person accept the gender to which they were assigned at birth (Meyerowitz; Califia). In fact, many medical experts

considered surgical and hormonal treatment of gender variance to be an outright collusion with the disorder, and as such harmful to the patient (Wiggins).

It is important to recognise, however, that *all* medical experts involved in producing knowledge about gender variance were making use of the discourse of pathology, both those who believed it to be a delusion *and* those who supported surgical and hormonal treatment. Moreover, because the medicalisation of gender variance culminated in 1980 with the inclusion of transsexualism in the *DSM-III* (APA, 1980), a psychiatric diagnosis, the history of psychiatry and its use of pathologisation as a tool of social control means that pathologisation, and specifically psycho-pathologisation, remain relevant to all discourses about gender variance, whether they are medical discourses or not.

4.5 Limitations

The majority of the secondary literature that has been published on the medicalisation of gender variance, such as Meyerowitz (2002), Stryker (2008), Valentine (2007), Rudacille (2005), and Califia (2003), provides an overview of key medical experts, some key gender-variant people, and key events related to that medicalisation. Some work, however, provides a more focused study of specific factors, such as Gill-Peterson (2018) who centralises both race and childhood, Snorton (2017) who centralises race, Prosser (1998) who focuses on the body, and Rubin (2003) who focuses on trans men. Nevertheless, the literature on the medicalisation of gender variance is marked by exclusion, erasure and a forgetting of those who were unintelligible to medical experts because they did not conform to expectations, and for this it must be held accountable. To do so, I have identified two overarching limitations of the literature that have a significant effect on the historical contextualisation of the WBD that I can produce: who is discussed in the literature, and how gender is conceptualised.

The literature on the history of the medicalisation of gender variance is significantly limited by *who* is included in the discussions. Firstly, the majority of the literature centralises medical expertise and involvement, and generally produces an overwhelmingly white, Western history of gender variance. While more recent literature has explicitly challenged this (Gill-Peterson, 2018; Snorton, 2017), whiteness remains a key characteristic of the literature and thus of the production of history of the medicalisation of gender variance. Even when scholars include gender-variant people in historical accounts, the people included are still mostly white. According to Gill-Peterson, Snorton, as well as Skidmore (2011), this may be because the gender variance of people of colour, in not conforming to medical expert expectations rooted in white heteronormative gender norms, was unintelligible *as* gender variance to medical experts. The result of this, though, is a skewed perception of who was influential. Secondly, the literature cannot fully account for the influences of gender-variant people who chose not to interact with medical experts, many of whom were people of colour. Though the literature does show that a number of well-known gender-variant activists and community members made conscious choices to reject medical expert involvement (Gill-Peterson), such a rejection does not preclude influencing or being affected by medical experts.

The other overarching limitation lies in how "gender" is conceptualised, both by the authors of the secondary literature as well as by the medical experts and gender-variant people discussed in the literature. Any analysis that does not centralise race necessarily misses the ways in which gender (and thus gender variance) is, and was, racialised, as well as how the process of medicalisation is racialised. Although the literature increasingly has taken into account the ways in which medicalisation is gendered, it has excluded analyses of the way racialised bodies are treated differently by medical experts as well as how racialised bodies were used as a resource to

develop medical knowledge and practices intended to benefit white bodies. Moreover, the ways in which the authors of the secondary literature ontologically conceptualise gender necessarily excludes and erases people who conceptualise gender in other ways, most notably in the context of Canada and the United States, Two-Spirit people. Because the Western conception of gender is rooted in colonial processes and institutions, the uncritical use of "gender" in the literature continues to enact colonial (and patriarchal) violence on people whose identities and experiences cannot be articulated within its bounds (Hunt, 2015).

4.6 Conclusion

In this chapter, I have attempted to present as thorough a historical contextualisation as possible for my analysis of the development of the WBD. The literature reviewed here reveals that the WBD developed in the context of medical experts who were working to try to make sense of sex/gender/sexuality (and the three concepts it was divided into) and the various "deviations" from norms that they saw in their patients. These gender-variant people, however, were also trying to make sense of their own identities and experiences, and tried to make sure that medical experts understood what—and who—they were. In addition to medical experts and gender-variant people, there were numerous other factors that likely had a role in the development of the WBD, such as socioeconomic forces, social institutions, technological developments and discourses. These engines of medicalisation worked together and interacted with one another as the process of medicalising gender variance progressed from the early medical-expert prospecting stage, to the claims-making competitions stage with a proliferation of proposed explanations, through Benjamin's claim of ownership before culminating in the institutionalisation of the transsexualism diagnosis in the *DSM-III* (APA, 1980).

5 Development of the wrong-body discourse

How the wrong-body discourse (WBD) became the dominant medical discourse on gender variance in Canada and the United States is a complex question, and one that cannot be answered definitively. However, it is possible to trace its development and identify a number of significant factors that likely contributed to it becoming dominant, and using Conrad and Schneider's (1992) five-step model of medicalisation,[19] create a thorough picture of how the WBD became institutionalised in the *Diagnostic and Statistical Manual III* (*DSM-III*) diagnosis of transsexualism. To answer this question, I consider where the WBD originated, how it developed, and what factors likely contributed to its dominance. First, I trace the origins of the WBD to the 1860s, when references to gender variance first appeared in work on homosexuality, and look at how early sexologists explored the phenomenon that at the time was called inversion. I then demonstrate how each of the three tenets of the WBD that I identified in the literature review in chapter 2 individually developed during the course of medical experts making competing claims about gender variance, and coalesced into a unified discourse when Benjamin (1966) claimed ownership[20] of gender variance as a medical condition named transsexualism defined by the WBD. I then show that each tenet of the WBD is evident in the text of the *DSM-III* diagnosis of transsexualism (APA, 1980), demonstrating that indeed, the WBD was institutionalised in the diagnosis of transsexualism.

One of the most striking features of the primary sources analysed in this chapter (for a full list, see Appendix A on p. 247) is their almost exclusive discussions of AMAB gender-

[19] Recalling Conrad and Schneider's (1992) model of medicalisation discussed in chapter 1, the five steps are: 1) a human phenomenon socially defined as deviant; 2) medical-expert "prospecting"; 3) claims-making competitions; 4) claiming ownership; and 5) institutionalisation (p. 266-271).

[20] The stage of claiming ownership involves having specific medical experts' discursive authority accepted and legitimated by other experts. A more detailed explanation of this stage can be found in the introduction, on p. 11-12.

variant people. Although this began to shift in the 1970s, AFAB gender-variant people were rarely mentioned and often completely absent in the texts—perhaps rather conspicuously, to a contemporary researcher. This feature is reflected throughout the present analysis, evident in many of the quotations I have selected to illustrate my points. This is done intentionally, for while the predominance of AMAB gender-variant people being seen by medical experts did not likely influence the dominance of the WBD, it was crucial to its development and the potential implications of the WBD. As such, while I mention it throughout this chapter and the next, I discuss the importance of this feature in chapter 7.

5.1 How did the WBD come into existence?

The precise origins of the WBD may never be clear. However, they can be traced back at least to the second half of the nineteenth century, a time when the discourse of inversion dominated and the scientific exploration of sex was gaining momentum. At a time when medical experts were exploring this phenomenon of inversion, numerous authors, both medical expert and not, published treatises theorising sexual behaviour, especially behaviour they characterised as deviant or perverse. Many cited one another, and many included case studies of patients with strikingly similar descriptions of their experiences. Together, these publications developed into a body of work that, in engaging with the discourse of inversion, created a discursive space in which the WBD could develop. Because these early experts had a wide variety of backgrounds, I have included the following table that states each included author's specific area of expertise.

Table 5

Early sexologists and their areas of expertise

Author	Area of expertise
Ellis, Havelock	Physician
Hirschfeld, Magnus	Physician, sexologist
Krafft-Ebing, Richard von	Psychiatrist
Moll, Albert	Psychiatrist
Symonds, John Addington[21]	Poet, literary critic
Ulrichs, Karl Heinrich	Lawyer
Westphal, Carl	Psychiatrist

5.1.1 A female soul

The first instance of a statement that resembles the WBD can be found in the work of Ulrichs (1864/1994), a lawyer who, while attempting to explain homosexual men whom he termed Urnings, argued that they were "born with the sexual drive of women and who have male bodies" (p. 35). In a series of pamphlets, he tried to refine this idea, arguing that Urnings were mentally feminine (p. 58) and that they were "feminine beings in male bodies" (p. 90). Throughout his work, a series of 12 pamphlets published from 1864 to 1880 on the topic of Urnings, the idea of an inner femininity prevailed, and by 1868, Ulrichs had begun to use the phrase "the feminine soul residing in a male body" (p. 363). Most often written in Latin, *anima muliebris virile corpore inclusa* (p. 509), this phrase is arguably the most influential of Ulrichs' work, cited by numerous others in the early days of sexology such as Krafft-Ebing (1886/1902), Ellis and Symonds (1897/2008), and Hirschfeld (1910/1991).

[21] Although Symonds appears as an author on the first edition of *Sexual Inversion*, he died prior to the publication of the book and subsequently his family had his name removed from all future editions (Crozier, 2008).

The work of Ulrichs is also notable for being the first to make explicit reference to discomfort in the body. Although he did not explore this discomfort to a significant extent, writing about it only in one pamphlet, he did note that Urnings experienced discomfort in regards to their bodies (1864/1994, p. 92-93). According to Ulrichs, this discomfort was directly related to the inner femininity that characterised Uranian[22] existence which was uncomfortable in the masculine body (p. 93). Ulrichs' early articulations that forecast contemporary expressions of transsexual experience seemed to already discursively connect two elements that later became inextricable as two of the WBD tenets: inner femininity and body wrongness. His ideas, however, did not immediately become widely influential.

Despite his attempts to share his ideas—Ulrichs frequently mailed his pamphlets to mostly lawyers throughout Germany, especially those working on cases of homosexuality (Kennedy, 2002a)—his influence on medical discourses was limited by his status as a lawyer and by his homosexuality. Many medical experts dismissed his work because of his lack of medical expertise (Kennedy, 1981; Ellis & Symonds, 1897/2008), while others considered it scientific but too biased by Ulrichs' homosexuality to be used widely (Moll, 1897/1931). Instead, much of Ulrichs' influence came through the work of Westphal (1869/2006), a psychiatrist, who cited Ulrichs, but is often given credit as being the first to publish on what Westphal termed "contrary sexual feeling" (Brooks, 2012; Bullough, 1994). Ulrichs also inspired the psychiatrist Krafft-Ebing's interest in homosexuality, which Krafft-Ebing acknowledged in an 1879 letter to Ulrichs (Kennedy, 2002b; 1981; Brooks). Whether these early sexologists agreed with him or not, it appears Ulrichs' ideas proliferated throughout this group.

[22] The adjectival form of Urning is Uranian.

Although it is impossible to say for certain how Ulrichs came to this articulation of homosexuality as having a male body but a feminine soul, work on disorders of sex development, then called hermaphroditism,[23] and on the concept of sex instinct may have contributed to making such an articulation possible. Recalling the historical context (chapter 4), it seems that Ulrichs was aware of this work and although he did not make the connection explicitly himself, both hermaphroditism and sex instinct played a part in shaping his conceptions of sex and sex instinct. At the time Ulrichs was writing, namely the second half of the nineteenth century, questions regarding different types of hermaphroditism were circulating, as were questions about the role of gonads in determining sex (Dreger, 2000). Ulrichs himself is noted as having referred to Urnings as a type of hermaphrodite (1864/1994, p. 38-39; 303), demonstrating that he was engaging with these very same questions. In theorising sexual intermediaries, Ulrichs also drew on embryological studies that demonstrated the lack of sexual differentiation in human embryos where the same tissue can form into either a penis or a clitoris (Brooks, 2012). From this, Ulrichs surmised that in order for this tissue to differentiate, there must be two "germs,"[24] one for masculinity and one for femininity, and that somehow, one of these was suppressed as the fetus grew (Pretsell, 2020). Ulrichs then proposed that there existed a "mental sexual germ" that functioned in a similar way, and that in the course of fetal development, these two germs—the sex germ and the mental sexual germ—could potentially misalign (Ulrichs, 1864/1994, p. 363). It is possible, then, that in contemplating hermaphroditism

[23] In this section I use the term "hermaphroditism" because that specific term, as well as the associated concept of "pseudohermaphroditism" formed the direct context of Ulrichs' work.

[24] In biology, embryos of most animals have either two or three germ layers, which are "group[s] of cells in an embryo that interact with each other as the embryo develops and contribute to the formation of all organs and tissues" (MacCord, 2013, para. 1). Germ layers were first identified in 1817 in Germany (para. 3), and most of the early work on germ layers continued in Germany for the next 30 years (para. 5-6). Thus, by the time he was writing, Ulrichs would likely have had access to much of the research on germ cells. Additionally, in contemporary understandings, a "germ" is "the primordium of a part of the body, esp. that of a tooth or feather" (Oxford University Press, 2020c).

and the conceptual changes occurring to sex instinct, Ulrichs conceived of the possibility of a type of hermaphroditism wherein a person had the mind of one sex, but the body (genitals, gonads) of the other. Since sex instinct was, according to Ulrichs, located in the mind, this misalignment would result in a person having the mind sex and thus sex instinct that did not align with physical sex.

5.1.2 Similar cases

Many sexologists engaging with Ulrichs' ideas published on similar topics and reported numerous cases of patients with similar experiences. First and foremost, Westphal (1869/2006), after having quoted at length from Ulrichs, characterises the two cases he presented as "contrary sexual feeling" in terms of having the nature (p. 106) and feelings (p. 107) of the other sex, using language almost identical to that of Ulrichs.[25] Krafft-Ebing (1886/1902), on the other hand, developed a taxonomy for cases he called "antipathic sexual feeling" that covered everything from homosexuality to transsexualism, including "*metamorphosis sexualis paranoica*," a disorder he described as the delusion that one had actually changed sex (p. 328). Many of Krafft-Ebing's cases in these categories involved patients feeling like they were women, including "the whole psychical personality and even bodily sensations," despite having male bodies (pp. 286; 314; 342). Hirschfeld (1910/1991), a physician and sexologist, reported on numerous patients who described feeling like the other sex (pp. 84, 116, 132, 152, 191) or as having never felt like the sex they were assigned at birth (pp. 151, 153), such as "Miss T. [who] feels she is completely a man, especially in the company of women" (p. 152). However, Hirschfeld considered these all cases of transvestism of varying severity. Although Ellis and Symonds (1897/2008) only refer to

[25] The similarity may be due to the translations as M. Lombardi-Nash is the translator of both texts, and actual similarity would have to be ascertained by a comparison of the original texts, both having been originally written in German.

Ulrichs in their literature review in their book on "sexual inversion," Ellis (1928), a physician, included one case of a patient who experienced himself as a woman in his discussion of "eonism" (p. 9). It is evident that regardless of what terms were being used, the cases reported by all of these sexologists were remarkably similar, and all were marked by feeling like the other sex.

In reporting on cases that reflected Ulrichs' original articulation, these sexologists contributed to the continuation of the discourse of an inner femininity encased in a masculine body, regardless of whether they agreed with Ulrichs' articulation or his proposed etiology. The more often that similar cases were identified and published, the more often medical experts and laypeople read the publications and became familiar with this articulation. In addition to more medical experts using this understanding to identify a similar cases among their own patients, patients themselves also contacted medical experts and used these same formulations to add their own experiences to be used in these medical texts (Oosterhuis, 2012). Ulrichs' influence thus continued.

5.1.3 Conditions of possibility

The earliest data demonstrate that a number of contextual conditions had to be met before the WBD could develop. Not only did sex instinct have to be separated from the physical traits associated with biological sex but medical experts had to see a pattern in their patients. This was made possible by the use of case studies, such as those published by Krafft-Ebing (1886/1902) or Ellis and Symonds (1897/2008), that other sexologists could reference and compare to their own. Together, these factors produced a discursive environment within which a new discourse could take hold and explain gender variance: the WBD.

5.2 How did the WBD develop?

By the late 1950s, the WBD was beginning to come into focus, although it would not be refined until the late 1960s. The primary sources reveal that each of the three tenets of the discourse that I developed from the literature review[26] can be individually traced through the primary sources beginning at the end of the nineteenth century, during which time medical experts were exploring the phenomenon or "prospecting" (Conrad & Schneider, 1992, p. 267). During the 1950s, the tenets gained substantial momentum as medical experts increasingly published their understandings and claims about gender variance, corresponding to Conrad and Schneider's third step. Within each tenet, I have identified a number of trends that I demonstrate together contributed to its development, shaping the discourse into one recognisable as that of the wrong body, and appearing as a unified whole in Benjamin's (1966) book, *The Transsexual Phenomenon*. This marks the moment Benjamin claimed ownership of the phenomenon that was now widely called transsexualism and solidified the authority of medical experts who used the WBD and believed in hormonal and surgical treatment. I then explain how each of the tenets is a key aspect of the *DSM-III* (APA, 1980) diagnosis of transsexualism as well as of the *Standards of Care version 1* (*SoC ver. 1*) (Berger et al., 1979), demonstrating that the WBD was, indeed, institutionalised in 1980 in the *DSM-III*.

A couple of points bear mentioning here. First, not every trend or theme of every tenet can be found in every primary source examined in this research. Rather, roots of the discourse can be found across the primary sources, especially in the nineteenth century before coming together as a more unified discourse in the 1960s and 1970s. And second, as I mention throughout this dissertation, the vast majority of examples included in the primary sources came from AMAB gender-variant people. This is reflected in my discussions. This imbalance is

[26] Recalling from the literature review, the three tenets of the WBD are: (1) the body feels wrong; (2) there is a disjuncture between sex and gender; and (3) hormones and surgery are the solution.

because AFAB gender-variant people were not interacting with medical experts to the same extent, and though the reasons for this were numerous (see: Devor, 1997; Cromwell, 1998; Lothstein, 1983), none of these reasons were discussed in the primary sources. The implications of this imbalance for the WBD is discussed in the implications section of chapter 7.

5.2.1 Tenet 1: Wrongness of the Body

The first tenet of the WBD, that of wrongness of the body, is rooted in the words of gender-variant people themselves. These words came to medical experts in the form of letters to doctors as well as interviews with gender-variant people which were then transcribed and reproduced in books and articles, reaching further medical experts as well as other gender-variant people, who read all of the literature they could find, particularly because it was so limited (Meyerowitz, 2002). Thus, although these words were then taken by medical experts and used to characterise gender-variant people, their origins are likely in the relationship between the experiences of gender-variant people, the literature they could access and the medical experts with whom they talked. The primary sources reveal that there is a core set of articulations that repeats throughout: wishing, discomfort, mistake, abhorrence of sex characteristics, and being trapped. The earliest consistent articulation is that of wishing, which is central to the discourse until abhorrence of sex characteristics becomes more frequently discussed at the beginning of the 1960s. The idea of being trapped in the wrong body, although iconic, does not actually appear until Benjamin's (1966) book, *The Transsexual Phenomenon*. Rather, discomfort in the body is a persistent thread throughout the first tenet.

5.2.1.1 Wishing and wanting

Throughout the entirety of the primary sources, the most noticeable articulation of body wrongness is in terms of wishing to be the other sex. From the earliest primary sources reviewed,

AMAB gender-variant people were both quoted and described as saying that they wished they were girls or women. The reciprocal, AFAB gender-variant people who stated they wished to be boys or men, was far less common, but nevertheless does appear at times. Krafft-Ebing (1886/1902), for example, noted a gender-variant person "first expressed … the wish to be a girl" at the age of fifteen (p. 308). Similarly, Hirschfeld (1910/1991) has a number of cases that wished they had been born women (pp. 28, 34, 63), including one gender-variant person who "prayed, "Dear God, please make me into a girl" (p. 88). Ellis (1928), too, reports on such cases, such as one whose "inner desire was to live as a girl" (p. 54).

The theme of wishing continued as the amount of literature on gender variance increased, though this articulation began to be less and less central to presentations of gender variance. It also began to be increasingly articulated as a *wanting to be* rather than a *wishing they were*. The difference between these two statements lies in the connotation of uncertainty associated with the term "wishing" that does not exist with the term "wanting" (Oxford University Press, 2020g; 2020f), signaling a shift in how gender-variant people viewed the possibility of a treatment for their condition. Hamburger et al. (1953), in their publication on the treatment of Christine Jorgensen, refer to her as having "a very strong desire to *be* a girl" (p. 393, emphasis added). Similarly, de Savitsch (1958) notes that a large number of patients presenting for surgery reported that they "always wanted to *be* a girl" (p. 87, emphasis added). By the 1960s, this articulation of desire became part of the description of transsexualism, with Benjamin (1964a) stating that "the transsexual…wants to *be* that woman" (p. 460, emphasis in original). From this point on, wanting to be the other sex became increasingly more frequent, and wishing to be the other sex, although not disappearing entirely and continuing to be found into the 1970s such as in

the work of Green, Newman and Stoller (1972) and Prince (1973), receded in terms of the proportion of articulations that reflected it.

5.2.1.2 Discomfort

As noted in the previous section, the first person to publish statements that are recognisably similar to the WBD was Ulrichs. In those works, Ulrichs (1864/1994) described Urnings as feminine souls in male bodies who experienced discomfort about the maleness of those bodies (pp. 90, 92-93). This articulation, however, did not always appear in the literature as explicitly as it did in the work of Ulrichs, but rather it must be discerned from the descriptions of experiences given by gender-variant people. Some gender-variant people quoted by medical experts described their discomfort in terms of having to wear a "burdensome mask" in their day-to-day lives (Krafft-Ebing, 1886/1902, p. 313). Others spoke of contradictions between their bodies and souls (Hirschfeld, 1910/1991, p. 129), and "often are depressed by the fact that they do not physically belong to the desired sex they love" (p. 182). Another described sleeping "with all the organs tucked back" (Ellis, 1928, p. 94) so as not to have to see them. Each of these experiences conveys discomfort with one's body without stating it in those specific terms.

Although discomfort can be inferred from each of the foregoing articulations of body wrongness, the first clear example of this articulation since Ulrichs (1864/1994) is in the late 1950s when de Savitsch (1958) reported a gender-variant person as "be[ing] tortured mentally by the fact that he was not a female" (p. 83). Rarely again reaching that level of explicit description, this articulation nevertheless continued in a significantly more obvious manner into the 1960s and 1970s. Benjamin (1964a), for example, noted that for AFAB gender-variant people, menstruation was "a psychological trauma" (p. 467), whereas Pauly (1974a) phrased this as a "painful awareness of and disgust for their female anatomical sex" (p. 501). The primary sources

also reveal the possible influence of changing and developing specialisations, as Lindgren and Pauly (1975) proposed an additional measure for assessing gender-variant people using the concept of body image dissatisfaction. Despite not using the term discomfort, it is evident that a negative emotional response specifically to sexed embodiment has been a key theme throughout these primary sources.

5.2.1.3 Abhorrence of genitals

Many gender-variant people quoted and described in the primary sources make reference to their hatred of their primary and secondary sex characteristics, often expressing this hatred as a wish to have them removed. The earliest example of the link between having genitals removed and inner femininity can be found in the work of Moll (1897/1931), a psychiatrist, who wrote about a gender-variant person who "wished to cut off his genitals" due to a "desire to feel entirely feminine" (p. 65). This reference to genitals reappears in the work of Ellis (1928), though only as a reference to the gender-variant person Moll had described earlier. Until the 1950s, however, this articulation did not otherwise appear, at which point it began to take over from wishing as the most frequent articulation and became central to the way body wrongness was communicated and articulated. Although it is not evident in the primary sources, the historical context (chapter 4) suggests that this may have been at least partly because of the growing popularity of fascism and the Nazi Party in Germany, and the subsequent distrust with which American medical experts regarded their German counterparts (see, in particular: Gill-Peterson, 2018; Meyerowitz, 2002).

This centrality was immediately part of the discourses about transsexualism. In their publication on the case of Christine Jorgensen, Hamburger et al. (1953) already describe gender-variant people as having an aversion to their genitals (p. 393). Despite opposing surgical

treatment, both Ostow (1953) and Wiedeman (1953) nevertheless not only repeat, but also centralise this aversion as the key characteristic of the gender-variant people in question. Many others publishing in the 1950s referred to "rejecting" genitals (Worden & Marsh, 1955, p. 1296), "hating" them (Bowman & Engle, 1957, p. 583), or getting rid of them (Prince, 1957, p. 19). This articulation continued to subtly change, shifting to such terms as "disgusting" (Benjamin, 1966, p. 22; Laub & Fisk, 1974), or even "a growth" or "a tumour" (Socarides, 1970, p. 342). Sometimes, medical experts even used the exact same word to describe this hatred of genitals. The word "abhorrence" appears in a large number of the publications, including Benjamin's (1964a, p. 460), Socarides' (1969, p. 1423), and Ovesey and Person's (1973, p. 64).

Although similar to the articulation of discomfort in the body, the distinguishing aspect of this articulation is the focus on the genitals. It appears that, over time, the conceptualisation of the experience of body wrongness started to narrow, increasingly focusing on the specific parts of the body about which the gender-variant people that medical experts most encountered felt discomfort.

5.2.1.4 Trapped in the wrong body

Although the notion of being trapped in the wrong body is the iconic articulation of the WBD, it did not actually appear until Benjamin's (1966) book, *The Transsexual Phenomenon*. Similar ideas can be found prior to this, such as Ulrichs' (1864/1994) feminine beings in bodies that made them uncomfortable (p. 90, 92-93), or references to masks (Krafft-Ebing, 1886/1902, p. 313). Benjamin, however, was the first to explicitly refer to the experience of being transsexual as being *trapped* (p. 17) or *imprisoned* (p. 126), and of this being specifically in *the wrong body* (p. 17). What is particularly notable about this articulation is that although it appears in Benjamin's book, it may have actually originated from a gender-variant person rather than

Benjamin himself. The appendix to Benjamin's book includes a direct quotation from a gender-variant person, Clara, who stated that she "was a woman, but was deformed by being trapped in the body of a man" (p. 269). While it is unfortunately impossible to determine for certain whether this phrase is from Clara, the quotation suggests that it may indeed have been her phrase which Benjamin then took and shared with others both through his practice and through his publications.

This phrasing was very quickly incorporated into the literature. Both Stoller (1968) and Green (1969c) used it to describe transsexualism, the latter using it in his conclusion to a book which included a large number of discussions, not all in agreement with one another, but all brought together by Green's concluding thoughts on the "female mind *trapped* in a male body" (p. 468, emphasis added). By the 1970s, this articulation was being explicitly used as part of research in the form of questions about whether participants felt like they were women trapped in male bodies (Prince & Bentler, 1972, p. 909), and as a defining statement of transsexualism (Rekers & Lovaas, 1974; Person & Ovesey, 1974a).

5.2.1.5 Solidification as a tenet

By the 1960s, the primary sources reflect a solidification of this tenet, wrongness of the body, as a fundamental aspect of the medical-expert understanding of transsexualism. Indeed, it became such an inextricable part of this conceptualisation that the discourse is named after this tenet. Beginning first with expressions of wishing, and then wanting, to be the other sex, the articulation of body wrongness then shifted to a focus on a specific part of the body: the genitals. However, what is noticeable about this shift is that despite AFAB gender-variant people existing and, albeit rarely, being acknowledged by medical experts, all of the examples of genital discomfort included by medical experts were from AMAB gender-variant people. In 1966,

Benjamin defined body wrongness by that genital discomfort, phrasing it as being trapped in the wrong body. In doing so, Benjamin equated genitals with gendered embodiment in medical-expert understandings of transsexualism. While other authors such as Stoller (1968), Prince and Bentler (1972), Laub and Fisk (1973), and Bentler (1976) also used body wrongness as a key descriptor of transsexualism, Green (1969c) contributed significantly to this conceptualisation of body wrongness rooted in the genitals by bringing together quite varied and at times disparate chapters as all being about the phenomenon of "a female mind *trapped* in a male body" (p. 468, emphasis added). This has reified the idea of being trapped in the wrong body as an accurate description of transsexualism, but it also has reified the centrality of the genitals to that experience of body wrongness.

Additionally, the primary sources demonstrate that regardless of whether medical experts agreed on etiology or even terminology, medical experts made use of the idea that transsexualism was defined by being trapped in this wrong body. Some of these medical experts, such as Socarides (1969; 1970), explicitly were opposed to the idea of transsexualism and its surgical treatment. Others, such as Pauly (1965; 1969a; 1969b; 1974), seemed uncertain at times, supportive but only because they could see no better way to help these patients. Still others, such as Prince (1978), felt that this articulation was not the only one that could be used, but nevertheless conceded that it was, in fact, central and widely used. In citing this articulation—and one another—throughout the literature, all of these authors contributed to centralising body wrongness as the most important aspect of transsexualism.

5.2.2 Tenet 2: Disjuncture between sex and gender

The second tenet of the WBD is the idea that there is a disjuncture between sex and gender. While it is not a statement of etiology, it is nevertheless an explanation of the cause of

the experience articulated by the first tenet, body wrongness. In contrast to the first tenet, this one is based on a combination of gender-variant people's words and medical experts' words, beginning with descriptions of feelings reported by gender-variant people and then being taken up by medical experts and modified using expert psychological discourses of the particular period in which these medical experts were writing. These changes were also then reflected in the words of gender-variant people themselves as they took on these new discourses in their conversations with medical experts. Thus, feelings and soul became mind, then psyche, then gender identity.

5.2.2.1 Feeling like a woman

Throughout all of the primary sources, the idea of feeling like a particular gender can be found. This usually took the form of feeling like a *woman*, due to the predominance of AMAB gender-variant people seen by medical experts. As discussed in the previous section, the first iteration of this, having a feminine soul, can be found in the work of Ulrichs (1864/1994), but this formulation appears in almost all of the early sexological works, from Westphal (1869/2006), to Krafft-Ebing (1886/1902), to Ellis and Symonds (1897/2008). Hirschfeld (1910/1991), whose work focused on a subset of the people that interested the earlier sexologists, namely those who wanted to wear the clothing of the other sex rather than sexual "deviants" or "perverts" in general, as a result found significantly more cases who described their experiences in terms of feeling like women.

Despite the development of other articulations of this tenet that are discussed below, the idea of feeling like a particular gender persisted throughout the literature and was often used in conjunction with other ways of expressing the experience. Hamburger et al. (1953) noted that feeling like a woman was deeply rooted, and Benjamin (1964a; 1966; 1967) as well as Stoller

(1968) and Pauly (1974a) all focused on this as a way to explain what the phenomenon of transsexualism actually was. However, simply feeling a certain way did not have the explanatory power that subsequent articulations would come to have, and indeed, this articulation became less central as the medicalisation of gender variance progressed.

5.2.2.2 Gender identity disturbance

The explanation of transsexualism began to shift in the 1950s, with "feeling" and "soul" being frequently replaced by references to the psyche, and then by references to identification, before finally taking the form of being a gender identity disturbance. Some authors explained transsexualism as, specifically, a man having a feminine psychology or psyche (Barr & Hobbs, 1954; Anchersen, 1956). Others, however, connected that idea of the psyche with identification, such as Prince (1957), who explained transsexualism in AMAB gender-variant people as an "identification with the female" (p. 19), which was very similar to Brown's (1957) explanation of the "psychological identity of the opposite sex" (p. 614). Both of these not only used the concept of identification, but also tied that identification to the sex that patients stated they felt like.

In 1964, Benjamin (1964a) referred to transsexualism as fundamentally "a disturbance of the proper sex and gender role orientation" (p. 459). This is the first explicit reference to gender, which had been defined less than ten years earlier by Money et al. (1955a; 1955b) under the term "gender role." However, Benjamin, like many of the medical experts in the 1960s, did not use consistent terminology. Benjamin (1969) also used the term "gender-role disorientation" (p. 1), while other articulations included "psychological gender identity" (Kubie & Mackie, 1968, p. 432) and "faulty gender identity" (Money & Brennan, 1969, p. 140). At the same time, authors continued to refer to psychological sex (Benjamin, 1966) and to feelings of belonging to the

other sex (Baker, 1969), both of which nevertheless seemed to express the same basic idea of an identification combined with Money et al.'s concept of gender role.

5.2.2.3 Conviction

The first mention of conviction can be found in the work of Worden and Marsh (1955), who stated that transsexuals have a "conviction of being female" (p. 1295). Unlike the notion of feeling, which is a subjective experience that cannot be argued, conviction carries with it the meaning of "an opinion or belief held as well proved or established" (Oxford University Press, 2020a, para. 6). In short, in stating "conviction of being female," Worden and Marsh were saying that transsexuals actually believed themselves to be female, whereas before, they felt female but knew themselves to be male. The idea of the conviction, although rare in the 1950s, can be found frequently in work published in the 1960s and 1970s, with medical experts often referring to gender-variant people as being convinced that they were of a particular sex, including Benjamin (1964a), Money and Brennan (1969), Prince (1973), and Person and Ovesey (1974a). The repetition of the word conviction may have reflected a change in how medical experts interpreted feelings of gender-variant people particularly because this articulation was predominantly used by medical experts, though it may also have been a reflection of a change in the words being used by gender-variant people themselves.

This idea of conviction was not always explicitly named so, however, and appeared both in terms of an "intense belief" or "fixed belief" (Hertz et al., 1961, p. 288; Stoller, 1968, p. 92) and of "insistence" (Pauly, 1969b). This insistence was also sometimes expressed as "stressing" the gender identity (Stürup, 1969, p. 454). Although not always using the term "conviction," the meaning remained in the ways these medical experts articulated their gender-variant people's senses of self. Additionally, "conviction" often appeared paired with such words as "irrevocable"

(Hoopes, 1969, p. 338), “permanent” (Benjamin, 1964a, p. 108), and “constant” (Meyer, 1974, p. 549). These pairings brought with them connotations of a strong belief despite evidence to the contrary, a position that both Worden and Marsh (1955) and Stoller (1968) explicitly took, with Stoller even stating that the conviction was “in the face of anatomic reality to the contrary” (p. 97).

5.2.2.4 Solidification as a tenet

Although “feeling like” was a consistent articulation throughout the literature, it was not until the concept of gender role (Money et al., 1955a; 1955b) was defined that this feeling like, or conviction of being, became a key aspect of the WBD. Prior to being articulated as a gender identity that did not align with sex, gender-variant people’s feelings did not have the explanatory power necessary to become a tenet that could connect experience or symptom with treatment. Once this concept was named by Money et al., and differentiated from sex, feelings could be made sense of using medical, specifically psychological, discourses that posited a particular relationship between the two aspects of a person, their gender role (and their identification with it, which later became gender identity), and their sex. Now these feelings could be articulated as a disjuncture between gender and sex. This disjuncture could be used to explain what was happening that made gender-variant people experience their bodies as wrong, even if it did not explain why this occurred, and to then provide an explanation of what a treatment could accomplish, namely align a patient’s gender and sex.

5.2.3 Tenet 3: Surgical and hormonal treatment is the solution

The 1950s marked a point of significant change in the interactions between gender-variant people and medical experts in the United States. One of the most notable is the explicit requests for surgical intervention, first in terms of castration and later, likely as knowledge of

Christine Jorgensen's transition spread, in terms of hormones and surgery. This did not immediately lead to medical experts agreeing on a treatment protocol, however. Rather, the data reveal that through significant ambivalence, uncertainty, and even reluctance, many medical experts came to the conclusion that there was no better solution at the time and so they would endorse surgical and hormonal treatment for some, though not all, gender-variant people. Moreover, the primary sources reveal that over the first ten years that surgery was notable in discussions of transsexualism, the requests for surgery came to be seen by medical experts as a key characteristic of transsexualism, eventually becoming a defining characteristic, a necessary though not sufficient symptom.

5.2.3.1 Desire for surgical treatment

The desire for surgical treatment does not significantly appear in the literature until the 1950s. Prior to this, there is one mention of a gender-variant person indirectly referring to castration in the work of Krafft-Ebing (1886/1902), and one instance of a gender-variant person explicitly requesting castration which can be found in Ellis' (1928) work. This is likely due to the fact that these kinds of surgical procedures were not being widely conducted and therefore were not seen as possibilities by gender-variant people. As discussed in the historical contextualisation (chapter 4), the first surgical procedures were taking place in the 1910s and 1920s in Germany (Bullough, 2007), and the first (semi-)autobiography—that of Lili Elbe—was published in 1933, thus it is likely that few gender-variant people had heard of surgical treatment and did not know that they could request such a procedure.

The majority of the references to this desire in the first half of the 1950s were in terms of castration. Indeed, even the use of the recently-developed synthetic hormones was termed "hormonal castration" (Hamburger et al., 1953, p. 396; Benjamin, 1954, p. 229), and as late as

1959, some medical experts, such as Randell (1959), referred to the desire for surgical treatment as one for castration (p. 1449). Very quickly, though, the articulation of this desire shifted into terms more recognisable as related to surgery. The first mention of surgical treatment—specifically, "the operation"—can be found in Cauldwell's (1950, ¶26) pamphlet on transsexual sex issues where he includes a letter from a person requesting information about available surgical treatments. Numerous other terms were also used, including "the 'sex-changing' operation" (Hertz et al., 1961, p. 289), "conversion operation" (Benjamin, 1964b, p. 106), and "sex transformation" (Stoller, 1968, p. 260). Regardless of the terminology, however, the desire for surgery was a key aspect of discussions around transsexualism.

5.2.3.2 Requests become demands

Quite quickly, medical experts came to see requests for surgical treatment as demands, and even as indicative of obsession. In 1953, Benjamin wrote that gender-variant people "demand a 'conversion-operation'" (p. 13). Although Hamburger et al. (1953) themselves framed this desire as a wish, in his response to their article Wiedeman (1953), like Benjamin, used the term "demand" (p. 1167). This demand was often paired with a recognition that the gender-variant person hated their genitals, such as in Wiedeman (1953), who stated that "the patient demanded a removal of the hated male organs" (p. 1167). Similarly, Benjamin (1964b) noted that "for the transsexual … the sex organs are objects of hatred and disgust and, therefore, their persistent request is for a "conversion operation" (p. 106). Occasionally, this pairing was presented with some empathy, such as with the acknowledgement of the suffering caused by the presence of those particular genitals (Worden & Marsh, 1955). More often than not, however, gender-variant people's "demands" were presented as manipulative efforts to achieve access to surgery (Benjamin, 1964a). Some medical experts, even, characterised the demands as "the most

important single goal of … life" (Pauly, 1965, p. 178), or as "an obsessional preoccupation" (Kubie & Mackie, 1968, p. 432), pathologising the desire for treatment.

In contrast to a request, to demand is defined as "asking by virtue of right or authority" (Oxford University Press, 2020b, para. 1) or "an urgent or pressing claim or requirement" (para. 6), which comes with connotations of intensity as well as an expectation of having the demand met. This shift from request to demand, then, seems to reveal a particular negative orientation medical experts had towards the requests of gender-variant people, likely because demands challenged medical experts' authority to decide who to treat and how in ways that requests did not. This is evident in how many medical experts characterised gender-variant people as difficult and annoying as a result of these "demands." De Savitsch (1958) refers to gender-variant people as "haunting" their doctors (p. 80), while Benjamin (1964b) notes that they are often "unreliable and ungrateful" (p. 106). It is likely that this representation of gender-variant people affected—and was affected by—the ways in which medical experts viewed requests for surgical treatment as well as the ways in which they interacted with gender-variant people.

5.2.3.3 A defining characteristic

As discussion of surgical treatment requests increased, medical experts began to define gender-variant people by these requests, possibly as an effect of the struggle for access to treatment hinging on surgical treatment. The shift from common request to defining characteristic is exemplified by changes in how Benjamin conceptualised the requests over the course of 12 years. In 1954, Benjamin wrote that "the transsexualist is primarily interested in having a conversion-operation performed" (p. 288). Ten years later, he had come to consider this interest to be "a foremost differential diagnostic point between transvestism and transsexualism" (1964a, p. 460), which is a significantly stronger position in his model than just a primary

interest held by the gender-variant person. Just two years after that, Benjamin (1966) argued that the desire for surgical treatment "can actually serve as definition" (p. 30), shifting the importance of this desire further still, now making it almost synonymous with transsexualism. By the following decade, even those who were opposed to the treatment of transsexualism using surgery, such as Socarides (1970), defined the condition first and foremost by this desire. Although some authors, such as Stoller (1968) challenged the idea that the desire for surgical treatment was enough to diagnose someone with transsexualism, it nevertheless had become not only a key characteristic, but central to the very definition of transsexualism.

5.2.3.4 Harm reduction

Despite these requests and "demands," surgical treatment was not immediately granted to anybody who requested it as is now the case as well. Benjamin (1967) was adamant that "the request for surgery from the patient … must not be based on a passing erotic mood of an immature personality, but it must be the permanent, deep conviction of a non-psychotic, reasonably intelligent and responsible person" (p. 117). Many others urged caution, while some argued that transsexualism was a delusion and that surgery was simply playing into that delusion (Bowman & Engle, 1957) or perversion (de Savitsch, 1958). Given this context, the question, then, is: what motivated medical experts to not only support surgical treatment, but to consider it the appropriate treatment for the disjuncture between sex and gender, albeit with extensive gatekeeping?

What the data suggest is that the motivation came not from a sense of solving the problem of gender-variant people experiencing their bodies as wrong, or even of necessarily believing that transsexualism was *not* a mental disorder, but from a desire to mitigate the harm and struggle experienced by gender-variant people. As Benjamin (1954) stated,

> If it is evident that the psyche cannot be brought into sufficient harmony with the soma, then and only then is it essential to consider the reverse procedure, that is, to attempt fitting the soma into the realm of the psyche. (p. 229)

From the work of Hamburger et al. (1953) onward, numerous medical experts wrote of reducing the struggle for the gender-variant people they were treating. Some argued that doing nothing was unjustifiable (Anchersen, 1956), or that treatment could be considered palliative (Money & Brennan, 1969). Bowman and Engle (1957) noted that those treating transsexualism "regard[ed] surgery as the best solution … because cure is at present unavailable, and the transformation allows the patient to keep his mental balance and purpose in life" (p. 587), to which Pauly (1969b) concurred, suggesting that should a better therapy become available, it would be welcomed. Even those opposed to surgery acknowledged that the desire to reduce suffering motivated those who supported it (Meerloo, 1967).

However, there were those who disagreed with surgical treatment for the experience of body wrongness, most of whom supported psychotherapy and psychoanalysis instead (Wiedeman, 1953; Gutheil, 1954). Gutheil argued that "poor therapeutic results do not necessarily prove that the etiologic concept is wrong" and that reticence was not a valid reason to not attempt a treatment (p. 238), while others suggested that psychotherapy had not been adequately attempted and asked if the only alternative was "to collaborate with the sexual delusions of our patients?" (Meerloo, 1967, p. 263). Nevertheless, the majority of works included at least one statement, if not several, about psychotherapy not being successful in treating transsexualism (Hertz et al., 1961; Pauly, 1965; Benjamin, 1966; Fisk, 1974), suggesting that the position of those who supported surgery did not dismiss other therapies without reason, but rather were motivated to find something that worked within a space of very limited options and

patients who were struggling to survive. These medical experts frequently stated that there was nothing else that could be done to help gender-variant people, because “psychotherapy… whenever it was attempted, failed in reversing the psychological trend” (Benjamin, 1967, p. 124; Masters, 1966; Person & Ovesey, 1974b).

5.2.3.5 Solidification as a tenet

In order to become a tenet of the WBD, surgery had to not only become an option, but also make sense and be seen as the best solution available, regardless of the reasons for this. Thus, although gender-variant people quickly recognised surgical and hormonal treatment as the best solution, medical experts reached this conclusion more slowly, turning to their values of reducing harm and helping patients in order to legitimate a treatment to which there was significant resistance both in the medical expert community and in society in general. This resistance, appearing as uncertainty, questions about efficacy and even suggestions of delusions, however, was addressed by the medical experts in order to demonstrate the importance of surgery to the treatment of transsexualism.

5.2.4 Unification of tenets into a discourse

The WBD, as a whole, can be seen as finally coming into focus in the work of Benjamin, specifically in his 1966 book *The Transsexual Phenomenon*. Although up until that point numerous sources drew on, and contributed to, different parts of the discourse, some focusing on what became one tenet, some on another tenet, it was Benjamin who brought them together to define transsexualism. In doing so, Benjamin claimed ownership of transsexualism as a disorder, being the first medical expert to publish a comprehensive explanation of transsexualism, which became the first authoritative medical text on the subject (Meyerowitz, 2002). In *The Transsexual Phenomenon*, Benjamin included a table that outlined his sex orientation scale and

in doing so, also summarised his conception of transsexualism (p. 30). In it, all three tenets of the WBD are not only evident, but are also grouped together as defining transsexualism.

Table 6

Benjamin's (1966) Sex Orientation Scale, group 3

[Variable]	Group 3	
Profile	*Type V* True Transsexual Moderate intensity	*Type VI* True Transsexual High intensity
Gender "feeling"	Feminine. ("Trapped in male body")	Feminine. Total "psycho-sexual" inversion.
Dressing habits and social life	Lives and works as woman if possible. Insufficient relief from "dressing."	May live and work as woman. "Dressing" gives insufficient relief. Gender discomfort intense.
Sex object choice and sex life	Libido low. Asexual, autoerotic, or passive homosexual activity. May have been married and have children.	Intensely desires relations with normal male as "female," if young. Later, libido low. May have been married and have children, by using fantasies in intercourse.
Conversion operation?	Requested. Usually indicated.	Urgently requested and usually attained. Indicated.
Estrogen medication?	Needed as substitute for or preliminary to operation.	Required for partial relief.
Remarks	Operation hoped for and worked for. Often attained.	Despises his male sex organs. Danger of suicide or self-mutilation, if too long frustrated.

In this table, elements from tenet 1, wrongness of body, can be seen in both the description of type V ("trapped in the wrong body") as well as the remarks of type VI (abhorrence of genitals). Tenet 2, disjuncture between mind and body, can be found both in gender feeling, where in both subtypes Benjamin notes that the feeling is feminine, and in the description of dressing habits and social life of type VI, where Benjamin notes that gender discomfort is intense. Finally, tenet 3, surgical and hormonal transition as the solution, can be found in the last three sections of this table. Both subtypes request "conversion operation", and it is "usually indicated" (type V) or "indicated" (type VI), estrogen medication is needed by both, and both types desire surgery, to a lesser (type V) or greater (type VI) extent.

As a unified discourse, the WBD continues through the end of the 1960s and into the 1970s. Two examples are especially notable, the first for its thoroughness, and the second for its brevity. In his descriptions of transsexualism in AMAB gender-variant people (Pauly, 1969b) and in AFAB gender-variant people (1969a), Pauly structures his questionnaires in a way that is consistent with the WBD. Reporting on AMAB gender-variant people, Pauly (1969b) stated that they were "disgusted with their developing male anatomy (100 percent) [tenet 1], became increasingly convinced that they belonged to the female sex (100 percent) [tenet 2], … and desperately desired a change-of-sex operation (100 percent) [tenet 3]" (p. 42). His (1969a) findings on AFAB gender-variant people also represent the three tenets, as they "were disgusted by all signs of their anatomic sex (100 percent) [tenet 1]; … wanted a surgical change of sex (100 percent) [tenet 3]; and still felt as though they belonged to the male sex (100 percent) [tenet 2]" (p. 66). More succinctly, Prince and Bentler (1972) noted that "wanting to live in the feminine role [tenet 2], feeling oneself trapped in the wrong body [tenet 1], and desiring a sex change operation [tenet 3]" (p. 910) were indicative of transsexualism.

Much like during the development of the tenets, the phrasing of the WBD in its complete and unified form reflects the predominance of AMAB gender-variant people's experiences. Benjamin's (1966) table made no mention of experiences of AFAB gender-variant people, nor is there a second table in his book that would outline how Benjamin's sex orientation scale might appear in AFAB gender-variant people. Despite the fact that Pauly (1969a) included in his work a discussion of AFAB gender-variant people's experiences, almost every example of transsexualism included references to such things as "lives and works as *woman*" (Benjamin, 1966, p. 30, emphasis added) and "the *feminine* role" (Prince & Bentler, 1972, p. 910, emphasis added) rather than references to the generic *opposite gender*. However, in its institutionalised form in the *SoC ver. 1* (Berger et al., 1979) and the *DSM-III* diagnosis of transsexualism (APA, 1980), the descriptions of transsexualism maintained gender-neutral language.

5.2.4.1 Standards of Care

The year 1979 marks the point at which the WBD takes a turn towards the institutionalisation that then takes place in 1980. In addition to appearing in the literature throughout the decade as a unit, it now appeared as a structuring discourse of the *SoC ver. 1* (full title: *Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons*), a document published by the Harry Benjamin International Gender Dysphoria Association (Berger et al., 1979). In providing a minimum standard for how medical professionals should treat and engage with gender-variant patients, the *SoC ver. 1* also reified a particular definition of transsexualism, one that was predicated upon the WBD. Moreover, the document presented the expected diagnostic criteria of the *DSM-III* diagnosis, transsexualism,

which although not yet published, had already been developed,[27] further reifying the dominant position of the WBD.

Tenet 1 appears explicitly in a number of places. For example, the *SoC ver. 1* (Berger et al., 1979) stated that the document applies to people who "[demonstrate] dissatisfaction with their sex of birth" (p. 2) as well as a "persistent sense of discomfort and inappropriateness about one's anatomic sex" (p. 4), the latter being a quotation of the expected *DSM-III* diagnostic criterion A. Tenet 2 can be found in the references to gender identity (pp. 1; 4) as well as to sex role (pp. 2; 10).[28] Finally, tenet 3 is evident throughout the document, most notably in centralising hormonal and surgical sex-reassignment as the appropriate treatments for transsexualism, but also in defining those to whom the document applies by their requests for surgery (p. 2) and their desire to have their genitals removed (p. 4). This desire is repeated in the document summary, stating that prior to hormonal treatment, this desire must be demonstrated by the gender-variant person (p. 10). Together, these elements demonstrate not only the presence of the WBD in the *SoC ver. 1*, but also its role in structuring those standards and defining to whom they apply.

5.2.4.2 DSM-III: Transsexualism

In 1980, the WBD was institutionalised in the *DSM-III* diagnosis of transsexualism (APA, 1980; for the full text of the diagnosis, see appendix D). Each tenet of the discourse can be found throughout the diagnostic description, and tenets 1 and 3 are also evident in the diagnostic criteria. First and foremost, the *DSM-III* presents tenet 1, body wrongness and discomfort, as an

[27] The actual wording of the diagnosis published in 1980 differed in only minor respects from those published in the *Standards* in 1979.

[28] Although the *Standards* use the term "sex role," based on the description of what the authors meant, I argue that they intended the same meaning as was generally indicated by "gender role," but because of uneven development of discourses and words, the authors had either intentionally or unintentionally made the decision to use "sex role." However, it would be interesting to find out if this were an intentional decision, if it were possible to.

"essential feature" of the diagnosis (p. 261), with a hatred for one's genitals being a frequent manifestation of this (p. 262). This experience of the body as wrong is then reified as the first criterion and thus required to receive the diagnosis of transsexualism.

Tenet 2, the disjuncture between sex and gender, while not explicit in the diagnostic criteria, is evident in the categorisation of transsexualism as a gender identity disorder, as well as the category description that presents "an incongruence between anatomic sex and gender identity" as defining of the category as a whole (APA, 1980, p. 261). Conviction, one of the developmental articulations of tenet 2, can also be found in the sections on course and subtypes of transsexualism, where the *DSM-III* notes that because of the gender-variant person's conviction of really being a man or a woman, they cannot be considered homosexual despite outward appearances (p. 262). Moreover, the term "gender identity" is repeated in the section on age of onset (p. 262), while feeling like the other sex is a key differentiating factor between transsexualism and delusion (p. 263), recalling the earliest articulations of the second tenet.

Finally, tenet 3 is found both in the description and in the diagnostic criteria of transsexualism. Several references to a desire to have genitals removed can be found in the description of the diagnosis (APA, 1980, p. 262), while the section on course and subtypes notes that the treatment is "surgical sex reassignment" (p. 262). Although the *DSM-III* notes that there is uncertainty as to the long-term efficacy of this treatment, it nevertheless situates surgery as the appropriate treatment for transsexualism. Additionally, the second diagnostic criterion requires a desire to have genitals removed (p. 263) in order to receive this diagnosis.

5.2.5 Stabilisation and coherence

As each tenet of the WBD solidified, the ideas underpinning those tenets became more closely connected, eventually developing into a discourse that both explained a problem and

provided an appropriate solution. While the 1950s and early 1960s were marked by each tenet individually appearing in different publications, *The Transsexual Phenomenon* (Benjamin, 1966) marked the point at which the discourse came into focus, and appeared as a unified discourse for the first time. Through his book, Benjamin claimed ownership of transsexualism at the same time as he produced the first unified account of the WBD. Once it appeared as a coherent discourse, the stability this coherence provided allowed for the WBD to become more widely used and, eventually, to be institutionalised as the diagnosis of transsexualism in the *DSM-III*. Both the stabilisation of the discourse and its institutionalisation, though, depended on a series of factors that contributed to the WBD becoming both robust and widely accessible to medical experts, without which the discourse may not have been as dominant or, potentially, as difficult to challenge.

5.3 How did this lead to discourse dominance?

Although it is not possible to say with certainty why the WBD became the dominant discourse within medical expert texts or the *DSM-III* diagnosis of transsexualism, there are a number of factors evident in the primary sources that I argue contributed. I have organised the factors into three categories. The first category comprises the discursive patterns and themes that are evident in the primary sources. The second category covers the effects of knowledge gatekeeping by a small group of medical experts. And the third category includes the various ways in which medical experts' related to gender-variant people and how they viewed the gender-variant people who came to them for treatment. These three categories, however, are not discrete. Rather, they are intertwined, and to a certain degree, the separation between them in this discussion is artificial, and is used in order to facilitate analysis. Moreover, this is not to say that

other factors did not play a part. Rather, these are the factors that I argue are evident in the primary sources.

What is most evident about these latter two factors that contributed to the dominance of the WBD is that they are two of the three main social control effects of medicalisation that I outlined in the first chapter (section 1.3.1): structural authority and regulatory effects; the effects of the third social control effect, technological access and development, were not evident in the primary sources. This suggests that the very process of medicalisation had a role in the WBD becoming the dominant discourse. The main way in which medicalisation as a process contributed to the WBD becoming dominant is the way in which it structures power relationships between medical experts and laypeople, validating medical-expert knowledge over all other ways of knowing. As such, medical experts' words had more weight in producing a discourse that medical experts would then take seriously. Although medical experts drew on the words of gender-variant people, medical authority meant that those words only mattered if medical experts decided that they did.

5.3.1 Characteristics of the discourse

A number of characteristics of the WBD emerged as I analysed the primary sources, each of which likely contributed to its increasing centralisation in medical texts on gender variance. First, the WBD is compatible with numerous etiologies, so that medical experts from diverse fields could all utilise the discourse without it challenging their areas of expertise. Second, there is a structural similarity between how a diagnosis forms (Jutel, 2009) and the tenets of the WBD. Third, the independence of the tenets provided a solid foundation for the discourse in a variety of different articulations. And finally, the set of assumptions on which the WBD is based are

intelligible within medical and scientific discourses as a whole, and so it *made sense* to medical experts.

5.3.1.1 Etiology

One of the most notable characteristics of the WBD is that it does not depend on any particular etiology to be intelligible or useful. While each tenet answers a specific question and thus relates to the next tenet, the tenets do not require any explanation of what causes the symptoms in order to make sense. Consider:

Table 7

WBD tenets and underpinning question

Tenet	Question	Answer
1	What are patients saying?	The body is experienced as wrong.
2	What do medical experts believe is going on? (Why are patients experiencing their bodies as wrong?)	There is a disjuncture between the sex and gender.
3	What is the solution to the problem? (How do we help patients experience their bodies as right?)	Hormonal and surgical treatment are the solution.

Tenet 1, which begins with gender-variant people's experiences, only presents the symptom: the body is experienced as wrong. Tenet 2 translates the symptom into medical (psychological) discourse; it describes how the symptom comes about, but not what causes it. In much the same way as the term "congestive heart failure" explains shortness of breath without reference to any disease that causes congestive heart failure, "a disjuncture between gender and sex" explains the symptom of the body being experienced as wrong without any claims on what causes the

disjuncture. Tenet 3 presents a solution to the symptom, a way to realign gender and sex, again without any reference to how gender and sex became misaligned, much like a heart transplant would resolve the symptoms of congestive heart failure without addressing the underlying cause of that congestive heart failure.

This independence from etiology is evident in the primary sources that discuss numerous etiologies suggested for transsexualism, all by authors who make use of the WBD. Proposed biological causes included unusual hormonal exposure in utero (Benjamin, 1966; Person, 2008) as well as the possibility that in the future, genes involved in gender identity would be discovered on sex chromosomes (Benjamin, 1966). Psychoanalytic explanations of transsexualism related it to a fear of castration (Gutheil, 1954), while psychological theories suggested that transsexualism was a paranoid delusional state (Pauly, 1965),[29] a problem with imprinting (Green & Money, 1961), due to childhood conditioning (Lukianowicz, 1959), or a failure in the development of gender identity as a result of an overbearing mother and distant father (Stoller, 1968). This wide range of possible etiologies were nevertheless all compatible with the WBD, which only describes symptoms and suggests a "best of" solution to those symptoms.

5.3.1.2 Tenets versus diagnosis

The outline of the three tenets of the WBD as in Table 3 above bears a striking resemblance to Jutel's (2009) model of how a personal experience becomes a diagnosis. Recalling the model discussed in the medicalisation section of chapter 1 (section 1.3.1), Jutel outlined three steps: 1) illness: an articulation of a personal experience; 2) disease: a biological

[29] Pauly (1969) retracted this statement.

retelling of the illness from step 1; 3) diagnosis: a medical retelling of the disease from step 2. Adding these steps to the previous table, the parallels emerge:

Table 8

Jutel's (2009) model of diagnosis, WBD tenets, and underpinning questions

Question	Tenet	Jutel (2009)
What are patients saying?	1. The body is experienced as wrong.	Illness: an articulation of a personal experience
What do medical experts believe is going on? (Why are patients experiencing their bodies as wrong?)	2. There is a disjuncture between the sex and gender.	Disease: A biological retelling of the illness
What is the solution to the problem? (How do we help patients experience their bodies as right?)	3. Hormonal and surgical treatment are the solution.	Diagnosis: A medical retelling of the disease

As can be seen in Table 8 above, Jutel's first step, which is a person's articulation of their experience, aligns directly with the first tenet of the WBD, which is also an articulation of a personal experience. Jutel's second step, which is a retelling of a personal experience in biological terms, is reflected in the conceptualisation of the second tenet, where a person's sex, in other words their biology, does not align with their gender, namely what is expected of that biology in terms of behaviour and personality. In this case, it is important to note that "gender" here falls under the realm of biology insofar as at the time of the development of the WBD—and often even in contemporary situations—gender is understood to be an expression of something internal, and thus is "biological" rather than learned or social. And finally, the third step in Jutel's

model is a medical articulation of the person's experience. In other words, a personal experience is translated into medical discourse and language. Although the third tenet focuses on a solution rather than on medical discourses of the situation as a whole, there is nevertheless a parallel between the two: the process of medicalisation, as explained by Conrad and Schneider (1992), can culminate in a medical solution. Thus this articulation of a solution forms part of what can occur in the third step of the diagnosis model that Jutel outlined.

This similarity between the structure of the WBD tenets and how a diagnosis develops may have played a part in the ease of creating a diagnosis out of the discourse in comparison to the possibility of doing so from another conceptualisation of gender variance. Because all three steps are already present in the discourse, shifting the tenets into a diagnosis would not have taken much effort. It is also possible that the structure of a diagnosis already shaped how medical experts thought about the "problem" of transsexualism, because the concept of a diagnosis shapes a large portion of medical thinking (Jutel, 2009), such that it may have structured the ways in which the discourse developed in the first place. This means that medical experts could have approached gender variance as a personal experience that needed to be translated first into biological terms and then into medical terms in order to make sense within medical discourse. Thus, there may have been a mutually reinforcing relationship between the structure of a diagnosis and the emerging structure of the WBD tenets.

5.3.1.3 Individual tenets

As demonstrated in the previous section of this chapter, each of the tenets of the WBD developed separately, albeit not entirely independently. As a result, they do not depend on one another to be intelligible. Tenet 1, wrongness of the body, came almost entirely from gender-variant people's reports and developed into a phrase that was short and easy to quote ("trapped in

the wrong body"). Because so many gender-variant people reported this experience, the tenet is supported by its valence among gender-variant people. Similarly, tenet 2, disjuncture between gender and sex, draws much of its strength from its origins in gender-variant people's experience with added scaffolding from psychological discourses on gender and sex, especially the work of Money et al. (1955a; 1955b) in which they not only articulated the relationship between gender and sex, but also argued that gender was fixed by eighteen months of age. Tenet 3, hormonal and surgical treatment are the solution, also began with the words of gender-variant people themselves, developing as an offshoot of the abhorrence articulation of body wrongness as hatred of genitals was often paired with wanting to have them removed. Medical experts quickly noticed it, however, and used it as a way to differentiate between types of gender-variant people, while simultaneously legitimating it by an appeal to their own motivations to alleviate patient suffering.

This independence is also evident in the way changes to one tenet do not necessarily disrupt the other two. Tenet 1, body wrongness, can remain the experience of gender-variant people regardless of whether the problem is articulated in terms of gender and sex (although new articulations of these concepts could lead to new ways of explaining the experience, such as stating it in terms of sexed embodiment rather than body wrongness). It also can remain the symptom if another treatment were to be found to resolve it. Similarly, tenet 2, a disjuncture between gender and sex, remains stable even if the symptoms are articulated in other ways (such as stating one's experience in terms of feelings) as well as if proposed solutions do not involve surgery of any kind (such as psychotherapy). And finally, tenet 3, hormonal and surgical treatment, can still be the solution even if the problem is not articulated in terms of body wrongness (such as, instead, using the articulation of feeling like a woman), as well as if the

medical explanation of symptoms is not expressed in terms of gender or sex, but another medical discourse (such as the brain's body image, a concept proposed as a way of assessing transsexualism by Lindgren and Pauly, 1975).

Because challenges to any one particular tenet of the discourse do not necessarily disrupt the other two, the WBD is quite robust, able to withstand shifts in the meaning of key concepts like gender or sex, as well as in available technology. This robustness and resistance to alternatives may have contributed to the discourse taking up so much discursive space, essentially not leaving much discursive space for other ideas to take hold and develop.

5.3.1.4 Basis in medical and scientific discourse

The final characteristic of the WBD that may have contributed to its dominance is the way it fit in with other medical and scientific discourses, being based on them as well as reinforcing them in turn. In short, the WBD *made sense* to medical experts, because it fit with what they already understood and knew. As discussed in the literature review (chapter 2), the secondary sources demonstrate that the WBD is based on a number of assumptions. Three of these, which are based in scientific discourses, appear in the data: gender and sex are not the same thing, where gender is in the mind and sense of self whereas sex is a biological category of the body and as such, a biological truth; gender and sex are both binary categories; and, there is a specific expected relationship between sex and gender that is "healthy" and "normal" such that there is a "right" sex (body) for each gender (mind).

For the WBD to be intelligible, there must be a distinction between sex and gender. In the WBD, gender is part of a person's inner core, namely their mind, whereas sex is a biological characteristic of the body (Barker-Plummer, 2013; Bettcher, 2014). Although earlier work had already been moving towards a differentiation between biological and social aspects of sex, as

discussed in the historical contextualisation (chapter 4), the separation between sex and gender was established by the definition of gender as "all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively" (Money et al., 1955b, p. 285). Although at the time Money et al. (1955a) also established sex as a multivariate status that comprised hormonal sex, gonadal sex, chromosomal sex, internal reproductive organs and genital morphology, in practice it was largely treated as univariate (Money, 1985a; see also Benjamin's, 1966, discussion of sex, p. 84). As medical dictionaries took up these definitions of sex and gender (Money), the key definitions necessary for the WBD to make sense were becoming entrenched. Indeed, the WBD appears in unified form only 11 years after the definition of gender, despite its tenets having roots in literature published 100 years previously, suggesting that this shift in terminology was key to its development.

In this earliest definition of gender, in the form of gender role, not only was gender clearly a social category, it was also a binary made up of boy/man and girl/woman. Sex, too, was a binary category, male and female, with a third category (then called "hermaphroditism") covering what did not "fit" neatly within this binary (Dreger, 2000). This, too, is consistent with other medical literature on both sex and gender, such as medical dictionaries, throughout the time that the WBD was developing (Kessler & McKenna, 1978; Money, 1985a). The primary sources reveal that the ways in which gender-variant people communicated their experiences to medical experts depended as much on binary concepts of sex and gender as did the articulation of the WBD. Feeling like a woman or wanting surgery to construct a particular body required there to be two and only two options to be intelligible. As these became part of the WBD, it, too, required only two options to be available.

Finally, the WBD is dependent upon a particular relationship between gender and sex, a relationship in which there is a "right" and a "wrong" body (sex) for each person (gender). In defining gender role, Money et al. (1955a) set up a relationship between a multivariate definition of sex, and the expected gender role that person would take. For them, this was only problematic when the variables of sex were not "concordant with one another" (Money, 1985a, p. 73), making it difficult to ascertain the correct "sex of rearing" (Money, 1985b, p. 280). In this case, what is considered correct or "concordant" is that which follows social norms: males are raised to be boys/men, and females are raised to be girls/women (Kessler & McKenna, 1978). Thus, when Benjamin (1967) stated that his understanding of transsexualism was that it is a "disturbance in the proper sex and gender role orientation" (p. 113), he was defining "proper" as masculinity for males and femininity for females. The result of the definition of gender role was the definition of the "right" bodies for men and women, as well: women were normally females, and men were normally males. In this context, the idea of "wrong" bodies became intelligible and, indeed, the first instance of the term "wrong body" is in Benjamin's (1966) work. According to the WBD, then, a "wrong" body for a man is female, whereas the "wrong" body for a woman is male.

5.3.2 Structural authority

In addition to the characteristics of the discourse itself, there are a number of contextual characteristics that likely contributed to the WBD becoming dominant. Many of these could be characterised as related to structural authority. Recalling the social control effects of medicalisation discussed in the introduction (chapter 1), structural authority refers to the system of gatekeeping of knowledge and knowledge production among medical experts. In the case of the WBD, the gatekeeping took place in three ways: medical experts dominating the literature;

medical experts mediating gender-variant people's voices; and a very small group of medical experts dominating the field of medical knowledge about transsexualism.

First and foremost, the majority of the primary sources that met the criteria of being cited widely and being for a medical-expert audience were written by medical experts. Of the 131 primary sources, 122 were written by medical experts. This means that only nine sources were written by people who were not medical experts. Although limitations on this research (as discussed in chapter 3 and in the conclusion, chapter 7) precluded me from being able to ascertain whether there were other publications that may have been intended for a medical-expert audience written by people who were not medical experts, the difference remains notable: people who were not medical experts were rarely publishing for a medical-expert audience.

Similarly, the input of non-medical expert voices was limited by the fact that although medical experts included the voices of gender-variant people, it was the medical experts themselves who made the decisions regarding what elements of those voices to include, where to include them, and how to contextualise them. Many of the texts analysed in this dissertation included direct quotations from gender-variant people from medical interviews, psychotherapy sessions, and even letters patients wrote to their doctors. What appeared in the text, then, was not only shaped by the authors' decisions, but by decisions of the gender-variant people themselves who were writing with a medical-expert audience in mind.

Finally, a very small group of medical experts was involved in half of the publications that met the criteria for this dissertation, and those same medical experts were involved in the development of the *DSM-III* diagnosis of transsexualism (APA, 1980) as well as in the *SoC ver. 1* (Berger et al., 1979). The most prolific medical experts were Harry Benjamin, Richard Green, John Money and Robert Stoller. Of the 131 publications that met the criteria, fourteen were

written by Green, ten were written by Money, eight were written by Benjamin, and another eight were written by Stoller. Additionally, Green and Money were coeditors for the 1969 volume, *Transsexualism and Sex Reassignment*, which had 32 chapters of which eight were written by Green and/or Money. This means that Green and Money had editorial and thus discursive influence over another 24 sources. In total, this translates to Green, Money, Benjamin and Stoller having direct influence over 64 publications of 131, or 48.9 percent.

Moreover, the *DSM-III* diagnosis of transsexualism (APA, 1980) drew heavily on the work of Benjamin, Green, Money, and Stoller (Drescher, 2010b). Their contributions to the development of the diagnosis consisted not only of published works but also their involvement in gender clinics and wide-spread treatment of gender-variant people (Drescher). Moreover, both Green and Stoller were part of the committee that determined the inclusion of transsexualism in the *DSM-III* (Zucker & Spitzer, 2005). In contrast, of these four, the *SoC ver. 1* only lists Green as an author explicitly. Benjamin's influence, on the other hand, came through first in the fact that one of the *SoC ver. 1* authors, Leo Wollman, was Benjamin's co-practitioner (Gill-Peterson, 2018), and second in the publishing authority being the *Harry Benjamin* International Gender Dysphoria Association.

The authorship of the primary sources demonstrates that an exceedingly small group of medical experts, who often worked together and cited one another, had direct influence on who could participate in knowledge production about transsexualism, the direction of discursive development, and thus on the eventual shape of the WBD. The structural authority produced by the process of medicalisation provides a possible explanation. In gatekeeping medical knowledge and the production of that knowledge, medical experts excluded gender-variant people who were not medical experts from having their knowledge seen as legitimate. Indeed, as was

demonstrated in the historical contextualisation (chapter 4), in order for gender-variant people to be able to publish for a medical-expert audience, they not only had to be vetted by medical experts (Meyerowitz, 2002), but also had to leverage their class privilege (Matte, 2014). Without the necessary legitimating medical degrees, medical experts likely did not consider most gender-variant people valid producers of medical knowledge.

Similarly, the role of these medical experts in gatekeeping treatment may have meant that what gender-variant people said to medical experts may have been altered, since gender-variant people knew that gatekeepers had particular expectations (Meyerowitz, 2002, Denny, 1992; 1996; Bolin, 1988). Although it is impossible to ascertain the degree to which this shaped what gender-variant people said or the ways in which it did so, it is highly likely that already-published medical-expert knowledge shaped the subsequent interactions medical experts had with gender-variant people. This then would have affected what medical experts learned from gender-variant people, and what they then chose to further publish, limiting the variability of narratives and potentially contributing to the dominance of the WBD.

By the time the WBD was in the process of being institutionalised in the *DSM-III* as the diagnosis of transsexualism (APA, 1980), a feedback loop of increasingly-limited variability had developed. It is already known in the secondary literature that gender-variant people sought out medical-expert publications to learn what they had to demonstrate in order to be granted access to treatment, and medical experts saw this agreement as proof that their way of conceptualising gender variance and defining transsexualism was correct (Bolin, 1988; Denny, 1992; 1996; Meyerowitz, 2002). In this process, tied directly to the process of medicalisation and the ways in which medical experts gatekeep knowledge production, the WBD became the only way to

articulate the experience of gender variance in order to get access to treatment, and the only way that medical experts could conceive of conceptualising gender variance.

5.3.3 Regulatory effects

Like structural authority, regulatory effects involve those with medical authority making decisions that influence the development of a discourse. The difference lies in the source of the discourses that structure interactions: in structural authority, they are the rules that govern the production and use of formal medical knowledge, whereas regulatory effects are produced by often-unconscious beliefs and values held by medical experts (see discussion of medicalisation, section 1.3.1). Reflecting the patterns identified in the historical contextualisation (chapter 4), the primary sources demonstrate regulatory effects in two ways: how medical experts used binary gender expectations to decide who to treat, and the ways in which medical experts conceptualised gender-variant people's trustworthiness and motivations.

The effects of binary gender expectations are most obvious when Benjamin (1967) states, "most important for the indication for a sex reassignment operation is the belief that a successful 'woman' can result" (p. 118). To Benjamin, a "successful woman" was one whose appearance matched gender expectations enough to not disrupt society (p. 118). Fisk (1974) articulates these expectations more explicitly, noting that not only was "passing" crucial, but so was an "appreciation of core gender principles" (p. 389). In other words, if the gender-variant person was willing to present according to gender expectations and cause no social disruptions, they were more likely to be approved for treatment. Not every author was so explicit, but many referred to evaluations taking place before gender-variant people were accepted for treatment (Edgerton et al., 1970; Person & Ovesey, 1974b) as well as to factors that were indicative of lower success, such as not appearing convincingly feminine or not being heterosexual (Wålinder

et al., 1978, p. 19). Because the WBD is dependent on the gender binary to be intelligible, the parallel influence of the gender binary on medical expert decisions likely contributed to the WBD continuing to develop and strengthen.

Other biases and opinions about gender-variant people likely affected what gender-variant people were willing to share and say about their experiences, as well as what of their information was considered valid and thus contributed to the development of the WBD. Perhaps most notable of these is the distrust and suspicion that medical experts seemed to frequently have towards gender-variant people. Some stated outright that "there is no indication of the extent to which the patient's stories and self-descriptions can be trusted" (Kubie and Mackie, 1968, p. 437), though others suggested that perhaps gender-variant people do not distort their experiences nearly as much as many medical experts believed (Pomeroy, 1969). Many believed gender-variant people to have a "selective memory" (Randell, 1959; Pauly, 1965; 1974a; Fisk, 1974), though some suggested that this may be unintentional due to patients being highly motivated to be accepted for treatment, implicitly recognising medical expert gatekeeping (Knorr et al., 1969; Pauly, 1974a; Green, 1974). Others still noted that gender-variant people have a "tendency to distort" (Pauly, 1965, p. 175) or are simply "unreliable" (Benjamin, 1964b, p. 106). Nevertheless, even the most trusting medical experts were significantly negatively oriented towards gender-variant people, referring to them as "pathetic" (Green, p. 81), "manipulative" (Knorr et al., p. 279), and "hostile" (Masters, 1966, p. 275). It is likely that because medical experts were disinclined to trust gender-variant people's words, they were more critical of the information gender-variant people provided, especially if it conflicted with their own views and understandings of transsexualism.

The primary sources demonstrate that medical experts had views and beliefs about gender-variant people that likely meant they would dismiss challenges to the WBD. The first—binary gender expectations—aligned with the assumptions underpinning the WBD in the first place. Not only, then, did this make the WBD more robust (as discussed earlier in this section), it also played out as a way that prevented gender-variant people who could challenge the WBD from accessing treatment and, often, even a diagnosis. Medical experts then could have seen gender-variant people who did not align with binary gender expectations as not relevant to the diagnostic criteria of transsexualism or the WBD underpinning them, limiting the possibilities of the WBD being challenged. Similarly, characterisations of gender-variant people as manipulative or hostile may have prevented medical experts from taking gender-variant people's explicit challenges seriously. When faced with gender-variant people who disagreed with how transsexualism was diagnosed or their experiences judged and assessed, medical experts could just dismiss gender-variant people as hostile rather than legitimate sources of other viewpoints. This is not to say that all medical experts necessarily purposely tried to limit gender-variant people's influence of the WBD, but that their beliefs prevented them from being open to any other way of conceptualising their relationships to gender-variant people.

5.3.5 Characteristics contributing to dominance

Despite not being able to say with certainty why the WBD became dominant, the primary sources revealed a number of factors that likely contributed. Moreover, these factors likely interacted with one another, furthering the discourse's dominance. First, the discourse was compatible with many different proposed ideologies, allowing significantly varied medical experts to all use the WBD. Secondly, medical experts limited the contributions of others to discussions about transsexualism, both by dominating the literature and by gatekeeping of

medical knowledge production. Finally, medical experts treated gender-variant people in ways that limited gender-variant people's abilities to challenge the WBD: they were characterised as not transsexual or as hostile and manipulative, and so any challenges could be easily dismissed.

5.4 Conclusion

It is evident from the data that the WBD developed in a context within which few other competing discourses were proposed, and none attained enough attention to compete in the discursive sphere. The first instance of the WBD was put forth as an explanation of homosexual behaviour at a time when the dominant discourse explaining both gender variance and homosexuality was inversion. As the differentiation between sex/gender and sexuality developed, so too did the WBD increasingly shape the ideas around gender variance. In appearing in the works of a number of sexologists, all of whom included cases of gender variance, the idea of a female soul in a male body began to be recognised as a phenomenon separate from sexual variance. By the time the idea was picked up and explicitly applied to gender variance in the middle of the twentieth century, it already had a foundation in medical discourses and the attention of a number of medical experts.

The primary sources revealed that each tenet of the WBD developed separately from the others. Even through the 1950s and early 1960s, the WBD continued as three separate tenets, albeit increasingly appearing together in discussions about gender variance. Indeed, the WBD did not appear as a single, coherent discourse until Benjamin's (1966) book *The Transsexual Phenomenon*, a book in which Benjamin explicitly brought together all three tenets as defining the phenomenon of transsexualism. From this point until its institutionalisation in the *DSM-III* diagnosis of transsexualism (APA, 1980), the WBD did not change and was used in the form presented by Benjamin by numerous medical experts.

The primary sources also reveal that the WBD in this period was a robust discourse, one that was notably resistant to challenges. Some of that resilience was inherent in the way the discourse was developed: it did not depend on any etiology, making it compatible with the points of view of numerous medical experts, and it was based in already-established medical and scientific discourses. Moreover, it was used consistently by a small group of medical experts who referenced one another's work repeatedly and worked closely together not only in treating gender-variant people but in developing the *DSM-III* diagnosis of transsexualism (APA, 1980). This left little room for other medical experts to suggest different interpretations of gender variance, and it also excluded non-medical expert gender-variant people from contributing and from disagreeing or challenging the WBD.

Having outlined how the WBD developed and some of the factors that may have contributed to the WBD becoming the dominant discourse in institutionalised medicine in Canada and the United States, I now turn to the way the WBD was used in practice. Evident in the primary sources is not just an understanding of the WBD, but patterns of its use, as well as reactions to challenges that faced medical experts trying to treat gender-variant people with hormones and surgery. In the following chapter, I will look at how the use of the WBD was, in practice, significantly more complicated and messy, and at how medical experts seemed to turn to *true transsexualism* to try to navigate this complexity.

6 The WBD, messiness and *true transsexualism*

As demonstrated in the previous chapter, the wrong-body discourse (WBD) has three tenets, three "truths" that made at least some gender variance intelligible to medical experts in the mid-twentieth century. These tenets—(1) body wrongness; (2) disjuncture between sex and gender; and (3) treatment is hormones and surgery—suggest a straightforward, coherent medicalised model of gender variance. However, how discourses are used in practice is significantly more complex, often ambivalent and, quite simply, *messy* (Law, 2004). In this chapter, I interrogate that messiness.

I begin this chapter with a discussion of how the three-tenet model of the WBD is not nearly as neat and tidy as it appeared in the previous chapter. I then look at how medical experts put the WBD into practice, compounding that messiness through the shift from transsexualism to *true transsexualism* which thus became a distinct diagnostic entity based on the WBD along with white middle-class binary gender and heteronormativity. Following this, I explore how and when *true transsexualism* was deployed, and suggest that this may have been an attempt to navigate some of the contextual messiness. I close the chapter with a discussion of how the use of the *true transsexual* as a guideline against which medical experts judged the legitimacy of a gender-variant person's gender variance produced a hierarchy of legitimacy based on the experiences of a very small subset of gender-variant people. I argue that this demonstrates that *true transsexualism* and the *true transsexual* represent one of the first iterations of transnormativity.

6.1 Discursive messiness

Although in the previous chapter I outlined a model of the WBD that suggests it is a coherent and logical discourse, the primary sources I quoted throughout that chapter demonstrate a significant undercurrent of complexity and imperfection. The characteristic of those examples

that stands out the most is that medical experts wrote exclusively or almost exclusively about AMAB gender-variant people, regardless of who they may have been interacting with, but presented their findings and conclusions as though they applied to *all* gender-variant people. In other words, the WBD developed out of experiences that were specific to AMAB gender variance, particularly the relationship to genitals, yet it was used to understand, conceptualise and diagnose all gender-variant people, both those who were AMAB and those who were AFAB.

6.1.1 Predominance of AMAB gender-variant people's experiences

The predominance of AMAB gender-variant people's experiences being included in texts for medical experts—overwhelmingly written by medical experts themselves—is notable from the earliest roots of the WBD. Recalling the discussion of the work of early sexologists in the previous chapter, the first instance of a statement that resembled the WBD was that of the *female* soul in a male body in the work of Ulrichs (1864/1994). As other sexologists published similar cases, the majority of these were also of AMAB gender-variant people. Krafft-Ebing (1886/1902), for example, quoted numerous gender-variant people who echoed the same statement: that they "felt like a woman in man's form" (p. 310). Hirschfeld (1910/1991) also included many quotations and descriptions, such as "the yearning to feel totally like a woman" (p. 63) and "inner womanly feelings" (p. 240). Although not entirely absent, cases of AFAB gender-variant people being included in descriptions were rare. Despite the occasional instance of a "masculine soul, heaving in the female bosom" (Krafft-Ebing, p. 399) or the gender-variant person who "never felt she was a girl" (Hirschfeld, p. 151), the overwhelming majority of examples included by medical experts were those of AMAB gender-variant people.

As the individual tenets of the WBD developed, the foundation of AMAB gender-variant experiences only strengthened. Although evident throughout all three tenets, this predominance

of AMAB gender-variant experiences was most noticeable in the first and third tenets. As the first tenet, body wrongness, developed (see section 5.2.1), medical experts included such examples as "inner desire was to live as a girl" (Ellis, 1928, p. 54) and "[slept] with all the organs [later described as penis and testes] tucked back" (p. 94). Other descriptions included a gender-variant person who "wished to cut off his genitals" (Moll, 1897/1931, p. 65), and those who wanted to be castrated (Hamburger et al., 1953), implying they were AMAB. Green's (1969c) concluding thoughts in *Transsexualism and Sex Reassignment* exemplified this trend: the book was about the "female mind trapped in a male body" (p. 468). In the third tenet, treatment is hormones and surgery, the predominance of AMAB gender-variant experiences is even more pronounced. Although very early examples of gender-variant people requesting treatment from medical experts do exist, such as the request for castration mentioned by Krafft-Ebing (1886/1902), the 1950s marked the beginning of requests for surgical treatment. In almost all of the cases found in the primary sources, these requests, when specified, involved penises and testes, such as "demand[ing] a removal of the hated male organs" (Wiedeman, 1953, p. 1167).

This predominance of AMAB gender-variant experiences had the effect of shaping the WBD into a representation of specific AMAB gender-variant experiences. When Benjamin (1966) claimed ownership of transsexualism through the publication of his book, *The Transsexual Phenomenon*, he also centralised genital hatred and genital surgery as defining of transsexualism. He both implicitly and explicitly equated transsexualism with genital surgery. Other medical experts followed suit, with such quotes as "despise and devalue their penis" (Kubie & Mackie, 1968, p. 439) and "a tumour between [my] legs. The tumour is my scrotum and my penis" (Socarides, 1970, p. 342). This focus on genitals was then institutionalised in the

text of the diagnosis of transsexualism in the *DSM-III* (APA, 1980; full text available in Appendix D), which includes a number of references to genitals: "persistent wish to be rid of one's genitals" (p. 261-262), "often find their genitals repugnant" (p. 262), and "males may mutilate their genitals" (p. 263). Although in the description of transsexualism the desire is limited by words such as "often" and "may," criterion B makes it clear that to qualify for the diagnosis, the gender-variant person must "wish to be rid of [their] genitals" (p. 263).

6.1.2 AFAB gender-variant experiences

This experience of hating genitals was not, in fact, the universal gender-variant experience, not even of those gender-variant people who interacted with medical experts during the development of the WBD. Although exceedingly rarely, the primary sources demonstrate that there were some gender-variant people, most notably AFAB gender-variant people, who did not want genital surgery. When considered together with secondary sources that corroborate this pattern, it becomes evident that the WBD was based specifically on the experiences of AMAB gender-variant people.

Although there were very few examples in the primary sources analysed in this dissertation that directly addressed the experiences of AFAB gender-variant people, those that exist are nevertheless enlightening. The most telling example is Pauly (1969a; 1969b), who published the results of a tandem set of surveys, one given to AFAB gender-variant people (1969a) and the other given to AMAB gender-variant people (1969b). In line with the WBD, the AMAB gender-variant people reported that their surgical priority was having their penises and testicles removed. In contrast, however, AFAB gender-variant people reported that their surgical priority was having their breasts removed, followed by a hysterectomy; phalloplasty was not a priority. Similarly, Hoopes (1969), when describing AFAB gender-variant people, noted that

they found menstruating "exceedingly disturbing, inexplicable, and humiliating" (p. 337), "were appalled by the development of breasts" (p. 339) and even paired the word "abhorrence" with breasts rather than genitals (p. 338). Money and Brennan (1969), too, recognised that breasts were the focus of AFAB gender-variant people's experiences, and even noted that what was comparable was actually a desire to be "rid of a protruding reminder and morphologic stigma of their natal sex" (p. 150). In other words, the desire was to remove visible markers of sex, not specifically genitals, and yet the institutionalised form of the WBD, the transsexualism diagnosis in the DSM-III, explicitly names the desire as one to get rid of genitals.

Secondary sources have also demonstrated that there is a difference in surgical desires between AFAB gender-variant people and AMAB gender-variant people—the focus on genitals is distinctly, although not exclusively, associated with AMAB gender-variant people. The 2015 U.S. Transgender Survey found that of the AFAB gender-variant respondents, only 2% had had genital surgery and another 26% stated they wanted genital surgery in the future (James et al., 2016, p. 101).[30] In contrast, of the AMAB gender-variant respondents, 10% reported having had genital surgery and another 45% stated that they wanted genital surgery in the future (p. 102).[31] Supporting this, other secondary sources have reported similar findings. According to Cromwell (1999), "the majority of FTMs and transmen do not have gender dysphoria … what many experience, however, is body-part dysphoria, which focuses on elements such as breasts and menstruation that are quintessentially female" (p. 105). Corroborating the work of Hoopes (1969) and Pauly (1969a), Cromwell stated categorically that "breasts are hated more than

[30] Specifically, 1% had a metoidioplasty and 1% had a phalloplasty, 15% wanted a metoidioplasty in the future, and 11% wanted a phalloplasty in the future. Because these two surgeries are usually mutually exclusive, I have added them to produce total numbers regarding genital surgery.

[31] Although orchiectomy and vaginoplasty are separately listed in the report, it is unclear whether participants could select more than one procedure. While a vaginoplasty requires an orchiectomy, an orchiectomy does not necessarily mean the person had a vaginoplasty. As a result, I selected only vaginoplasty as the number to use in my comparison.

genitals" (p. 106). Beek et al. (2015) also found a disparity: 77.3 percent of surveyed AMAB gender-variant people wanted genital surgery, while only 57.5 percent of surveyed AFAB gender-variant people wanted genital surgery. And finally, Salamon (2016) argued that for AFAB gender-variant people, mastectomy is central to being seen as masculine as "masculinity is not determined by the presence of a penis" but rather by "the absence of breasts" (p. 318). Both the primary and secondary sources then challenge the idea that desire for genital surgery is universal to all gender-variant people.

6.1.3 Reasons for and effects of the predominance of AMAB gender-variant people

When considering the predominance of AMAB gender-variant people, the question arises as to why more AMAB gender-variant people interacted with medical experts than did AFAB gender-variant people. While many of the primary sources dismissed this as due simply to the fact that fewer AFAB gender-variant people existed (see for example: Benjamin, 1966), this was more likely due to a combination of factors. These factors possibly included: a media fixation on Christine Jorgensen (Cromwell, 1999); the greater flexibility in social roles available to women that may have allowed AFAB gender-variant people to express their masculinity without interacting with institutionalised medicine (Garber, 1989); medical-expert disinterest in AFAB gender-variant people (Gill-Peterson, 2018) and in female patients in general (Cromwell); women wanting to be men in a patriarchal society being seen as "natural" and even expected, so not worthy of medical interest (Lothstein, 1983); and/or medical experts' "obsessive focus" on AMAB gender-variant people's bodies (p. 166). Other, more general gendered medical practices may have also played a role, such as the common practice of treating medical knowledge based on male bodies as universally applicable to all bodies (Epstein, 2007), though this is not mentioned in the literature specific to the WBD or the medicalisation of gender variance.

It is possible that medical experts were aware that the WBD did not reflect AFAB gender-variant experiences but concluded that this was not problematic because they believed that fewer AFAB gender-variant people than AMAB gender-variant people existed. As such, it did not matter because the WBD would still reflect the experiences of the majority of gender-variant people. Regardless of whether medical experts were aware of this or not, the primary sources demonstrate that the WBD was based on AMAB gender-variant experiences and not AFAB gender-variant experiences. Moreover, the predominance of AMAB gender-variant people likely had a distinct effect on the form that the WBD took, leading to a centralisation of genital surgery in the WBD and the use of the desire for that surgery as a defining characteristic of transsexualism—key elements of the WBD. The WBD, then, was a partial discourse that was treated as a universal discourse.

6.2 Contextual messiness: Transsexualism versus true transsexualism

As discussed above, the WBD itself was messy. Rather than being a coherent and logical discourse that articulated gender variance in medical terms, it was a partial discourse based on the experiences of AMAB gender-variant people, and really, those of only some AMAB gender-variant people: those that chose to interact with medical experts. Despite already being problematic in this way, it was used within medicine as a universal explanation for gender variance and formed the foundation of the diagnosis of transsexualism in the *Diagnostic and Statistical Manual-III* (*DSM-III*) (APA, 1980). The use of the WBD by medical experts, however, only compounded this messiness. Medical experts began to add additional characteristics that they expected gender-variant people to embody. Together with the WBD, these assumptions and expectations defined *true transsexualism*, a distinct diagnostic entity that developed during the 1960s and 1970s and reflected medical experts' beliefs about the normalcy

of white middle-class binary gender and heteronormativity. However, *true transsexualism* also contained within it the original predominance of AMAB gender-variant experiences. This shaped the way medical experts wrote about those assumptions and expectations such that they used AMAB-gender-variant-associated descriptors like *femininity* and *looking for a husband* rather than gender-neutral language. This is evident in the examples below. In the following section, I show how this also shaped how medical experts conceptualised *true transsexualism.*

6.2.1 *True transsexualism* emerges

Early in the discussions and debates that medical experts were having on gender variance, some medical experts began to use words like "genuine" and "true" to differentiate a subgroup of their patients. Indeed, the first examples of this can be found in the work of Hamburger (1953) and Hamburger et al. (1953). In both of these texts, the authors discussed cases of "genuine transvestism," and they explicitly described this as being the most severe type of transvestism. They further defined "genuine transvestism" as not only dressing in the clothing of the opposite sex (the definition of transvestism as a whole), but also having an aversion to one's genitals, feeling like the other gender, and a desire for especially genital surgery (Hamburger et al., p. 396; Hertz et al., 1961; Bowman & Engle, 1955). Recalling that prior to the use of the term "transsexualism," all gender variance was called "transvestism" (Meyerowitz, 2002), these examples demonstrate that "genuine transvestism" did, indeed, refer to transsexualism, since both reflected the same tenets of the WBD. Moreover, it is evident that both "genuine" and "true" were used as descriptors to differentiate what later became called transsexualism within the realm of transvestic behaviour.

The term *true transsexualism* was first used in *The Transsexual Phenomenon* (Benjamin, 1966), the book through which Benjamin claimed ownership[32] of transsexualism. In this book, Benjamin explicitly argued that *true transsexualism* was identifiable by the tenets of the WBD.[33] Other medical experts also wrote about *true transsexualism*, although Benjamin was the most prominent medical expert to use the term. Most of these other medical experts used similar phrases, such as in discussions centred on ensuring gender-variant people "*truly* [fit] the transsexual pattern" (Knorr et al., 1969, p. 275, emphasis added), as well as "establish[ing] that the transsexuals … represent *true* instances of gender dysphoria" (Bentler, 1976, p. 569, emphasis added). Other terms were also used by medical experts to convey the same meanings as *true transsexualism*, such as "classical transsexualism" (Fisk, 1974), "primary transsexualism" (Person & Ovesey, 1974a; 1974b), "traditional transsexualism" (Bentler, 1976) and even "Benjamin's classical transsexualism" (Laub & Fisk, 1973). Although these terms and phrases differed, the primary sources that used them all used the three WBD tenets as the conceptual foundation. However, they all carried with them something more, as well.

6.2.2 Medical experts' assumptions and expectations

While the WBD was explicitly based on three tenets, in practice, medical experts expected gender-variant people to demonstrate a number of additional characteristics. These characteristics were not diagnostic criteria and alone they were not used to diagnose transsexualism, but they were nevertheless treated as almost equal in weight. If gender-variant people did not embody these additional criteria along with the WBD tenets, they were not seen

[32] Recalling Conrad and Schneider's (1992) model of medicalisation discussed in chapter 1, the five steps are: 1) a human phenomenon socially defined as deviant; 2) medical-expert "prospecting"; 3) claims-making competitions; 4) claiming ownership; and 5) institutionalisation (p. 266-271).

[33] Referring back to the table discussed in the previous chapter on p. 146 (Benjamin, 1966, p. 31; also found in Appendix C), Benjamin defined *true transsexualism* as involving being trapped in the wrong body (tenet 1), experiencing a disjuncture between one's sex and one's gender (tenet 2), and requiring surgery to correct this problem (tenet 3).

as good candidates for treatment and most often denied access to surgical and hormonal treatment. This indicates that the additional characteristics were important to medical experts. Broadly grouped, the characteristics were those based in binary gender, those based in heteronormative sexuality, and those based in the belief that being gender variant necessarily causes suffering.

6.2.2.1 Binary gender expectations

The first set of expectations associated with *true transsexualism* were based on the newly-developed concept of gender and on an unexamined acceptance of the gender binary. This appeared in three ways: medical experts expected that all gender-variant people with *true transsexualism* would 1) present themselves in a way that was consistent with binary gender expectations of femininity and masculinity, 2) have the same lifelong gender identity, and 3) have never experienced any ambivalence about their gender identity.

First, medical experts evaluated gender-variant people based on how well they aligned their appearance and behaviour with contemporary binary gender expectations. In particular, a patient's "femininity" (Stoller, 1968, p. 250), physique (Wålinder et al., 1978, p. 19), and a patient's ability to be "accepted as a woman" (Benjamin, 1967, p. 118; Fisk, 1974), were of utmost concern to medical experts. Stoller himself noted that he judged an AMAB gender-variant person's femininity by his own automatic pronoun use (p. 235), and medical experts were reported as judging AMAB gender-variant people's "femaleness" by how sexually interested they were in their patient (Kessler & McKenna, 1978). Together, these demonstrated to medical experts that a gender-variant person had what Fisk called an "appreciation of core gender principles" (p. 389), namely, conformity to binary gender expectations.

Second, medical experts believed that, in cases of *true transsexualism*, gender-variant people had a lifelong gender identity that did not match their sex as assigned at birth. Many medical experts described gender-variant people as "having been expressing this femininity [gender] since earliest childhood" (Stoller, 1968, p. 251), or even explicitly stating that the gender identification had to be "lifelong" (Laub & Fisk, 1973, p. 390). This expectation also took the form of concerns to ensure that symptoms were not caused by a "transient situational event" (Knorr et al., 1969, p. 275) or a "situational crisis" (Edgerton et al., 1970, p. 42). Despite the fact that a lifelong conviction was not part of the diagnostic criteria that became part of the *DSM-III* diagnosis of transsexualism—only two years were required (APA, 1980)—medical experts nevertheless expected gender-variant people to have had a lifelong gender-variant identity.

Third, medical experts expected that all cases of *true transsexualism* would demonstrate consistency in gender identity. Gender-variant people were expected to have never experienced any ambivalence about their gender identity, nor about the treatment that they required (Pauly, 1969a, p. 44; Knorr et al., 1969, p. 276). Some medical experts explicitly required the "absence of ambivalence" for cases of *true transsexualism* (Edgerton et al., 1970, p. 42; Pauly), while others warned that if gender-variant people had ever successfully lived in their originally-assigned gender, or enjoyed their bodies prior to surgery, they did not qualify for a diagnosis of *true transsexualism* (Stoller, 1968, p. 251). Gender-variant people who expressed any uncertainty about proceeding with treatment did not qualify either (Pauly, 1969b).

6.2.2.2 Heteronormative sexuality expectations

The second set of expectations revolved around heteronormative sexuality. Prior to transition, gender-variant people were expected to be asexual because as people who would be heterosexual after treatment, medical experts believed gender-variant people would be unable to

participate in homosexual-appearing practices prior to transition. Following transition, gender-variant people with *true transsexualism* were expected to demonstrate not only heterosexual attraction, but also sexual propriety as well as the centralisation of family and finding a spouse. This not only reflected heteronormativity, but in particular for AMAB gender-variant people, specifically white middle-class heteronormative womanhood (Skidmore, 2011).

Prior to treatment, gender-variant people were variously expected to have had "no sexual experience other than masturbation" (Ovesey & Person, 1973, p. 65) or even having experienced no "pleasure derived from [the] penis" (Green, 1974, p. 82). These expectations were based in the belief that *true transsexualism* involved a hatred of one's genitals that would manifest as difficulties in sexual contact and sexual relationships (Ovesey & Person, p. 65). Other assumptions based on this belief about the sexuality of gender-variant people included having no history of erotic cross-dressing (Baker, 1969, p. 1413) nor of a homosexual identification (Person & Ovesey, 1974b, p. 192). Medical experts articulated these expectations of almost complete and of complete asexuality in terms of motive: in *true transsexualism*, there were no sexual or erotic motivations of any kind (Pauly, 1969b; Fisk, 1974). The only "authentic" motives were non-erotic, namely those related to gender identity only (Knorr et al., 1969, p. 275; Edgerton et al., 1970).

After treatment, patients were expected to want to find, specifically, a husband, and to have a family (Stoller, 1968). Medical experts believed that the primary goal of all people with *true transsexualism* was to "marry and adopt children" (Benjamin, 1964a, p. 464). Prince (1957) concurred, noting that in cases of *true transsexualism*, "marriage, motherhood, and a husband" were the patient's utmost desire "as a fulfillment of … femininity" (p. 20). Moreover, medical experts highlighted the difference between homosexuality and the heteronormative desires of

patients with *true transsexualism*. Although patients might have engaged, or expressed a desire to engage, in behaviours that appeared homosexual, they were, in fact, heterosexual because of the inner "feminine" identity (Benjamin; Prince, p. 19-20). Their attraction was to "normal heterosexual men" (Benjamin, p. 464) and they viewed themselves as heterosexuals (Benjamin, 1966, p. 28). Indeed, medical experts even reported that their patients abhorred homosexuality (Stoller, 1968).

6.2.2.3 Distress and misery

The last expected characteristic of *true transsexualism* evident in the primary sources is that of being distressed. Medical experts conceptualised all gender-variant people with *true transsexualism* as miserable due specifically to their gender identity. This expectation can be found in the descriptions of gender-variant people prior to treatment, as well as in the ways in which medical experts articulated their own intentions in providing treatment. Medical experts repeatedly referred to misery and suffering (Benjamin, 1964b, p. 107; Meerloo, 1967), as well as unhappiness (Benjamin, 1966, p. 66), or desperation (p. 79; Fisk, 1974). Hamburger (1953), for example, described gender-variant people as "deeply unhappy persons" (p. 375; Anchersen, 1956; Pauly, 1965). Working from this assumption, medical experts also characterised their own intentions as attempts to create a "tolerable existence" for gender-variant people (Hamburger et al., 1953, p. 396; Baker, 1969), to reduce their suffering (Green, 1974), and to "offer hope" (Barlow et al., 1973, p. 569). Liking one's gender-variant identity disqualified gender-variant people from a diagnosis of *true transsexualism*.

6.2.3 *True transsexualism*: the messy practical application of the messy WBD

The primary sources reveal that while medical experts based their understanding of gender variance on the three tenets of the WBD, in practice, a number of other expectations

played a role in medical expert decisions surrounding diagnosis and treatment. Not every gender-variant person that expressed feeling wrong about their body, and thus presented with a disjuncture between their sex and gender, was granted access to surgical and hormonal treatment, as the WBD would suggest they should. Rather, medical experts expected that gender-variant people would present an appropriately-binary gender appearance that was the reflection of a lifelong, stable gender identity, as well as a desire to be heterosexual after treatment and persistent misery and distress due to their condition in order to be seen as good candidates for treatment.

Moreover, the messiness of the WBD itself is evident in the assumptions and expectations: medical experts wrote of the requirement for appropriate *femininity*, and for *finding a husband*, with no discussion of masculinity or being a husband. What Denny (2004) characterised as "the clinics attempt[ing] to turn out well-adjusted, attractive, heterosexual graduates" (p. 29) was, in fact, the attempt to produce heteronormatively-attractive *women*, with little concern for the kinds of men AFAB gender-variant people would be. These additional required, but not diagnostic, criteria raise the question of why medical experts made use of the concept of *true transsexualism* instead of simply transsexualism. In other words, what sort of contextual messiness necessitated this? To answer this question, I turn to the patterns associated with the use of *true transsexualism* as evident in the primary sources.

6.3 Use of *true transsexualism*

While most of the primary sources in this research used the term "transsexualism," a significant portion included the term *true transsexualism*. To better understand why medical experts might have chosen *true transsexualism* over just transsexualism, I first create a map of situations in which *true transsexualism* was used. I then consider some definitions of the word

"true" that could indicate what purpose the word might have had in the phrase *true transsexualism*, given the patterns of use I found. This leads to the conclusion that *true transsexualism* may have been an ideological tool used to try to stabilise the WBD as the discourse was still new and not widely accepted. It would appear that the WBD was held together by discourses of white middle-class heteronormativity and binary gender. However, this ideological tool was imperfect in itself, and together with the messy context within which it was used, produced a hierarchy discussed in the following section.

6.3.1 When was "true" used?

Although it is not possible to ascertain for certain why medical experts chose to use the term *true transsexualism* instead of just transsexualism, there were several situations in which the term "true" was used. The primary sources reveal a predictable pattern of when medical experts used the term "true" that suggests "true" was deployed intentionally. First, "true" was deployed in discussions of other, similar phenomena, namely homosexuality and transvestism, where it was used to help differentiate between the disorders. Second, it was used in discussions centred on the legitimacy of surgical treatment for transsexualism, where it was used to help ascertain for whom the treatment was best suited. These two situations, however, are not as distinct as they appear below, and it is likely that combinations of these reasons played into each instance of the use of the use of *true transsexualism*.

6.3.1.1 Differentiation: Who is this treatment right for?

As discussed in the historical contextualisation (chapter 4), at the time that the WBD was developing and coming into focus, and the *true transsexualism* diagnostic entity was coming into existence, there were numerous other, similar phenomena being explored: disorders of sex development (then called hermaphroditism), transvestism and homosexuality. According to

Person and Ovesey (1974a), people with any of these diagnoses could also present as the "opposite" gender and request surgical and hormonal treatment, and the request itself was not synonymous with a diagnosis of *true transsexualism*; Prince (1978) referred to these other phenomena as types of pseudotranssexualism. However, according to medical experts such as Benjamin (1966), these other disorders were not to be treated with surgery and hormones. Indeed, Fisk (1974) explicitly cautioned that no other disorder should be treated with hormones and surgery (p. 387). In these cases, the word "true" was used to differentiate between what was, and was not, transsexualism. In order to differentiate, medical experts considered the expected characteristics to ensure that the patient could be diagnosed with *true transsexualism*, which Person and Ovesey articulated as assessing "family history, developmental history, psychodynamic patterning, personality structure, and clinical course" (p. 4). By basing *true transsexualism* on these additional characteristics, medical experts could more precisely discern what disorder they were observing, because not all patients should be treated the same way.

The first main type of pseudotranssexualism (Prince, 1978) consisted of people who were homosexual but, troubled by the morality of their sexuality, asked for hormonal and surgical treatment so that they could be heterosexual (Pauly, 1965). Pauly (1969b) later articulated the difference between this type of pseudotranssexualism and *true transsexualism* as being found in the lifelong gender identity. In short, the latter situation involved a gender-variant identity prior to genital sexuality and therefore could not be considered a situation involving homosexuality (p. 43). Here, "true" seemed to be used to differentiate between an inherent gender-variant identity and gender variance that was acquired in some way later in life but did not reflect a core internal state. According to medical experts, only inherent gender variance was appropriately treated with hormones and surgery.

The other main type of pseudotranssexualism (Prince, 1978) was differentiated from *true transsexualism* based on the characteristic of expected asexuality: an erotic motive indicated transvestism, whereas a lack of such a motive (recall: "authentic motive" in the previous section) indicated *true transsexualism* (Fisk, 1974). Although Benjamin (1966) additionally differentiated between transvestism and *true transsexualism* by the request for surgery (tenet 3), which he did not believe would be present in transvestism (p. 2), others such as Prince and Bentler (1972) explicitly disagreed, arguing that many conditions could lead people to this request, including transvestism (p. 910). This potentially necessitated these other characteristics for differentiation. Nevertheless, "true" here was a way to differentiate between a sexual motive and a non-sexual motive, where the latter was seen as legitimate gender variance and the former remained in the category of sexual perversions that had previously contained gender variance as well.

6.3.1.2 Legitimating treatment: Who is right for this treatment?

The task of differentiation formed the foundation on which medical experts could ask the question: which patients would do best with this treatment? Indeed, as Person and Ovesey (1974a) noted, "the differentiation … is not just of academic interest; it is of crucial importance for the psychiatrist who must evaluate applicants for sex reassignment" (p. 4) and decide which gender-variant people could—and would—receive treatment. Laub and Fisk (1973) even argued that "it [was] hazardous … to surgically alter a person's sex simply upon his request" (p. 388). Rather, only a small subset of gender-variant people requesting surgical treatment were seen as suited for it. All other people, gender variant and not, had to be protected from the harms that medical experts believed inappropriate hormonal and surgical treatment would cause. Indeed, Benjamin (1953) cautioned that "if the patient has been unwisely selected … the success of the operation will be negated and tragedy may be the outcome" (p. 13-14). Unlike the question of

differentiating between similar phenomena, however, in this case it appears that medical experts were differentiating between gender-variant people who all would have otherwise qualified for treatment, if the only criteria were those of the WBD tenets.

6.3.2 What does this reveal about *true transsexualism* and its use?

The two situations in which medical experts tended to use the term *true transsexualism* discussed above raise the question of how the word "true" performed the function of helping medical experts differentiate between phenomena and legitimate treatment. For this, I look first to the meanings of the word "true" that are evident in the primary sources. I then analyse the situations in which *true transsexualism* was used together with the meanings of "true" that seem to be predominantly drawn upon by medical experts in those situations to reveal an undercurrent of medical-expert anxieties. Based on the data, I argue here that the word "true" could have been used in an attempt to stabilise the WBD by drawing on other, established discourses, in a context of questions about the dangers, morality, and even legality of treating transsexualism with surgery and hormones. Under the name *true transsexualism*, medical experts drew on the discourses of white middle-class heteronormativity and binary gender to hold up the WBD.

6.3.2.1 The meanings of "true"

Although there are numerous definitions of the word "true" that exist in present-day English, three of these are evident in the primary sources: "rightly or properly bears the name" (Oxford University Press, 2020e, para. 3), "in accordance with fact or reality" (para. 2), and "authentic" (para. 3). First and foremost, according to the Oxford English Dictionary (OED), "true" is commonly used in discussions of classification to mean that something "rightly or properly bears the name" (para. 3). In this context, a case of *true transsexualism* would, first and foremost, be understood as a case that is accurately and properly called transsexualism. Indeed,

this usage can be widely seen in the data and is exemplified by the following quotation from Benjamin (1966): "a large group of male transvestites (TVs) can be called 'true' because cross-dressing is the principal if not the only symptom of their deviation" (p. 38-39). Here, "true" was used to convey the centrality of the defining feature, cross-dressing. Benjamin also made use of this meaning when he described one patient thus: "Ricky V., in his late fifties, is more of a true transsexual. … She owns no male clothes. No one in the office knows of her true status" (p. 71).[34] In describing Ricky V. this way, Benjamin was saying that she was typical of transsexualism, and that the characteristics Benjamin laid out were those that could be expected of people with transsexualism. While this definition likely underpins all of the discussions in which *true transsexualism* was used, it is also important to remember that the definitions of "true" would not have been used exclusively, and that multiple meanings likely exist in each example.

The second definition of "true," "in accordance with fact or reality" (Oxford University Press, 2020e, para. 2), suggests that "true" can be used to make a claim regarding the reality of what is being described; it *really* exists, objectively and outside of the observer. Using this definition, medical experts describing a case as *true transsexualism* were not only stating that in this case, the transsexualism of the gender-variant person was real as opposed to apparent, similar, or even false, but also that transsexualism was a real phenomenon as described, existing outside of the patient. One of the most notable examples of this definition is when Benjamin (1966) described a gender-variant person's desire to *be* a woman rather than just dress as one as "the true transsexual sentiment" (p. 101). Here, Benjamin was drawing on the meaning of "true" as "objectively real" to communicate that this desire described by gender-variant people was

[34] The pronouns here appear contradictory. However, in the original work, Benjamin notes that because Ricky V. lived as a woman, he would use the pronoun "she" from that point onward.

reflective of a reality outside of the person themselves, and that it was, in fact, part of a real medical condition.

The third definition of "true," namely "authentic" (Oxford University Press, 2020e, para. 3), draws on a number of ideas including trustworthiness, truthfulness, accuracy, reliability and credibility. Using this definition, describing transsexualism as "true" can communicate that medical experts believe what gender-variant people are reporting. Moreover, this definition suggests that medical experts saw gender-variant people with *true transsexualism* as being honest and forthcoming about their symptoms. Although this definition is most evident in how medical experts wrote about what gender-variant people said rather than specific single sentences, there are two examples that are particularly illustrative of "true" being used to draw in meanings of authenticity, accuracy, reliability and credibility. First, when Benjamin (1967) stated that "a *sex reassignment*, or *conversion operation*, is the overwhelming wish of all true transsexuals…" (p. 117), he was drawing not only on the second meaning of "true" as reflective of reality, but also on the belief that *true transsexuals* could be trusted in reporting this desire. And second, when Edgerton et al. (1970) titled a section in their paper, "Is the patient truly a transsexual and authentically motivated for surgery?" (p. 41), the authors drew on the meaning of "true" as reliable and trustworthy to have medical experts ask themselves whether they believe what their patient is telling them about *why* they desire surgical and hormonal treatment. Gender-variant people with *true transsexualism* are thus produced as credible and reliable. Having been ascertained as trustworthy and reliable in their reports of symptoms, the diagnosis of *true transsexualism* then could also communicate to other medical experts that *these* gender-variant people were vetted and could be believed by other medical experts, in contrast to the gender-variant people that medical experts widely described as manipulative and not trustworthy.

6.3.2.2 Why use "true"? Medical-expert anxieties

As is evident in the discussion in the previous chapter, many of the primary sources focused on defining what transsexualism was, and how it was not homosexuality or transvestism. In this context, Fisk (1974) noted that "as originally intended, the term transsexual was to specifically identify a person who was not to be confused with a homosexual or a transvestite" (p. 387). Given this assertion, the question arises: why did some medical experts start using *true transsexualism* instead of transsexualism, if the word served at least one of the purposes, namely differentiation, already? Could it not then also be used equally to legitimate treatment? Throughout the discussions regarding differentiation and the legitimation of treatment, an undercurrent of medical-expert anxieties is evident in the primary sources. Recalling the context within which the WBD developed (chapter 4), namely the history of gender variance being considered a perversion and the perception that surgical and hormonal treatment for a "mental disorder" was dangerous, unprofessional or even potentially a violation of medical ethics (Worden & Marsh, 1955; Meerloo, 1967), medical experts had many anxieties regarding the treatment of transsexualism (Denny, 1996; Meyerowitz, 2002). The primary sources suggest that in such instances, medical experts turned to the word "true" as one way to navigate those anxieties. The way medical experts used the word "true" to differentiate between similar phenomena suggests anxieties around questions of morality and free choice, and the question of who was right for the treatment. On the other hand, the use of "true" in the context of legitimating treatment for transsexualism appears to have been rooted in anxieties around the seriousness of a surgical treatment for a disorder that had no biological markers and was thus

dependent entirely on what patients said,[35] and the question of whether surgical and hormonal treatment was right for transsexualism.

Transsexualism was, and still is, considered by many medical experts to be a controversial diagnosis, not only because many medical experts believed (and many still believe) that it was a delusion, but also because of its history of being seen and classified as a perversion (Wiggins, 2020). Even fully-supportive medical experts, such as Benjamin (1971), wrote of their concerns about the unknowns in trying to decide who to treat and how to treat them. Others, like Pauly (1965), noted that opposition to the surgical treatment of transsexualism focused on the role of medical experts: were medical experts who treated transsexualism with surgery and hormones incompetent, irresponsible (p. 178) or "collaborating with … sexual delusions" (Meerloo, 1967, p. 263)? It appears that the word "true" was deployed in such instances as a way to highlight that certain people whom others might label as perverts or delusional were, in fact, neither perverts, because in *true transsexualism* there was no erotic motive (Baker, 1969, p. 1413), nor delusional, because *true transsexualism* did not involve any delusions nor "primary mental disease" (Benjamin, 1966, p. 85). Rather, *true transsexualism* was a medical condition outside of gender-variant people themselves, valid and real, because it was "true," meaning "in accordance with fact or reality" (Oxford University Press, 2020e, para. 2). Moreover, it could be identified and differentiated from situations where there were delusions, or from other phenomena that might present in a similar way but need different treatments, such as homosexuality or transvestism (the "perversions") so that medical experts could defend themselves against accusations of participating in "perverted" desires.

[35] I make this statement based on the *DSM-III* criteria found in Appendix D, and the criteria outlined in the *DSM 5* for gender dysphoria, the most contemporary version of the diagnosis (APA, 2013, p. 452-453). Both of these sets of criteria depend entirely on patient self-reports of experiences, feelings, desires, and their own histories (see also: Lev, 2005).

Additionally, transsexualism raised questions of morality and free will: do gender-variant people have a choice in their behaviour? Is treatment, in fact, colluding with perversion? Are medical experts as morally culpable as the "perverted" gender-variant people whom they treat? Stoller (1968) brought this anxiety into focus by asking "if a greater part of one's sense of gender is created by factors beyond one's control…then, if one persists in expressing that gender, is one sinning?" (p. 261). Navigating these questions could also be made easier by drawing on the meaning of "true" as "in accordance with fact or reality" (Oxford University Press, 2020e, para. 2). By referring to certain cases as *true transsexualism*, medical experts could argue that this was a valid medical condition with a demonstrable, objective reality outside of the gender-variant person's mind and thus not a question of free will. Gender-variant people with *true transsexualism* had an illness, and could not simply choose to not be transsexual, and treating them to alleviate their symptoms was not only not immoral, but *not* treating them was, in fact, the immoral act.

The treatment itself also seemed to cause many medical experts significant anxiety. This is evident in statements such as Pauly's (1965), who commented that "the decision to operate is an extremely complex and controversial one" (p. 172) and later, that "the recommendation for a change-of-sex operation is made reluctantly after soul-searching deliberation, and in view of the fact that no other alternatives are currently available" (Pauly, 1969a, p. 80). Indeed, as noted in the previous chapter, the treatment was widely seen as radical (Socarides, 1969, abstract), drastic (de Savitsch, 1958, p. 91), and even mutilating (Worden & Marsh, 1955, p. 1297). Surgical and hormonal treatment of transsexualism stands out from other situations in which invasive medical treatments such as surgeries are used in that, unlike other medical conditions such as heart disease or cancer, transsexualism depends entirely on what the gender-variant person has said;

there are no biological markers that medical experts can rely on (see footnote 35 on p. 189). It thus was, and is still, significantly more suspect, both as a valid condition and as a condition requiring surgery and hormones. Because of this context, it is likely that medical experts did not only use "true" as "in accordance with fact or reality" (Oxford University Press, 2020e, para. 2) to demonstrate medical-expert practices of differentiation between similar phenomena. Medical experts likely also drew on "true" as "authentic" (Oxford University Press, 2020e, para. 3) to communicate the rigour of evaluating gender-variant people and determining that these particular gender-variant people, those with *true transsexualism*, could be trusted about their symptoms and thus treating them with surgery and hormones, though it might appear drastic or radical, was actually appropriate, since medical experts had nothing else on which to base the diagnosis.

Finally, one of the most significant anxieties that is evident in the primary sources is the potential for gender-variant people to disrupt the normative gender expectations that underpin society. While no medical expert explicitly stated so in any of the texts analysed in this research, this anxiety can be seen in the focus on gender-variant people being required to fulfil binary gender expectations and the connection that medical experts made between this fulfillment and better treatment outcomes. Candidates who were considered "good" were those gender-variant people who had demonstrated their investment in binary gender and heteronormative expectations: those likely to become "successful women" (Benjamin, 1967, p. 118) or men, who had the appropriate "appearance" and thus were able to "pass" (p. 118); those who qualified for *true transsexualism*. In this context, it appears as though medical experts believed that many of the characteristics associated with *true transsexualism* were indicative of a better treatment outcome (Wålinder et al., 1978; Person & Ovesey, 1974a), discursively equating binary gender and heteronormative conformity with a good treatment outcome. In this context, "true" appears

to mean “authentic” (Oxford University Press, 2020e, para. 3) and, together with its connotations of reliability and trustworthiness, could have been used to communicate that these specific gender-variant people could be trusted to be truthful not only about their symptoms and presentation, but also about their intentions to maintain the heteronormative and binary-gendered status quo.

6.3.3 Using “true” to stabilise the WBD

The presence of these anxieties suggests that the WBD was not a stable discourse and could not legitimate hormonal and surgical treatment for transsexualism on its own. Indeed, as noted previously, the context within which medical experts treated transsexualism was one of significant opposition to the treatment offered and questioning of the professionalism and even competence of medical experts who provided surgical and hormonal treatment. The primary sources suggest that although the WBD explained that hormonal and surgical treatment was appropriate, the discourse was not enough to defend against these challenges. Medical experts had to find other ways to defend against opposition, and for this they turned to the concept of *true transsexualism* to draw on the stability of the discourses of white middle-class binary gender and heteronormative sexuality in order to demonstrate the validity of the WBD as a justification for their treatment decisions.

Being a new discourse, the WBD was not yet established nor widely accepted. There were two additional factors that particularly contributed to this instability: the fact that it was based on gender-variant people’s reports because there were no biological markers of transsexualism (see footnote 35 on p. 189), and the fact that it included no etiological explanation for transsexualism. Because the WBD was based on gender-variant people’s reports, there could always be some doubt as to whether medical experts had interpreted their patients’

words correctly, or whether they were being drawn into delusions or perversions. This was reflected in many of the criticisms, such as Bowman and Engle (1957), who argued that surgical treatment "play[ed] into the patient's illusions" (p. 587), and Meerloo (1967), who questioned whether medical experts "have to collaborate with the sexual delusions of [their] patients" (p. 263). Moreover, many medical experts who opposed the hormonal and surgical treatment of transsexualism argued that those who supported it gave up on psychotherapy too quickly. Many medical experts used the ineffectiveness of psychotherapy as evidence in support of hormonal and surgical treatment, such as Hertz et al. (1961), Pauly (1965), and Stoller (1968). However, according to Gutheil (1954), "patients' uncooperative attitude" was not a reason to abandon that treatment method (p. 238), nor was it a reason to question whether psychotherapy was the appropriate method.

Additionally, the same lack of etiological explanation in the WBD that made it robust and compatible with numerous explanations and understandings of gender and sex also meant that the discourse could not be propped up by scientific explanations which would bring with them the legitimacy of scientific knowledge. As discussed in the previous chapter, the three tenets of the WBD—wrongness of the body, disjuncture of sex and gender, and treatment through hormones and surgery—offered no explanation of the experience of transsexualism. This meant that nothing in the discourse could be used to counter the accusations of delusion or perversion.

However, other, related discourses had the potential to offer those explanations that the WBD lacked, particularly because the WBD was already dependent on those discourses to make sense. According to the literature review (chapter 2), binary gender and heteronormativity are both assumptions that underpin the WBD. Without binary gender, the ideas of feeling like one gender instead of the other would just not make sense, and without heteronormativity, gender

variance could be conceptualised as "latent (or manifest) homosexuality" (Gutheil, 1954, p. 233). Tying the WBD more closely to binary gender could, then, provide some stability to the WBD by demonstrating that it is a logical extension of the more stable binary gender discourse. Moreover, expecting heteronormative sexuality from gender-variant people, which also draws on the discourse of binary gender, could be used to demonstrate that rather than being homosexual, the WBD explained how apparently-homosexual people could actually be heterosexual. The data suggest that medical experts may have used *true transsexualism* and its associated expected characteristics of investment in binary gender and heteronormativity to do just that.

Recalling the earlier discussion of *true transsexualism* in the previous section of this chapter, medical experts treated binary gender and heteronormative sexuality characteristics as expected, elevating them to almost the same level as the diagnostic criteria that made up the WBD. In addition to feeling wrongness in their body and having a disjuncture between sex and gender, gender-variant people had to present in gendered ways that were considered acceptable to the medical experts, and had to express a desire to be heterosexual after treatment, usually by stating the desire for marriage and a family. Finally, patients had to be absolutely miserable, a misery that was expected by medical experts to be unproblematically resolved by surgical and hormonal treatment that removed the source of their misery, namely having a disjuncture between sex and gender.

The way this stabilised the WBD lay in the ways that *true transsexualism* was able to defend against accusations of delusion, perversion and collusion that the WBD alone could not. In contrast to the WBD, *true transsexualism* carried with it an added dimension of explanation drawn from the discourses of binary gender and heteronormative sexuality. A gender-variant person diagnosed with just transsexualism could, argued many medical experts, believe they

were “really the other gender” because they were delusional, or because they found it erotic, and nothing in the WBD could counter those explanations. A gender-variant person diagnosed with *true transsexualism*, however, had a gender identity as firmly situated within binary gender as any cisgender person. Moreover, gender-variant people with *true transsexualism* were “normal”—not delusional or perverted—as evidenced by their “authentic motive,” namely the lack of a sexual motive, and their “normal” heterosexual orientation that simply required surgical and hormonal treatment to be revealed. Here, binary gender provided a grounding for a phenomenon that many medical experts found highly suspect and morally problematic. Instead of being a perversion, *true transsexualism* was a situation in which a non-perverted person simply *seemed* perverted due to having the wrong body, and that “normalness” was evidenced by the person demonstrating all of the expected characteristics that medical experts assumed those with *true transsexualism* would show.

6.4 Transnormativity: An ideological effect of the WBD

The development of the concept of *true transsexualism* was, most likely, the outcome of an unconscious effort by medical experts to bring legitimacy to the surgical and hormonal treatment of transsexualism. Faced with multiple pressures including gender-variant people in distress and requesting treatment, and medical experts criticising the surgical and hormonal treatment of transsexualism (as discussed in chapters 4 and 5), medical experts seemed to turn to *true transsexualism* and its underpinning discourses of white middle-class binary gender and heteronormativity in order to defend their treatment as legitimate. However, this also produced a hierarchy of legitimacy: some gender-variant people were defined as more legitimate, more “true,” than others. Perhaps more problematically, this hierarchy of legitimacy defined AMAB gender-variant people as more legitimately transsexual than AFAB gender-variant people, by

virtue of the WBD on which *true transsexualism* was based being rooted in AMAB gender-variant experiences. This, I argue, represents one of the earliest iterations of transnormativity.

As discussed in chapter 1 (section 1.3.2), transnormativity is a set of normative expectations based on an ideology that produces a hierarchy of legitimacy among gender-variant people (Johnson, 2016). In this section, I demonstrate that an iteration of transnormativity, then, is an ideological effect of the WBD and its stabilisation through *true transsexualism*. I first show that medical experts shifted their language into discussing the *true transsexual*, solidifying and reifying that as the subject position into which they expected gender-variant patients to step. Then I show that *true transsexual*, defined by the WBD together with the additional expected characteristics discussed in the previous two sections, came to represent gender variance in a way that reflects the ideological structure of transnormativity. I conclude with an explanation of how medical experts' practices of using the *true transsexual* to decide who could and could not access surgical and hormonal treatment created a hierarchy of legitimacy among gender-variant people, in line with how transnormativity is explained in the literature.

6.4.1 The *true transsexual* emerges

Many medical experts who wrote about *true transsexualism* and the characteristics that were associated with it often phrased their discussion in terms of the *true transsexual*, linguistically replacing a diagnostic entity with a subject position. In the earliest texts that made use of the "true" theme, those published in the 1950s discussed above that were about "true transvestism" [36] and "genuine transvestism," medical experts were consistent in speaking only of diagnostic entities. Hamburger et al. (1953), for example, wrote about "genuine transvestism in a young man" (p. 396), "transvestic men," and otherwise referred to the people about whom they

[36] Recall that in early work, transsexualism was considered a type of transvestism.

wrote as “patients” (p. 396; Hertz et al., 1961). Similarly, Anchersen (1956) wrote about “genuine transvestism” along with “persons who suffer from this abnormity” (p. 250). However, in the mid-1960s, this language began to shift.

While the earliest instances of this linguistic shift can be found in the work of Anchersen (1956), who mentioned “genuine transvestites” (p. 249), followed by Prince (1957), who referred to the “true transvestite” (p. 20), this shift took hold more significantly in the mid-1960s. It began with *The Transsexual Phenomenon* (Benjamin, 1966) in which Benjamin referred to a number of gender-variant people as *true transsexuals* (p. 71). In addition to defining the *true transsexual* by the WBD in a succinct table (p. 31; see also the discussion in the previous chapter), Benjamin also explicitly tied *true transsexuals* to the three tenets of the WBD. According to Benjamin, *true transsexuals* find their genitals disgusting (p. 22), reflecting the first tenet of the WBD, the feeling of wrongness about the body. Moreover, “being a woman … is the *true transsexual* sentiment” (p. 100-101, emphasis added), reflecting tenet 2, a disjuncture between gender and sex. And, reflecting tenet 3, hormones and surgery as the solution, Benjamin argued that “a sex reassignment, or conversion operation, is the overwhelming wish of all *true transsexuals*…” (Benjamin, 1967, p. 117, emphasis in original). Other medical experts followed this linguistic pattern of referring to certain patients as *true transsexuals*, such as Pauly (1969, p. 44), Edgerton et al. (1970, p. 41), Laub and Fisk (1973, p. 390), and Ovesey and Person (1973, p. 65; Person & Ovesey, 1974a, p. 6). Although an increase in the usage of *true transsexual* is evident in the 1960s and into the 1970s, this linguistic form was not always used by medical experts. Benjamin used this phrasing the most, but given his level of influence, as discussed in the previous chapter, this likely translated into a significant contribution to the production of the *true transsexual* subject position.

Two characteristics are evident in the discussions of the *true transsexual*. First, the *true transsexual* is the embodiment of the assumptions and expectations associated with *true transsexualism*; it is the subject produced by the ideology of *true transsexualism*. And second, the *true transsexual*, in other words the "ideal" transsexual, is an AMAB gender-variant person who wants genital surgery and conforms to the gender binary and heteronormativity, reflecting the predominance of AMAB gender-variant experiences as the foundation of the WBD itself.

Looking at the data, it is evident that the *true transsexual* embodied all of the assumptions and expectations associated with *true transsexualism* as well as the WBD. First and foremost, the *true transsexual* was a person who was not only invested in the gender binary, but who could successfully "pass" as the gender they identified as, without disrupting social gender norms. The *true transsexual's* gender identity was also a lifelong conviction, since *true transsexuals* "invariably date[d] the beginning of their deviation to earliest childhood" (Benjamin, 1966, p. 39) and were "transsexual from the beginning" (Person & Ovesey, 1974b, p. 191). Equally, *true transsexuals* experienced no ambivalence regarding their gender identity or the treatment involved, and were not "motivated for surgery by some transient situational event" (Knorr et al., 1969, p. 275). Secondly, *true transsexuals* were believed to be asexual prior to treatment, and heterosexual after. *True transsexuals* were expected to have no sexual experiences outside of, at most, masturbation (Ovesey & Person, 1973, p. 65), but their life goals were expected to be quiet family life. Finally, reflecting the expectation of misery, Benjamin (1967) noted that *true transsexuals* pursued sex reassignment so vehemently because they are miserable in their current lives and "they feel it is at present their only chance for a happier future" (p. 117). All of these characteristics, though, were in addition to the expectation that the *true*

transsexual was a person who not only hated their body, but also felt like the "other" gender and wanted hormonal and surgical treatment.

However, the *true transsexual* was not just any gender-variant person who could embody racialised and classed gender binary norms and heteronormativity, but specifically an AMAB gender-variant person who could do so. This is most evident in medical expert discussions that included expectations that the *true transsexual* could reflect the expectations of femininity to their satisfaction. Accordingly, she was "sufficiently feminine" (Stoller, 1968, p. 250) and with a physical build that was considered appropriate for a woman (Wålinder et al., 1978, p. 19) or even "completely unremarkable" (Benjamin, 1964a, p. 465), and therefore "a successful "woman" [could] result" from treatment (Benjamin, 1967, p. 118). Moreover, as a woman, the *true transsexual* was expected to want to find a husband and raise children (Prince, 1957; Hertz et al., 1961). The undercurrent of the WBD based in AMAB gender-variant experiences, however, is also evident in these primary sources, as the *true transsexual* was explicitly defined as one who not only felt their body was wrong but, specifically, hated their genitals (Benjamin, 1966, p. 31).

6.4.2 The *true transsexual* and transnormativity

Recalling the definition of transnormativity in chapter 1 (see section 1.3.2), transnormativity is an ideology about what transsexualism is, that produces a hierarchy in which some gender-variant people are seen as more "authentically" or "truly" transsexual than others. Most commonly in American and Canadian contexts, it is based on white middle-class binary gender and heteronormativity, though multiple iterations of transnormativity exist in different contexts. The primary sources seem to suggest that the ways in which medical experts used *true transsexualism* and, specifically, *true transsexual*, reflect the ideological pattern that Johnson (2015; 2016) identified as transnormativity. Each key element of transnormativity identified in

chapter 1 is evident in the discussion above, and is summarised in the following table, along with examples from primary sources that reflect those elements.

Table 9

The true transsexual and transnormativity

Transnormativity	*True Transsexual*
All gender-variant people have same experiences and plans for treatment (Richie, 2016)	All *true transsexuals* hate their genitals (Green, 1974) All *true transsexuals* cannot engage in intimate sexual relationships (Ovesey & Person, 1973) All *true transsexuals* want hormones and full surgical treatment (Benjamin, 1966; Socarides, 1970) All *true transsexuals* want a heteronormative partner and a family (Benjamin, 1967; Hertz et al., 1961)
The ultimate goal of treatment is "passing" (Riggs et al., 2019; Thomas, 2019)	All *true transsexuals* want to disappear into society after treatment (Benjamin, 1967; Hertz et al., 1961) All *true transsexuals* can "pass" successfully (Stoller, 1968; Fisk, 1974)
Gender is unchanging (Sumerau et al., 2020)	All *true transsexuals* have a gender that is lifelong and unambivalent (Laub & Fisk, 1973) All *true transsexuals* have known they were gender-variant since early childhood (Stoller, 1968)

Bringing the expectations together, it is evident that in only validating some gender-variant people as *true transsexuals* and excluding others from accessing surgical and hormonal treatment, medical experts produced the hierarchy of legitimacy that the literature on transnormativity identifies as a crucial aspect of the ideology. Not only was this hierarchy dependent upon the ability to pass and "blend in" with cisgender society, it also placed heterosexuality and heteronormative family life above all other kinds of relationships and family structures. As well, it privileged those who were white, who were more likely to get a diagnosis of transsexualism and access treatment, as well as those who had the class privilege of being able to access resources to help them present in heteronormative binary gender ways.

Moreover, this hierarchy also placed AMAB gender-variant people above AFAB gender-variant people in being able to fulfill the expectations of medical experts and embody the *true transsexual*. The language used structured medical expert understandings such that the "ideal" transsexual was, in fact, an AMAB gender-variant person. Although this hierarchy is implicit in most of the primary sources, Stoller (1968) did make this requirement clear, stating that "only those males who are the most feminine, have been expressing this femininity since earliest childhood, have not had periods of living accepted as masculine males, have not enjoyed their penises, and have not advertised themselves as males" should qualify for hormonal and surgical treatment (p. 251). Because of the different social context within which AFAB gender-variant people would have been raised and lived, as well as their different relationship to the wrongness of their bodies and genitals, AFAB gender-variant people would likely have had greater difficulty stepping into the *true transsexual* subject position and accessing hormonal and surgical treatment; they would thus be lower in the hierarchy of legitimacy.

Additionally, medical experts using the word “true” also contributed to the production of a hierarchy. Although seemingly simplistic, anyone who did not qualify as a true transsexual was necessarily not only not true but potentially “pseudo” or even false. Furthermore, not qualifying as a true transsexual also carried with it the potential meaning that one’s transsexualism was not “in accordance with fact or reality” (Oxford University Press, 2020e, para. 2), which could mean delusional, or not “authentic” or credible (para. 3), suggesting a possible perversion. Together, these meanings further produced groups of gender-variant people whose transsexualism was in some way inferior, incomplete, or not even real; a hierarchy of legitimacy.

6.5 Conclusion

As discussed in the previous chapter, the WBD has three distinct tenets that were not only identified in the secondary sources (chapter 2, literature review) but also evident throughout the primary sources. The actual discourse, however, and its use by medical experts, was far less clear and precise. Not only was the discourse based on the experiences of a subset of gender-variant people—those assigned male at birth—medical experts also came to expect additional characteristics that gender-variant people had to embody in order to be granted access to hormonal and surgical treatment. These expectations largely reflected white middle-class binary gender and heteronormativity, and appear to have been linked to attempts by medical experts to demonstrate the validity of their approach to treating transsexualism through surgery and hormones. In their attempts to defend their treatment of transsexualism, medical experts produced a subject position, the *true transsexual*, a combination of the WBD and medical-expert expectations and assumptions, that they required gender-variant people to step into in order to be considered good candidates for treatment. The *true transsexual*, however, did not represent all gender-variant people, but rather was based not only in white middle-class binary gender and

heteronormativity, but also on the experiences of AMAB gender-variant people. This disadvantaged a number of different groups of gender-variant people in their attempts to gain recognition as transsexuals and access surgical and hormonal treatment by defining their gender variance as not legitimate in some way. In short, it had the ideological effect of producing transnormativity.

7 Conclusion and Future Directions

This dissertation began with questions of how the wrong-body discourse (WBD), one of many possible ways to conceptualise and articulate gender variance, became the dominant medicalised discourse in Canada and the United States, and what some of the ideological effects of this were. To answer these questions, I looked to publications intended for medical-expert audiences in order to trace the trajectory of the WBD from the earliest mentions to its institutionalisation in the *DSM-III* diagnosis of transsexualism in 1980. I found a number of possible factors that likely contributed to the dominance of the WBD. I also noticed some themes that suggest that the WBD and *true transsexualism* are implicated in wider material interests than the three-tenet WBD model would imply. In this chapter, I revisit each of my research questions, tying together all of my research to answer each in turn. I then explore some of the implications of my research as a whole. Following this, I discuss the limitations of my research, before closing the chapter with potential future directions for myself or other researchers to explore.

7.1 Answering the research questions

Although this research represents only a partial account of how the WBD developed and became dominant, the primary sources show strong enough trends that I can make several arguments which have enough support to be compelling. I outline each of them here as they pertain to the four research questions that I outlined in my introduction chapter.

7.1.1 How did the WBD develop?

The primary sources discussed in chapter 5 reveal that the WBD developed through three distinct tenets—wrongness of the body; a disjuncture between sex and gender; and hormonal and surgical solution. These are the same three tenets that I identified from the secondary literature reviewed in chapter 2. Although related to one another, each tenet followed its own trajectory of

development beginning during the "prospecting" stage of medicalisation and into the claims-making competitions stage.[37] The earliest articulation that is recognisably related to the WBD was the idea of a female soul trapped in a male body. Over time, this idea developed into the body being experienced as somehow "wrong." Parallel to this, the idea of *feeling like* a woman shifted into articulations of *being* a woman before finally being articulated in terms of a misalignment or disjuncture between sex and gender. The development of this second tenet is particularly closely linked to the development of sex and gender as concepts, as it depended on the development of "gender identity" as separate from sex in the mid-1950s in order to take the form in which it appeared in the WBD. Alongside these two developing tenets, gender-variant people were asking medical experts for treatment. While at first, gender-variant people rarely asked for any specific treatment, it appears that as treatment became more widely known, particularly through popular media stories of transsexual celebrities like Christine Jorgensen, gender-variant people began to request specific treatments. Medical experts came to conceptualise gender-variant people in terms of those treatments, but also concluded that hormones and surgery were the appropriate and even only possible treatment for transsexualism.

The publication of *The Transsexual Phenomenon* by Harry Benjamin in 1966 marked not only the moment when the three tenets were brought together into one coherent discourse, but also the moment when Benjamin claimed ownership over transsexualism and other medical experts who also conceptualised gender variance in terms of the WBD gained discursive authority and legitimacy in their approaches. According to Benjamin (1966), transsexualism was defined by three key criteria: feeling trapped in the wrong body and hating one's genitals (tenet

[37] Recalling Conrad and Schneider's (1992) model of medicalisation discussed in chapter 1, the five steps are: 1) a human phenomenon socially defined as deviant; 2) medical-expert "prospecting"; 3) claims-making competitions; 4) claiming ownership; and 5) institutionalisation (p. 266-271).

1), feeling "feminine" (specifically, because his model was based almost exclusively on AMAB gender-variant people) (tenet 2), and both asking for, and needing, hormonal and surgical treatment (tenet 3). Because this was the first medical reference book on transsexualism in Canada and the United States (Meyerowitz, 2002), and because of Benjamin's dominance of the field, his book set the standard for how medical experts would understand and evaluate gender-variant people seeking treatment for their gender variance. The primary sources showed that Benjamin's conceptualisation of transsexualism was prevalent among the publications that followed, supporting my contention that his book marked the moment when Benjamin claimed ownership over the medicalisation of gender variance. This centralisation of a particular understanding of transsexualism—through the WBD—was then institutionalised in the first version of the *Standards of Care* (*SoC ver. 1*) published in 1979 by the Harry Benjamin International Gender Dysphoria Association (HBIGDA, now the World Professional Association for Transgender Health, WPATH) and the 1980 diagnosis of transsexualism in the *Diagnostic and Statistical Manual of Mental Disorders-III* (*DSM-III*) published by the American Psychiatric Association (APA).

7.1.2 How did the WBD become the dominant discourse?

In chapter 5, I demonstrated not only that the WBD developed over time and only really became a coherent discourse in the mid-twentieth century, but also that there were a number of factors that likely contributed to the dominance of this particular discourse over others. First and foremost, the discourse itself had several characteristics that made it quite robust. It was compatible with numerous etiological theories because it did not depend on any particular etiology to make sense and so a variety of medical experts could use it. It also followed the discursive pattern of how experiences become diagnoses, requiring no extra labour on the part of

medical experts to follow what to them would have been a familiar discursive pattern. Each tenet developed on its own such that they had independent foundations and a challenge to one tenet did not immediately translate into a challenge to the entire discourse. And finally, the WBD was based in medical and scientific discourses. As a result, it made sense to medical experts already using medical and scientific discourses in the course of their work.

The second factor lay in the involvement of a small group of people who dominated the publication field and cited not only one another but themselves repeatedly. Of the 131 sources that met the criteria for this research project, 122 were written by medical experts. Of these, 64 were written or edited by: Harry Benjamin, Richard Green, John Money, and/or Robert Stoller. These same people were involved in the development of gender identity clinics, the *SoC ver. 1,* and the *DSM-III* diagnosis of transsexualism. This, together with the fact that when gender-variant people's opinions were included, they were chosen and managed by medical experts, meant that what was published was dominated by very few people who often worked together and drew on one another's ideas.

The contributions of gender-variant people were further limited by the distrust and suspicion with which medical experts treated what gender-variant people said. The primary sources showed that medical experts routinely characterised their patients as manipulative and demanding, believing them to have a selective memory and likely to distort their histories and symptoms in order to gain access to treatment. Although some medical experts acknowledged that gender-variant people were looking to Benjamin's book, they took this not as a question regarding the representativeness of the discourse but as evidence that patients were not to be trusted, that they were being dishonest. This significantly limited possible challenges to the WBD, not only because gender-variant people did not feel they could divulge when their

experiences differed from what medical experts expected, but also because if they did, they were more likely to not get access to treatment rather than to shift the minds of medical experts.

7.1.3 How was the WBD actually used by medical experts?

In chapter 6, I showed that while the WBD appeared precisely defined in medical expert publications, in practice, the WBD itself as well as its use were significantly messier. With the deluge of gender-variant people requesting treatment, other medical experts questioning the validity of treating transsexualism with hormones and surgery, and the newness of the WBD, medical experts were faced with a complicated and difficult situation to navigate. Medical experts responded to these challenges by developing the idea of *true transsexualism*, which they based on three meanings of the word "true:" accurate, factual and real, and authentic. Using *true transsexualism*, medical experts differentiated among the numerous gender-variant people who were showing up at their offices requesting hormonal and surgical treatment for gender variance. In this way, they could also legitimate the use of hormones and surgery as the treatment for a small subset of the gender-variant people who asked for the treatment. And finally, they could help stabilise the new discourse that explained the phenomena of gender variance.

Whereas in medical texts transsexualism was defined by the WBD, in practice, *true transsexualism* was based on the WBD together with a number of additional characteristics that medical experts treated as almost equal in weight to the explicit diagnostic criteria. The primary sources reveal that medical experts expected that *true transsexualism* would always involve a binary gender presentation, along with a lifelong, stable gender identity. Medical experts also believed that in all cases of *true transsexualism*, gender-variant people would be heterosexual after treatment, but that before treatment they would be asexual due to their hatred of their own genitals which would, according to the medical experts, prevent them from being able to have

sexual relationships. And finally, medical experts assumed that *true transsexualism* was characterised by abject misery prior to treatment, and they expected gender-variant people to be emotionally unstable and unable to hold jobs. Together, this meant that while many gender-variant people met the diagnostic criteria for transsexualism, only some met the added expectations of *true transsexualism*, and thus only some were granted access to hormonal and surgical treatment.

7.1.4 What ideological effects did the WBD have?

In chapter 6, I discussed how the way the WBD was put into practice by medical experts had the effect of producing the ideology of the *true transsexual*, a person who embodied not only the WBD but also all of the added characteristics that medical experts had come to expect gender-variant people to have. The problem with the *true transsexual*, however, was that this "ideal" transsexual was not representative of the full range of gender-variant people who wished to have medical treatment. Rather, it reflected not only white middle-class binary gender and heteronormativity, but also the experiences of AMAB gender-variant people, particularly their relationship to their genitals. In using the *true transsexual* as the standard against which they judged all gender-variant people who came for treatment, medical experts produced a hierarchy in which some people's gender variance was seen as legitimate, and others' was not, in particular AFAB gender-variant people but also any gender-variant person who did not embody the same appearance and life goals. In short, some people were seen as more "truly" transsexual than others. This was the kind of hierarchy of legitimacy that Johnson (2015; 2016) argued is a hallmark of transnormativity. Indeed, just like transnormativity presents all gender-variant people as having the same desires, experiences and goals, medical experts believed that all *true transsexuals* wanted the same things in life: to live quiet lives, have spouses and children, and

disappear into cisgender society. This suggests that *true transsexualism* and the *true transsexual* were one of the earliest forms of transnormativity in Canada and the United States.

7.1.5 Tying it all together: The feedback loop

Overall, this dissertation suggests that one of the key processes underpinning the WBD and its rise to dominance, as well as the development of ideological effects, was a feedback loop between medical experts and the gender-variant people who interacted with them. As is evident in the historical contextualisation (chapter 4), this relationship stands out in the secondary literature. While some authors focused on the influence of medical experts and others looked at how gender-variant people shaped the medicalisation of gender variance, together they created a picture of the WBD developing within a context in which medical experts influenced gender-variant people, and gender-variant people influenced medical experts. The primary sources analysed in this dissertation help clarify the details of this relationship.

According to Cromwell (1998), the WBD was imposed on gender-variant people in a top-down process of discursive development. The secondary literature shows that gender-variant people were keenly aware of medical experts' expectations, especially those related to the WBD and *true transsexualism*, and of the power relationship between themselves and those medical experts (see: Bolin, 1988; Denny, 2002; Meyerowitz, 2002). Medical experts were gatekeepers of treatment, and violating their expectations would mean not being able to access hormonal and surgical treatment (Meyerowitz; Gill-Peterson, 2018). As a result, gender-variant people presented themselves, their experiences and their histories carefully to ensure that medical experts would recognise them as *true transsexuals* and provide them with treatment (Denny; Bolin). Medical experts, on the other hand, saw this as validation of their conceptualisation of transsexualism and of the WBD-based model (Bolin; Meyerowitz). There is also evidence,

however, that gender-variant people played an active role in shaping the medicalisation of gender variance. In particular, Matte (2014) demonstrated that Reed Erickson and the Erickson Educational Foundation (EEF) had a stake in supporting this particular medicalised model of gender variance as it conferred medical and social legitimacy on gender variance that was otherwise inaccessible. Through the EEF, which provided a large portion of the funding for research on and treatment of gender variance (Matte; Meyerowitz), gender-variant people actively shaped the direction that medicalisation of gender variance took. Although not discussed in the secondary literature, it is possible that the medical experts whom the EEF funded saw this financial support as validation of their WBD-based model of transsexualism in a similar way to how they saw gender-variant people embodying medical-expert expectations as validation.

The analysis presented in this dissertation helps develop a more detailed understanding of this process. Rather than being top down or bottom up, this analysis demonstrates that the most likely relationship between medical experts and gender-variant people was a feedback loop. Although gender-variant people knew what they had to say to be seen as legitimately transsexual, the primary sources suggest that in addition to this, gender-variant people may have also been articulating experiences in similar ways because these articulations resonated. As discussed in depth in chapter 5, medical experts included the words of gender-variant people throughout their publications. Although these words were likely edited and selected using a medical-expert lens, and thus they cannot on their own stand in for what gender-variant people thought, saw or felt, they nevertheless do offer a glimpse of gender-variant people's contributions to the discourse. In particular, in the earliest stages of medicalisation when the WBD was not yet formed, the repetition in gender-variant people's words suggests that those experiences were, indeed, shared by at least some gender-variant people. With nothing at stake

tied specifically to the WBD at that time, the similarity among at least some gender-variant people's experiences suggests that the WBD is based on an actual experience rather than entirely imposed on gender-variant people by medical experts.

Indeed, the question of where the idea of transsexuals being *trapped* in the wrong body originated may never be answered completely. However, there is evidence in the primary sources that the originator of the phrase may have been a gender-variant person. The appendix to Benjamin's (1966) book *The Transsexual Phenomenon* includes a direct quotation from "Clara" that she "was a woman, but was deformed by being trapped in the body of a man" (p. 269). It is possible that "Clara" was a pseudonym, specifically for a trans feminine person named Carla Erskine. According to Timm (2020), Carla had a significant relationship with Harry Benjamin, exchanging letters with him in the early 1950s on numerous topics related to transsexualism. Carla also had connections to Louise Lawrence and Christine Jorgensen, and although in the end she decided that becoming famous was not something she was prepared to do (and even asked her surgeon to not publish her name when reporters wanted to write about her transition), it is evident from Timm's work that Carla had a significant role in the community. If, indeed, "Clara" was Carla, it is possible that the phrase "being trapped in the wrong body" either came from a gender-variant community, or in conversation between gender-variant people and medical experts, and then entered Benjamin's sphere of influence through Carla, among others.

The analysis in chapters 5 and 6 also suggests that this feedback loop tightened over time, limiting the possibilities for various conceptualisations of gender variance to be seen as legitimate. As shown in chapter 5, the WBD developed out of three individual tenets which became more coherent until they were explicitly articulated in their final form by Benjamin (1966). Describing the tenets as increasing in coherence is, however, the same as saying that the

articulations of the WBD decreased in variability, both in terms of the kinds of quotations included by medical experts, and in the discussions medical experts themselves had in their publications. The analysis in chapter 6 suggests that this decreasing variability was likely inextricable from the development of *true transsexualism*, as additional expected characteristics meant that fewer gender-variant people were seen as legitimately transsexual, and increasingly, variation in gender-variance presentation and experience was excluded from being seen as legitimate and thus being able to affect how gender variance was conceptualised.

It is undeniable that many gender-variant people have had to reject parts of themselves in order to fit the WBD and *true transsexualism* so that they could access treatment, and this kind of coercion precludes true consent and equal participation (Silver, 2013). However, the primary sources reveal that the relationship between medical experts and gender-variant people is more complex than simply a top-down imposition of medicalisation. Even in a collection of sources overwhelmingly written by medical experts—the primary sources in this research—gender-variant people's contributions are evident. It would appear, then, that underpinning the development of the WBD, its rise to dominance, and the development of the *true transsexual*, is a feedback loop of medical experts and gender-variant people, each with their own interests, trying to navigate both the decisions of the other and the historical context within which they were operating.

7.2 Implications

Having answered the four research questions that I set out to address through this dissertation, I come to this question: what does any of this analysis mean? What does studying the development of the WBD and the *true transsexual* actually offer? I argue that there are two main implications. First, there are various material interests at play that need to be considered

when examining the WBD and its effects. What material interests come into play and could therefore be triggered and challenged—and potentially defended by those who benefit—by a challenge to the WBD? And second, medical experts saw far more AMAB gender-variant people than AFAB gender-variant people during the development of the WBD. Knowing the effects this had on the shape of the discourse, could this have other effects on AFAB gender-variant people?

7.2.1 Material interests

Looking at the data discussed in chapters 5 and 6, together with Fairclough's (1989) definition of ideology as a set of ideas that "arise[s] from a given set of material interests" (p. 94), it is evident that the *true transsexual* was an ideology based in the WBD. As an ideology, it reflected certain material interests, though in texts those material interests often appeared only as traces and sometimes not at all (Wodak, 2001; Carvalho, 2008). Indeed, some of the material interests relevant to the development of the WBD and *true transsexualism* can only be inferred from the historical context that I discussed in chapter 4. However, four are evident. First, the ideology of *true transsexualism* was a way for medical experts to reinforce their professional status. Second, *true transsexualism* was a way to reinforce medical expert authority and dismiss laypeople's expertise about their own lives. Third, *true transsexualism* supported the gendered and racialised hierarchy that presented white middle-class binary gender and heteronormativity as "normal." And fourth, medical expert expectations of gender-variant patients during and after treatment contributed to, and served interests based on, cisnormativity.

The first of these material interests lay in the professional positions of the medical experts who treated transsexualism with hormones and surgery. For the entirety of the history of the medicalisation of gender variance, medical experts who treated transsexuals as anything other than people suffering from delusions or perversions were treated with suspicion and their

medical authority questioned and challenged (Meyerowitz, 2002; Wiggins, 2020). Recalling the uses of "true," medical experts deployed *true transsexualism* in order to differentiate among gender-variant people and to legitimate the treatments they were providing. Underpinning these uses, however, were medical expert anxieties that other medical experts saw treatment of transsexualism with hormones and surgery as dangerous, unprofessional or even unethical. Indeed, Meyerowitz noted that medical experts "tailored their medical model to enhance the public image of the program" (p. 226). How medical experts were perceived was evidently of significant concern. Deploying the ideology of *true transsexualism*, then, was a way for medical experts to bolster their professional positions not only as experts of transsexualism but as medical experts in general.

Related to this is the second material interest, that of institutionalised medicine and the authority of medical experts over laypeople/patients. During the claims-making stage of medicalisation, there were "turf wars" between various medical experts who were each trying to present their interpretation of transsexualism as the most accurate. However, in addition to this, there was a clear demonstration of distrust towards gender-variant people. Medical experts saw gender-variant people as obsessive and manipulative. They characterised requests for surgical treatment as demands, and frequently referred to gender-variant people as having a tendency to distort and as being unreliable. Frequently, gender-variant people who came to gender clinics met all of the necessary diagnostic criteria but were nevertheless turned away, told that they were not *true transsexuals* (Denny, 1992). This was especially common in gender-variant people of colour, who were instead given diagnoses of homosexuality or schizophrenia despite not meeting the criteria for those disorders and meeting the diagnostic criteria for transsexualism (Gill-Peterson, 2018). It is evident, then, that medical experts routinely ignored the lived experiences

of gender-variant people and their own self-knowledge about their gender variance. While it is not possible to say with certainty why this was the case, the effect of these practices were clear: institutionalised medicine maintained authority over gender-variant people themselves in the context of gender variance, reifying the overall position of institutionalised medicine as the producer of knowledge and truths about human phenomena.

The third material interest was that of the overall organisation of a society that is based on racialised and classed binary gender as well as heteronormativity where "normal" is defined by being white, middle-class, heteronormative and binary-gendered. Unlike the previous two material interests, it is significantly more difficult to pin down exactly *who* specifically benefits in this situation. Nevertheless, this material interest haunted interactions between medical experts and gender-variant people from before the WBD was solidified and before transsexualism became an official diagnosis. From the earliest days of the WBD, medical experts judged gender-variant people using white middle-class binary gender and heteronormativity standards. This was significantly more obvious as medical experts turned their expectations into a set of secondary criteria almost equal in weight to the official diagnostic criteria when they began to use *true transsexualism* rather than the WBD as the guide to granting treatment: gender-variant people of colour were significantly more likely to be denied access to treatment and even to the diagnosis of transsexualism than were white gender-variant people. Through the regulatory effects of medicalisation, medical experts maintained their own socioeconomic positioning as well as the discourses upon which that socioeconomic positioning was based. This served to reify the positions of whiteness, middle-class-ness, heteronormativity, and binary-gendered-ness as *normal* and all other ways of being as deviant or abnormal.

Building on the previous material interest in which medical experts reified the *normality* of white middle-class binary gender and heteronormativity, the fourth material interest was that of cisnormativity, the privileging of cisgender experiences and points of view (Boe et al., 2020). Underpinning cisnormativity is the idea that although sex and gender are not the same, there is nevertheless a natural and normal gender for each of the two binary sexes: males become boys/men and females become girls/women. In a mutually-reinforcing system, cisnormativity maintains binary sex and binary gender, and each of the binaries maintain cisnormativity. Medical experts' investment in cisnormativity was evident not only in the expectations they had of gender-variant people presenting heteronormative binary gender, but in their expectation that gender-variant people would, upon receiving treatment, disappear into society. Medical experts required that gender-variant people would demonstrate their own investment in binary gender and heteronormativity such that they would not disrupt gendered expectations in society, or, in other words, they would not disrupt *cisnormative* expectations. Moreover, medical experts expected that, upon receiving treatment, gender-variant people would stop associating with other gender-variant people, further maintaining cisnormative assumptions in Western society by limiting the visibility of, and thus awareness of, gender variance.

7.2.2 Predominance of gender-variant patients assigned male at birth

As discussed throughout this dissertation, medical experts saw significantly more AMAB gender-variant people than AFAB gender-variant people during the development of the WBD. This likely had an impact on the way that the WBD developed, particularly in the centralisation of the relationship to genitals, which is not reflected in AFAB gender-variant experiences (see section 6.1.2). Although not widely discussed in the secondary literature, Cromwell recognised that this predominance of AMAB gender-variant people seen by medical experts likely had an

impact on how medical experts viewed and understood AFAB gender-variant people. In addition to believing that AFAB gender-variant people were exceedingly rare (Benjamin, 1966), medical experts also believed that transvestism did not occur in AFAB people at all (Cromwell, 1998; see also: Benjamin). Further, AFAB gender-variant people were conceptualised as a significantly more homogeneous group (Cromwell, 1999), and much more androgynous than AMAB gender-variant people who, according to medical experts, more often demonstrated exaggerated binary gender presentations (Cromwell, 1998). I argue that the primary sources, together with Cromwell's assertions, suggest some further possible effects: AFAB gender-variant people may not have recognised themselves as transsexuals; medical experts may have been more inclined to reject AFAB gender-variant people and so fewer AFAB gender-variant people may have taken the time and risk to interact with medical experts; and more AFAB gender-variant people may have turned to other ways of self-identifying.

First, although the primary sources demonstrate that gender-variant people were aware of the WBD and even used it, it is significantly likely that AFAB gender-variant people did not see themselves in the WBD because it was based on AMAB gender-variant experiences. Indeed, as both Devor (1997) and Cromwell (1999) noted, some AFAB gender-variant people did not even identify their own gender variance as transsexualism or as treatable for many years because the only examples they saw or heard about were of AMAB gender-variant people that specifically qualified for a diagnosis of transsexualism. All of the transsexual celebrities during the period up to 1979, such as Christine Jorgensen and Renee Richards, were AMAB gender-variant people, and so many AFAB gender-variant people did not realise that "transsexuals" could also have been AFAB, or that there was any treatment that they could be offered (Devor). Although neither

Devor nor Cromwell tie this specifically to the way the WBD was defined and used by medical experts, it is likely that there is a relationship.

Second, it is also possible that fewer AFAB gender-variant people than AMAB gender-variant people were seen by medical experts because AFAB gender-variant people chose not to interact with medical experts in the first place. This may have been the result of two different situations. First, because medical experts defined *true transsexualism* by the desire for genital surgery, anybody who did not want genital surgery—even if they wanted everything else—was seen as not a *true transsexual*. This was likely known by many AFAB gender-variant people as information about medical experts and how to best interact with them was widely shared among gender-variant people as a whole (Bolin, 1988), and so knowing they were likely to be denied treatment and even a diagnosis of transsexualism, AFAB gender-variant people may have chosen to not even try. And second, since many AFAB gender-variant people did not want genital surgery, they may have believed themselves to be something other than *true transsexuals* since they did not meet that criterion.

This leads to a third possible effect: the exclusion of AFAB gender-variant people from the WBD may be one of the reasons why more AFAB gender-variant people than AMAB gender-variant people identify specifically as non-binary. It is possible that those who do not see themselves in the WBD may still recognise themselves as gender variant. As a result, they may look for other possible identities that resonate, such as non-binary. Non-binary is a gender identity that is "not male or female…but does not exclude people who are intersex or have a diversity/disorder of sexual [*sic*] development" (Richards et al., 2017, p. 5). Moreover, non-binary is an identity that includes "people who identify as a single fixed gender position other than male or female…those who have a fluid gender…those who have no gender" as well as

"those who disagree with the very idea of gender" (p. 5). This kind of identity, then, can include AFAB gender-variant people who, by virtue of not wanting genital surgery, do not see themselves reflected in the WBD.

Drawing these possible effects together, my research suggests that anything that is based on the WBD, such as diagnosis, treatment protocols, policies, and best practices, may not actually be appropriate or "best" for the majority of gender-variant people. The WBD carries with it the specificity of a particular experience—that of white AMAB gender-variant people who chose to interact with medical experts—and thus so does anything that treats the WBD as the foundation for understanding gender-variant people and experiences. The vast network of policies and practices that affect gender-variant people in Canada and the United States may need to be reassessed beginning at the foundation in order to address concerns that gender-variant people have raised about how representative and applicable these policies and practices are.

7.3 Limitations

There are a number of limitations that arose from decisions I made in the course of this research. Some were a result of my particular position as a PhD candidate at a Canadian university during the COVID-19 pandemic, while others were the result of methodological practices that I chose for my research. As a result, although the research presented here was thorough, it also provides an incomplete picture. On the other hand, this does provide opportunities for future research, which I outline in the last section of the conclusion chapter.

The first limitation of this research project lies in the fact that although I have experience with the German language, I am not fluent, and therefore could not read texts that were not translated into English. The literature review and historical contextualisations both suggest that

there are likely relevant texts to be found written in German prior to 1860, but finding these texts and understanding them was beyond the scope of this project. This limitation is significantly mitigated by Meyerowitz's (2002) contention that texts written in English were the most influential on the medical experts in Canada and the United States. Nevertheless, many experts did have ties to Germany and spoke German, such as Benjamin who was born in Germany (Gill-Peterson, 2018; Devor, 2021), and the influence of texts written in German would have come through Benjamin in ways similar to the influence of German eugenics ideas (Gill-Peterson). Moreover, translations always involve loss of original meaning and the production of new meaning, as translators—even the most educated and experienced translators—bring something of themselves to the translation. In the case of my data, the majority of translations were all produced by the same translator (Michael A. Lombardi-Nash), whose expertise in older German texts on sex, gender and sexuality is unmatched (Kennedy, 2002a; 2002b). His influence, then, is likely significant, though at the same time, it is impossible to measure with certainty. The fact that I am limited to English, then, likely had many facets of influence on this research project.

The second limitation comes from the outright lack of research on the medicalisation of gender variance in Canada as well as the use of the *DSM* in a Canadian context. Although, as discussed in chapter 3 (section 3.3.1.1), there is a strong argument for the relevance to Canada of the work that has been published to date on the medicalisation of gender variance in the United States, the question of exactly how this process played out in Canada remains entirely unanswered. The relevance is, rather, ascertained mostly through outcome: Canadian gender identity clinics were based on the American model (Matte, 2014); the *DSM-III* was adopted as the manual of mental disorders over the *ICD-9* despite the *ICD-8* having been used in Canada prior to this alongside the *DSM-II* (Kogan & Paterniti, 2017; Junek, 1983). Beyond this level of

relevance, however, it is unclear whether there were Canadian challenges or influences, or if there existed different applications of the WBD by Canadian medical experts. Moreover, it remains unclear whether Canadian medical experts had any role at all in the development of the WBD and its institutionalisation as the *DSM-III* diagnosis of transsexualism (APA, 1980).

The third limitation comes from the closure of the University of Victoria library due to COVID-19. While I had by this point accessed almost all of the texts written by medical experts and thus only found that I could not access 10 texts out of 121 that matched my criteria, I was unable to access any texts written by gender-variant authors that were not available through the library website. This means that I was unable to include all of the print media that was available in the Transgender Archives. Indeed, I was not able to even look through the documents and had only looked through the finding aid, and thus I am unable to state how many texts would have met my criteria. Unfortunately, I can only identify key gender-variant people who were discussed in the literature review and the historical contextualisation, and these I have included in the analysis and discussion.

The fourth limitation that it is important to consider is the fact that the development of the discourse, despite being a medical discourse, cannot be adequately accounted for by looking solely at medical expert texts. Rather, there are numerous discursive realms that played a part in the development and trajectory of the WBD during the time period that this project covers, such as autobiographies by transsexual and other gender-variant people; letters and newsletters shared between gender-variant community members; sensationalist pulp novels about transsexualism; news media stories; daytime television programmes; other popular media representations of transsexualism; pamphlets put out by support organisations; and laws regarding sex, gender and sexuality. As Foucault (1981) noted, discourses exist in mutually constitutive relationships with

other discourses across numerous discursive realms. As a result, the analysis here is only a partial answer to the questions I have posed.

The final limitation that must be recognised is the way in which I ascertained influence. Although number of citations is a reasonable way to measure whether or not a particular publication is being widely read, in order to establish *when* a particular work was influential is significantly more difficult. To do this, I would have had to make a list of all the publications that cited the texts I included, and then counted the number that were in each decade. Otherwise, the number of citations could reflect more recent use of the text. Two examples particularly stand out. The first is Ovesey and Person's (1976) article titled "Transvestism: A disorder of the sense of self." According to Google Scholar, the original article was cited only 61 times, excluding it from this research, but the 1999 reprint was cited 110 times. This demonstrates that the measure of influence I devised using the number of times a source was cited cannot account for temporality. The second is Hirschfeld's (1910/1991) book, *Transvestites*. According to Bullough (2007), this book was not translated into English until 1991, and thus its influence on medical experts operating in Canada and the United States was likely significantly limited. On the other hand, the historical contextualisation chapter demonstrates that Benjamin was connected to many German medical experts and brought their ideas with him to the United States. Despite this, Hirschfeld's book met the criteria for influence I had set, suggesting that my criteria could not account for such factors. This limitation, however, did not cause unnecessary exclusions, but rather likely included texts as influential that may not have been as influential at the time. A citation number of zero, for example, would mean that even when the text was published, it was not likely cited. In contrast, a citation number of 100 could mean the text was cited widely when it was published or any time between its publication date and the time I looked up the text in

databases that show citation counts. Thus, while I likely did not miss influential texts, I may have included some texts in the analysis that were not as influential as they seemed. Unfortunately, this limitation did not become clear until after I had already completed the data collection.

Although there are a number of limitations, this does not mean that the present research is without merit. Having a basis in Foucauldian analyses of power and knowledge production, I do not contend that this research—or any research—can provide a complete picture. All research is always partial, and together with other published works, can produce a more thorough overall picture. Therefore, while this research has its limitations, it nevertheless contributes significantly to the understanding of how the WBD developed.

7.4 Future directions

This dissertation answers a number of questions. However, it also leaves a number of questions unanswered, opening up possibilities for future research. While there is not enough room to outline all of the possible questions that could arise from this research, I have selected the ones I believe are most important in relation to the goals I have set out for this dissertation. Each, I believe, would help provide a more comprehensive picture of how the WBD developed.

In what ways did gender-variant people contribute to the development of the WBD?

Recalling the limitations discussed in chapter 3 and the previous section of this chapter, I originally intended to include texts written for medical experts by gender-variant people in this research project. This could have taken the form of newsletters, direct letters, or other publications. Conducting such research could enrich the preliminary understanding of the involvement of gender-variant people in the medicalisation of gender variance that I have presented here. This dissertation demonstrates that a feedback loop existed between medical experts and gender-variant people, and that this feedback loop is evident in the works of medical

experts. However, how well the words included by medical experts reflected what gender-variant people actually meant cannot be discerned from the data that I analysed here. The primary sources suggest that medical experts had points of contact, specific gender-variant people who connected both with gender-variant communities and with the medical experts. Moreover, the historical contextualisation suggests that gender-variant people did not always identify, or even agree, with the WBD. Understanding how the discourse developed and was used within gender-variant communities could clarify the role gender-variant people had in the development of the WBD and in the medicalisation of gender variance. It could also reveal information about those gender-variant people who chose not to interact with institutionalised medicine.

What other literature has been written about the WBD?

In searching for literature on the WBD, I found a number of references to something researchers called "the medical model." It appeared similar to the WBD, but was not explicitly defined nor was it explicitly characterised by the idea of being in the wrong body. However, some of the ways in which researchers have discussed this medical model suggest a relationship to the WBD. Wilton (2000), for example, discussed the medical model together with what she called "discourses of MTF transsex" (p. 237) in the context of her own discomfort with "the notion of a woman trapped or concealed in a man's body" (p. 237). Lev (2005), on the other hand, noted that there are consequences to the medical model, consequences that I would argue are very similar to the ideology of transnormativity and the hierarchy it creates. It is also possible that literature on "the traditional transsexual narrative" is related (Pearce, 2018, p. 34), as Pearce discussed the structuring effects this narrative has had on both medical-expert texts and autobiographical publications. It is possible that these writings could add to contemporary

understandings of how the WBD developed, as identification of the discourse may be related to gender-variant challenges to it.

How did institutionalisation affect the WBD?

In order to make this dissertation manageable in size, I changed the end date from 1999 to 1979. However, the original end date of 1999 would have included the period after the institutionalisation of the WBD in the diagnosis of transsexualism to when gender-variant patients began to connect with one another using social media. Based on the ways in which the diagnosis has changed through subsequent iterations of the *DSM*, it is likely that the WBD has been challenged and engaged with in ways that could be evident in data from 1980 to 1999. Moreover, the possible shifts in power relationships between medical experts and gender-variant people, first through self-diagnosis which arose in the 1980s (Conrad, 2007) and then through the community-building activities made possible by the Internet and social media (Cavalcante, 2016; Anshu, 2020) could be particularly revealing for understanding the development of the WBD. This research could also take the form of looking at how the WBD developing throughout these two time periods (1980 to 1999, and then 2000 to the present) has related to transnormativity.

How did the various medical-expert texts relate to one another?

In this project, I chose to measure influence using Google Scholar and Web of Science to find citation numbers. It is possible, however, that these numbers are incomplete, and it would be particularly useful to map out who cited whom and also when. This could provide a more accurate picture of influence at the time of publication and over the course of the period of interest. Recalling the discussion in chapter 3 and the previous section of this chapter, the numbers I used were a total citation count that I did not realise, until after I had completed my analysis, reflected citation totals *across all time* and therefore did not, in fact, accurately reflect

influence during the period of 1860 to 1979. Future research could take up the question of who was influential, and perhaps even who influenced whom through a network map of citations. Even this, however, may not be completely accurate, because it is possible for medical experts to have read publications but not cited those specific ones because they already had better citations, or had different citing practices. Perhaps a better measure of influence could be devised.

What role did the ICD have in the development of the WBD?

In this dissertation, although I recognise that the *International Classification of Disease* (*ICD*), published by the World Health Organisation (WHO), likely played at least some role in the medicalisation of gender variance in the United States and Canada, I was not able to address the relationship between the *ICD* and the development of the WBD. The historical contextualisation literature, however, suggests that the *ICD* was not inconsequential. According to Matte et al. (2009), the *DSM* was originally developed to address the American context, which many medical experts felt was distinct from the European context within which the *ICD* was developed. This immediately situates the *DSM* and all of its diagnoses in a relational context to the *ICD*. The proximity of inclusion dates for a diagnosis of transsexualism also suggests a relationship: the *ICD-9* included it in 1975, whereas the *DSM-III* included it in 1980 (Beek et al., 2016). Researchers have also noted the similarity in changes that have occurred to diagnoses in the *ICD* and the *DSM*, such as the category of placement of transsexualism, likely reflecting changes in medical-expert conceptualisations of gender variance (Drescher et al., 2012). Finally, in the context of the WHO moving gender variance from the mental health disorders and placed them in the category "Conditions Related to Sexual Health" effective 2022 (Sudenkaarne, 2020), Beek et al. speculated that since the WHO's influence is greater than that of the APA, the APA

may do the same at some point in the future, again suggesting that there is a link between the *ICD* and the *DSM* that needs to be explored.

What is the relationship between the WBD and biopolitics?

I based chapter 6 on the overarching question of what the WBD does. Although the chapter ended up presenting only part of the original idea I had for the answer—transnormativity as an ideological effect of the WBD—my preliminary maps connected the WBD to biopolitics through the concept of gender. According to Repo (2013), gender was developed as a tool of biopolitics in order to bring human development under control to maintain the social order (p. 230). Whereas, according to Foucault (1990), sexuality had been used as a biopolitical tool from the Victorian Era onward, the shifting understandings of how sex and sexuality developed from innate to learned, and the troubling of earlier understandings caused by disorders of sex development, necessitated a new way of ensuring that the social order was reproduced and maintained. According to Repo, the new concept of gender, understood to be *behavioural* and *learned*, brought early childhood into the realm of biopolitical importance (p. 240). Repo also argued that this conceptualisation of gender could explain, and thus contain the potential threats caused by, gender variance: gender had been *learned wrong*. Together with Irving's (2008) work in which he argues that treatment for transsexualism emphasises an integration of the gender-variant person (back) into the capitalist workforce, this context raises the question: does the WBD play a role in neutralising the potential threat to the capitalist biopolitical project? I suspect that the WBD, in providing a path for gender-variant people who could potentially challenge the concept of binary gender (which, as noted above, is an important biopolitical tool), is key to the neutralisation of gender variance. More than what Repo suggests that gender explains gender variance, the WBD is a way to feed gender-variant people back into the productive role expected

of adults, the role outlined by Irving as a key goal of treatment. Although Irving's discussion is preliminary and does not engage with either WBD literature nor the concept of transnormativity, I believe that such an analysis could be built from the work I have presented here.

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Appendix C: Benjamin's Sex Orientation Scale

Source: *The Transsexual Phenomenon* (Benjamin, 1966, p. 31)

	Group 1		Group 2		Group 3	
Profile	Type I Transvestite *Pseudo*	Type II Transvestite *Fetishistic*	Type III Transvestite *True*	Type IV Transsexual *Nonsurgical*	Type V True transsexual *Moderate intensity*	Type VI True transsexual *High intensity*
Gender "feeling"	Masculine	Masculine	Masculine (but with less conviction.)	Undecided. Wavering between TV and TS.	Feminine. ("Trapped in male body").	Feminine. Total "psycho-sexual" inversion.
Dressing habits and social life	Lives as man. Could get occasional "kick" out of "dressing." Not truly TV. Normal male life.	Lives as man. "Dresses" periodically or part of the time. "Dresses underneath male clothes."	"Dresses" constantly or as often as possible. May live and be accepted as woman. May "dress" underneath male clo`thes, if no other chance.	"Dresses" as often as possible with insufficient relief of his gender discomfort. May live as man or woman; sometimes alternating.	Lives and works as woman if possible. Insufficient relief from "dressing."	May live and work as woman. "Dressing" gives insufficient relief. Gender discomfort intense.
Sex object choice and sex life	Hetero-, by-[sic], or homosexual. "Dressing" and "sexchange" may occur in masturbation fantasies mainly. May enjoy TV literature only.	Heterosexual. Rarely bisexual. Masturbation with fetish. Guilt feelings. "Purges" and relapses.	Heterosexual, except when "dressed." "Dressing" gives sexual satisfaction with relief of gender discomfort. May "purge" and relapse.	Libido often low. Asexual or auto-erotic. Could be bisexual. Could also be married and have children.	Libido low. Asexual, auto-erotic, or passive homosexual activity. May have been married and have children.	Intensely desires relations with normal male as "female," if young. Later, libido low. May have been married and have children, by using fantasies in intercourse.
Kinsey Scale	0-6	0-2	0-2	1-4	4-6	6
Conversion operation?	Not considered in reality.	Rejected.	Actually rejected, but idea can be attractive.	Attractive but not requested or attraction not admitted.	Requested. Usually indicated.	Urgently requested and usually attained. Indicated.
Estrogen medication?	Not interested. Not indicated.	Rarely interested. Occasionally useful to reduce libido.	Attractive as an experiment. Can be helpful emotionally.	Need for comfort and emotional balance.	Needed as substitute for or preliminary to operation.	Required for partial relief.
Psychotherapy?	Not wanted. Unnecessary.	May be successful. (In a favorable environment.)	If attempted is usually not successful as to cure.	Only as guidance; otherwise refused or unsuccessful.	Rejected. Unless as to cure. Permissive psychological guidance.	Psychological guidance or psychotherapy for symptomatic relief only.
Remarks	Interest in "dressing" only sporadic.	May imitate double (masculine and feminine) personality with male and female names.	May assume double personality. Trend toward transsexualism.	Social life dependent upon circumstances.	Operation hoped for and worked for. Often attained.	Despises his male sex organs. Danger of suicide or self-mutilation, if too long frustrated.

Appendix D: *DSM-III* diagnosis full text

Source: *Diagnostic and Statistical Manual III* (APA, 1980, p. 261-264)

302.5x Transsexualism

The essential features of this heterogeneous disorder are a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex. The diagnosis is made only if the disturbance has been continuous (not limited to periods of stress) for at least two years, is not due to another mental disorder, such as Schizophrenia, and is not associated with physical intersex or genetic abnormality.

Individuals with this disorder usually complain that they are uncomfortable wearing the clothes of their own anatomic sex; frequently this discomfort leads to cross-dressing (dressing in clothes of the other sex). Often they choose to engage in activities that in our culture tend to be associated with the other sex. These individuals often find their genitals repugnant, which may lead to persistent requests for sex reassignment by surgical or hormonal means.

To varying degrees, the behaviour, dress, and mannerisms are those of the other sex. With cross-dressing, hormonal treatment, and electrolysis, a few males with the disorder will appear relatively indistinguishable from members of the other sex. However, the anatomic sex of most males and females with the disorder is quite apparent to the alert observer.

Associated features. Generally there is moderate to severe coexisting personality disturbance. Frequently there is considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex.

Course and subtypes. The disorder is divided according to the predominant prior sexual history, which is coded in the fifth digit as 1 = asexual, 2 = homosexual (same anatomic sex), 3 = heterosexual (opposite anatomic sex), and 0 = unspecified. In the first, "asexual," the individual reports never having had strong sexual feelings. Often there is the additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual (object choice is same anatomic sex) arousal pattern preceding the onset of the Transsexualism is acknowledged, although often such individuals will deny that the behaviour is homosexual because of their conviction that they are "really" of the other sex. In the third group, "heterosexual," the individuals claims to have had an active heterosexual life.

Without treatment, the course of all three types is chronic and unremitting. Since surgical sex reassignment is a recent development, the long-term course of the disorder with this treatment is unknown.

Individuals who have female-to-male Transsexualism appear to represent a more homogeneous group than those who have male-to-female Transsexualism in that they are more likely to have a history of homosexuality and to have a more stable course, with or without treatment.

Age at onset. Individuals who develop Transsexualism often evidenced gender identity problems as children. However, some assert that although they were secretly aware of their gender problem, it was not evident to their family and friends. The age at which the full syndrome appears for those with the "asexual" or "homosexual" course is most often in late adolescence or early adult life. In individuals with the "heterosexual" course, the disorder may have a later onset.

Impairment and complications. Frequently social and occupational functioning are markedly impaired, partly because of associated psychopathology and partly because of problems encountered in attempting to live in the desired gender role. Depression is common, and can lead to suicide attempts. In rare instances males may mutilate their genitals.

Predisposing factors. Extensive, pervasive, childhood femininity in a boy or childhood masculinity in a girl increases the likelihood of Transsexualism. Transsexualism seems always to develop in the context of a disturbed parent-child relationship. Some cases of Transvestism evolve into Transsexualism.

Prevalence. The disorder is apparently rare.

Sex ratio. Males are more common than females among people who seek help at clinics specialising in the treatment of this disorder. The ratio varies from as high as 8:1 to as low as 2:1.

Familial pattern. No information.

Differential diagnosis. In **effeminate homosexuality** the individual displays behaviours characteristic of the opposite sex. However, such individuals have no desire to be of the other anatomic sex. In **physical intersex** the individual may have a disturbance in gender identity. However, the presence of abnormal sexual structures rules out the diagnosis of Transsexualism.

Other individuals with a disturbed gender identity may, in isolated periods of stress, wish to belong to the other sex and to be rid of their own genitals. In such cases the diagnosis Atypical Gender Identity Disorder should be considered, since the diagnosis of Transsexualism is made only when the disturbance has been continuous for at least two years. In **Schizophrenia**, there may be delusions of belonging to the other sex, but this is rare. The insistence by an individual with Transsexualism that he or she is of the other sex is, strictly speaking, not a delusion since what is invariably meant is that the individual *feels like* a member of the other sex rather than a true belief that he or she *is* a member of the other sex.

In both **Transvestism** and **Transsexualism** there may be cross-dressing. However, in Transvestism that has not evolved into Transsexualism there is no wish to be rid of one's own genitals.

Diagnostic criteria for Transsexualism

A. Sense of discomfort and inappropriateness about one's anatomic sex.
B. Wish to be rid of one's own genitals and to live as a member of the other sex.
C. The disturbance has been continuous (not limited to periods of stress) for at least two years.
D. Absence of physical intersex or genetic abnormality.
E. Not due to another mental disorder, such as Schizophrenia.

Fifth-digit code numbers and classification. The predominant prior sexual history is recorded in the fifth digit as:

1 = asexual
2 = homosexual (same anatomic sex)
3 = heterosexual (other anatomic sex)
0 = unspecified