Embodying Resistance:

An Analysis of Authority Over Sex and Gender in the Trans Identity

An honors thesis for the Department of Anthropology

Bryn M. Clark

Tufts University 2014

Acknowledgements

Thank you so much to my two wonderful advisors, Stephen Bailey and Ronna Johnson, for making this thesis possible. Professor Bailey's intellectual inspiration as a teacher and support as my advisor have been invaluable these past four years. I would not be the same student without his encouragement. Professor Johnson made me feel like this thesis was possible even when I was discouraged. I always walked away from our meetings energized and ready to push forward given her fresh perspectives and kind words. Both Professor Bailey and Professor Johnson have been amazing role models throughout this process.

A special thanks to my graduate writing tutor, Katie Swimm, who helped me structure my very first section and organize my thoughts when I could not.

I would also like to thank Hannah Schuchert for endless amounts of support, encouragement, and companionship during late hours in the library and Eaton Hall.

Thank you to my family and friends for listening to me talk constantly about sex, gender, and trans rights, and especially to my mother for copy-editing the final draft.

Lastly, I cannot express the depth of my appreciation to all my participants. It is their voices that created this thesis and their stories that brought the concepts of sex and gender alive in my mind.

Contents

Introduction

My last interview did not go smoothly. It should have happened during the Fall, but complications left me sitting in the notoriously androgynous Diesel Café on a rainy February afternoon. I felt I had gotten more information than I knew what to do with already, but I couldn't turn down the opportunity to meet with someone willing to share his story with me.

It took a while for our discussion to find a rhythm, and even longer for my apprehension to settle. We didn't connect as well as I had with other participants and didn't hit that stride of comfortable conversation often reserved for friends. Yet it was fitting that during my final interview, in the last moments of our jerky, awkward conversation, he summed up the truth behind sex and gender that all my other participants had been dancing around:

> *They seem like they are the same thing because for most people they are. If you are a female and you're a woman, they seem synonymous. If you're assigned male and you're a woman then it's obvious to you that your assigned sex is not your gender, and you change your body to female because you feel like you're a woman and you're female. Those are the same thing to you: having your body in alignment with your gender. Those seem like the same thing. Then you have someone who says, well I feel like my body should be female but my gender identity's not a woman really. Then they can distinguish those things. (Interview, Participant 10)*

It seemed like such a simple statement, but this concept of separation, while so clear in my participants' experiences, is invisible to the vast majority of society.[1] My participants found congruency with their authentic selves through embodying incongruency between normative ideas of sex and gender.

Most of the individuals I spoke with identified as genderqueer and therefore, by default, challenged the binary. However, their experiences spoke to a deeper distinction between sex and gender. The many different manifestations of trans identity and the distinction between sex and gender are not nonexistent, but rather are indefinable by mainstream medical notions, and by my experience as a cisgender woman.[2] It was when individuals spoke of their own lived experiences that a pivotal theoretical concept, that of resistance, became visible.

---

[1] Society represents the web of social interactions connecting individuals of a similar culture, or individuals who are under the same institutional system. This concept is key in addressing the relationship of sex and gender as many of the assumptions made regarding the two occur during social interactions. The link between sex and gender is drawn through social perceptions rather than individual truths, and therefore society serves as the network facilitating both normative and subversive behavior.

[2] The term *trans* will be used in place of transgender in order to open up the trans community to include all individuals who do not identify with the sex they were assigned at birth, and therefore are not cisgender. This includes, but is not limited to, genderqueer, agender, polygender, transmasculine, transfeminine, transgender, transsexual, and many more identities claimed in this larger community. This definition in no way indicates surgical status or the degree to which an individual has undergone a medically facilitated transition.

Claiming individual authority over sex and gender through resistance challenges the influence of societal norms in my participants' lives. They developed their unique gender embodiments through negotiating sex and gender as different components of one intersectional identity, thus complicating medical models that pathologize nonlinear relationships between the two.[3] These same medical models pervade society, erasing identity as something other than a product of human flesh in mainstream representations of trans individuals, a concept my participants actively contradict.[4]

In searching for the relationship between sex and gender I turned to individuals to provide the authoritative voice rather than the voices of medicine and academia. Medical models dominate the mainstream, hiding resistance that reveals this more nuanced and personal authority located in the individual. Scholarly theory has attempted to address issues of authority by deconstructing and explaining the causes of medicalization, but does not adequately capture the complexity of gender embodiment either. Both scholarly theory and overarching structures of power frame sex and gender as codependent or even identical. However, the negotiation of gender expression and physical form visible in an individual is not inherently indicative of an association between sex and gender without this imposition of societal power structures.[5] Problems of inappropriate authority leading to incorrect associations cannot be solved through the same systems of power that create them. Therefore, turning to the individual to provide a

[3] For the purposes of this paper, I define *gender embodiment* as the different ways in which physical sex and gender expression come together within a given individual to represent their gender identity.
[4] Oxford dictionary defines mainstream as, "The ideas, attitudes, or activities that are regarded as normal or conventional; the dominant trend" ("Mainstream"). I would like to incorporate Judith Butler's concept of the heterosexual matrix into this definition. The heterosexual matrix refers to a societal structure in which dominant trends are highly linked to a heteronormative discourse. This leads to the exclusion of subversive forms of gender and sexuality on the basis that they are non-normative and therefore unintelligible (Butler 1990:98-99).
[5] Gender expression is, "the external manifestation of a person's gender identity, which may or may not conform to the socially-defined behaviors and external characteristics that are commonly referred to as either masculine or feminine. These behaviors and characteristics are expressed through carriage (movement), dress, grooming, hairstyles, jewelry, mannerisms, physical characteristics, social interactions, and speech patterns (voice)" ("Glossary of Gender and Transgender Terms: 2010:3).

multi-faceted representation of sex and gender reveals that sex and gender operate as distinct components of an identity rather than codependent aspects of a "natural" human being.

Through discussions with trans community members, I found the nuance lacking in mainstream depictions of sex and gender. I sought out conversations with those challenging the binary, and through these conversations came to understand Participant 10's above statement on the invisibility of congruent incongruency. Neither the medical models defining trans identity through societal norms nor the academic theory attempting to deconstruct these norms capture the relationship of sex and gender at its source: the individual. It is only through the individual lens that sex and gender completely dissociate, acting as distinct axes of identity intersecting at different points in different people. I argue that it is through resisting overarching structures of power and claiming authority over their own identity that trans individuals represent the dissociation of sex and gender.

In order to provide an adequate background on current mainstream perceptions of trans identity, in the remainder of the introduction I discuss terminology, trans medicalization, and key theoretical analyses of sex and gender. It is crucial to begin with terminology in order to provide a foundation for understanding more complex interactions between a person's gender and sex. Given the degree to which incorrect terminology can be offensive and essentializing, setting a consistent vocabulary will facilitate accurate representation of each participant's identity. After establishing a common language, I justify the claim that the medicalization of trans identity has largely influenced mainstream conceptions of what it means to be trans and how gender and sex relate to this. This discussion will encompass broader implications of how medical models serve to normalize certain behaviors and physical traits while pathologizing others. Thirdly, I turn to Michel Foucault and Judith Butler, two theorists who have defined the deconstruction of sex and

gender in modern society through analyzing the influence of power structures. Their work will serve as the theoretical framework through which I approach resistance. Ultimately, the voices of my participants will challenge the association of sex and gender in both medical and theoretical models throughout the following chapters.

Terminology

As previously stated, it is essential to use correct and clear terminology to ensure accurate representation of each person's unique and nuanced identity. By using correct terminology for trans identities, with a mind toward respecting self-labeling and definition, I hope to dispel the tendency to make assumptions about a given individual's sex and gender identity. I will define key concepts such as sex, gender, and gender embodiment, which serve as the foundation of my argument. I will also reiterate my meaning of the identifier *trans*, as well as a brief clarification of *trans medicalization*. Definitions of more standard terms relating to trans identities, such as gender expression, cisgender, and genderqueer, are located in the appendix.

Throughout my writing, sex refers to an individual's flesh, including their secondary sex characteristics, as well as their genitals and internal reproductive organs. I use the terms male and female to describe the sex an individual was assigned at birth, and further draw a distinction between sex and gender through the use of the terms female-bodied and male-bodied. I only employ the terms female and male in conjunction with the concept of sex, and never associate them with gender. In contrast, I exclusively invoke the terms woman and man when discussing gender and gender identity. Gender refers to, "a social construct regarding culture-bound conventions, roles, and behaviors for...women and men and boys and girls" (Krieger 2001:694). When a person's sex and gender are in alignment, meaning a person is female-bodied and

identifies as a woman or is male-bodied and identifies as a man, they are cisgender. When an individual's sex and gender do not align they are trans.[6] Gender identity spans both cis and trans identities, portraying a more nuanced combination of stereotypically defined masculine and feminine traits to accurately represent the nuance in an individual's unique and innately felt gender identity. A person with a masculine gender identity may use masculine gender pronouns (he/him/his), whereas a person with a feminine gender identity may use feminine gender pronouns (she/her/hers). Pronouns are a powerful tool in ensuring accurate representation of self and therefore an individual may deviate from these two pronoun categories and use gender neutral pronouns.[7] Gender embodiment goes a step further than gender identity and gender pronouns to encompass the physical manifestation of gender identity, whether through gender expression or physicality.[8]

My research encompasses various nonbinary trans identities, and therefore when referring to the trans community, I use the term trans to refer to trans*. Trans* is an umbrella term that refers to the entire trans community, which includes people who do not identify with any gender. This expands the community from just those who identify with transgender to include those who have not gone through a transition of any kind, medical or not, but still identify outside the category of cisgender. Trans medicalization denotes the process of medically transitioning and how throughout history, the trans identity has incorrectly been isolated to a medical realm for the purposes of establishing gender normativity and productivity. Trans

[6] Alignment refers to a normative correspondence between sex and gender (female-bodied and woman, male-bodied and man); However, in an effort to present both cis and trans as equally natural I do not focus on this in the body of my paper.

[7] Throughout this paper I will use they/them/their/theirs/themselves as the singular and plural gender neutral pronoun. Other commonly used gender neutral pronouns include ze/hir/hir/hirs/hirself, taken from the German language, ey/em/eir/eirs/emself, and xe/xem/xyr/xyrs/xemself (Simonoff 2014). The use of pronouns correlates highly with individual identity, leading to an endless amount of variation and personal alterations.

[8] Physicality refers to the current state of a person's body and is not ultimately defined by their birth sex or their physical attributes at birth. It encompasses all surgical or hormonal steps the individual has taken in a medically facilitated transition.

medicalization, while crucial in advancing healthcare needed for a portion of the trans community, has acted as a form of gender policing through essentializing the trans identity and disallowing gender identities that do not normatively correspond to a certain physical body.

The Medicalization of the Trans Identity

The vehement association of sex and gender in depictions of trans individuals, seen in the medicalization of the trans identity, has perhaps been one of the most gruesome representations of the assumption that sex and gender are inherently linked. This particular framework captures trans identity in the mainstream, adhering to the definition of medicalization as a process where "medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms" (Riessman 1983:4). Medicalization leads to the objectification and victimization of trans individuals, downplaying the authority they have over their own identities. In order to demonstrate the effect of this medicalization, I first provide examples of transitional medicine's influence on the mainstream. Secondly, I address the reality that many trans people need to interact with the medical field in order to actualize their identity, and finally I detail the ways in which this medicalization has led to the pathologization of trans individuals and the invisibility of their authentic selves.

Mainstream conceptions of trans identities have overwhelmingly focused on a medical model of transition.[9] This obsession with surgery, hormone therapy, and psychoanalysis dates back to the mainstream emergence of trans healthcare in the 1950s, exemplified by the famous case of Christine Jorgensen, the first American woman to gain national media recognition for undergoing gender reassignment surgery (Meyerowitz 2002:48-49, 51; Docter 2008:107;

[9] Transition refers to "the process that people go through as they change their gender expression and/or physical appearance (e.g., through hormones and/or surgery) to align with their gender identity" ("Glossary of Gender and Transgender Terms" January 2010:4).

Rudacille 2005:194).[10] After returning from Denmark, where she received her surgery, she was met with the media headline "EX-GI Becomes Blonde Beauty" (Docter 2008:107). This famous headline conveys that binary-driven medicine and public concepts are what ultimately garnered her trans status a degree of acceptance in mainstream society. This acceptance hinged on the ability gender reassignment surgery had to produce a match between Jorgensen's internal gender identity and a normative female body through transitioning her from one gender stereotype, the hyper-masculinized GI, to the other, the beautiful, effeminate blonde bombshell. This demonstrates how the protocol for medically facilitated transitions, and its effect on the mainstream, reflects and reinforces rigid, binary-driven ideas of female, feminine, womanhood and male, masculine, manhood.

The permeation of this medical model into the mainstream has continued to provide binary-based notions of trans identity solely focusing on the physical body and surgery. Earlier this year, Katie Couric asked trans super model Carmen Carrera about her genitals on national television while discussing the unrelated topics of fashion and Carrera's modeling career (Carrera 2014). There has also been increased news coverage on the inclusion of trans people in athletics. Articles focus on school and fitness center policies that mandate normatively corresponding genitals as a requirement for participating in the sport corresponding to the individual's gender identity (Park 2014). These examples reaffirm that the mainstream focus continues to be directed toward genital surgery and a fascination with medical transitions that change a female body into a male body or vice versa, rather that the diversity of individual

[10] The 1950s holds special significance in terms of advances in trans healthcare mainly due to the intense surge of science and technological advances (Meyerowitz 2002:50). Harry Benjamin, a German endocrinologist and pioneer of trans health, started treating more trans patients after WWII (Meyerowitz 2001:41). During this decade the first version of the Diagnostic and Statistical Manual of Mental Disorders was published containing various diagnoses related to gender identity (Rudacille 2005:195). The 1950s also represent "a new era of comprehensive, even obsessive, coverage" of trans individuals in the media beginning with the case of Christine Jorgensen (Meyerowitz 2002:49).

experiences associated with being trans.

Despite the mainstream representation driven by medical norms, medicine continues to be a paradox for trans individuals wishing to alter their physical body because the aid of doctors is essential to safe endocrinological and surgical procedures. Transgender scholar Susan Stryker comments on this in her book *Transgender History*, saying, "For those transgender people who have felt compelled to change something about their embodiment, medical science has always been a two-edged sword—its representatives' willingness to intervene has gone hand in hand with their power to define and judge" (Stryker 2008:36-37). The judgment of healthcare professionals implicit in having a medically safe transition signifies a disproportionate allocation of authority to the healthcare industry, and therefore a deprivation of authority in the trans community. After Christine Jorgensen received national attention for undergoing gender reassignment surgery, "hundreds of [trans individuals] approached doctors in order to convince them to recommend or perform surgery. But they ran into constant conflicts with doctors who insisted on their own authority to define sex and gender, diagnose the condition, and recommend the treatment" (Meyerowitz 2002:6). In the cases where American doctors did not outright refuse to treat somebody, they took control of the patient's transition, assuming that if someone did not want to be a woman or man then they wanted to be the exact opposite (Hausman 1995:47). In the post-World War II movement to increase transgender medical rights, paired with unprecedented medical advances giving physicians the unique power to change someone's sex, medicine became a way to exercise power over the individual (Foucault 1977:204).

This medicalization of the trans identity locates trans individuals within the confines of their flesh. This flesh is then pathologized and made *treatable* in a medical model that fixes a problem it creates. As trans healthcare continued to grow in the latter half of the 20th century, a

system of standardized diagnostic criteria and treatment methods developed to cure this "problem" of mismatched material and materiality.[11] Treatment involved hormone therapy and surgical procedures and ultimately led to a system of medical jargon and trans labeling (Rudacille 2005:194-195). This mirrors the medicalization of reproduction for cisgender women. Medical standardization of the birthing process characterizes women as a broken machine that must be fixed if it does not work exactly according to plan, creating tension between doctors who operate the "machine" and women who feel disempowered and dehumanized in the process (Martin 1987:56-57). Historian and gender studies expert, Joanne Meyerowitz focuses on how standardization facilitates a similar dialogue between physicians and their trans patients: "From the doctors' and scientists' point of view, medical examinations and psychological tests could determine a person's sex and verify a person's gender identity. From the point of view of their patients, sex and gender were usually matters of self-knowledge" (Meyerowitz 2002:6). In a Foucauldian analysis of society, this medicalized assessment has become the overarching structure, holding power over individual behavior and identity by funneling trans individuals through a standardized treatment path. Today, health insurance companies act as one of these overarching structures of power, claiming authority by exercising economic control over clients. Insurance plans that cover transitional healthcare, such as Blue Cross Blue Shield, require that an individual live in the *opposite* gender role for a 24-month period of time in order to qualify for coverage ("Medical Policy: Transgender Services"). Accessing services necessitates objective criteria and categorization, something that essentializes the trans identity and drives it toward binary definitions. In contrast, listening to the patient as a guide is more subjective and individually tailored, though often stigmatized as less legitimate and profitable.

[11] Material and materiality are Judith Butler's concepts of sex and gender and will be discussed further in the following section.

Later in the 20th century, liberal health professionals formed the Harry Benjamin Gender Dysphoria Association in 1979 to mitigate the harm medicalization causes the trans community and ensure respect for transgender patients (Meyerowitz 2002:8). This organization is known today as the World Professional Association for Transgender Health (WPATH), and is responsible for creating the Standards of Care for trans individuals, a set of guidelines for treatment and medical policy relating to the trans community ("WPATH History"). The Standards of Care have increased the quality of trans healthcare, but they continue to operate within a medical model rather than questioning and breaking out of the system (Lombardi 2001:870). The term "medically necessary" encapsulates this paradox of improved treatment corresponding with further medicalization. WPATH deems transitional treatment, such as hormone therapy and gender reassignment surgeries, medically necessary given the diagnosis of gender identity dysphoria, more commonly known as gender identity disorder until the DSM-V (Rudacille 2005:211).[12] Healthcare providers and insurance companies use this diagnosis to invoke medical necessity as a justification for insurance coverage, but the definition of medical necessity is in keeping with a mainstream model of trans identities. To be deemed medically necessary a treatment must be:

> (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. ("WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide")

[12] Gender Identity Dysphoria/Disorder (GID) is "characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned sex…The term gender dysphoria denotes strong and persistent feelings of discomfort with one's assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex" (American Psychiatric Association 2010:535).

The discussion of "generally accepted standards of medical practice" refers to treatment that has been proven effective with credible and agreed upon research. WPATH strongly feels that transitional healthcare, including hormone therapy and surgery, are medically necessary given studies that have demonstrated an increase in quality of life and mental health in the aftermath of such procedures, further standardizing and pathologizing the process of transition ("WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide"). The use of the word convenience in part (c) brings an added level of subjectivity to the assessment of whether transition-related healthcare constitutes medical necessity, suggesting that a physician has the authority to judge an individual's identity. In addition, the fact that the entirety of this concept hinges on a pathological diagnosis of gender identity dysphoria, which has historically served as a gatekeeper for treatment, suggests that being trans is inherently disordered and medically treatable through binary-driven medical transitions.

Aside from its correlation to medical necessity, the diagnosis of gender identity dysphoria continues to be controversial because it suggests incongruency as the source of mental health issues within the trans community. WPATH reasons that "the designation of Gender Identity Disorders as mental disorders is not a license for stigmatization or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is an important step in offering relief, providing health insurance coverage, and generating research to provide more effective future treatments" (Rudacille 2005:211). This statement is reasonable when addressing issues of gatekeeping and the requirement of many trans patients to get a letter from their therapist to legitimize the need for medical treatment. However, Stryker comments, "Far too often, access to medical services for transgender people has depended on constructing transgender phenomena as

symptoms of a mental illness of physical malady, partly because 'sickness' is the condition that typically legitimizes medical intervention" (Stryker 2008:36-37). The permeation of symptoms and diagnoses into the mainstream instantiates a system of gender policing, where a discontinuity in sex and gender necessitates medical treatment to establish a congruent and medically normative gender embodiment.

It is difficult to dispel this particular narrative of trans identities because medical treatments are necessary for a portion of the trans community. However, generalizing this medical discourse to the entire community serves as a method of regulation and discipline rather than a system of respectful healthcare and self-expression. Through confining the trans experience to a medical model, medical institutions and structural power work to normalize congruency and to pathologize incongruency. The generalization of this forced association between sex and gender to the mainstream erases the legitimacy of ambiguity in American society, therefore depicting trans individuals as lacking the authority to dictate their own gender embodiment. The theoretical frameworks of poststructuralism that attempt to deconstruct this gender policing continue to search for authority in structural power rather than individual experiences.

Theoretical Frameworks for Understanding Sex and Gender

The deconstruction of the medicalization of trans identity requires an analysis of how larger institutional powers set norms and influence mainstream notions of sex and gender. In addressing the influence of societal structures of power, such as the medical field, poststructuralists Michel Foucault and Judith Butler provide key explanations as to how medicalization polices individuals in the mainstream through harnessing Foucault's concept of

biopower.[13] However, their lack of attention to the potential for resistance suggests that their theories only apply to those already living within the mainstream, making non-normative experiences invisible and offering a limited view of the relationship between sex and gender in society. Through an overview of their theoretical frameworks, beginning with Foucault and then Butler, and finally bringing their theory on resistance together, I point out the necessity of looking at the lived experiences of individuals to uncover the nuances of this relationship.

Foucault's theory of power situates the sexed body in a structure of societal authority, namely held by the medical discipline.[14] His conclusions depict a society where larger industries discipline the individual and regulate populations through controlling the definition of truth. Truth therefore becomes the structure through which societal norms arise and deviance becomes pathologized (Foucault 1978:53-54). Individual resistance threatens to destabilize the state through abstaining from stable and normative categories, and circumventing this societal policing (Foucault 1978:147). In order to maintain stability, Foucault sees society through a top down lens where overarching authorities negate individual autonomy, and where resistance is sparse within the confines of this structure. This analysis of society explains the need to medicalize sex, and therefore gender embodiment and the trans identity, in order to maintain societal productivity through heteronormativity, which necessitates the distinct categories of sex and gender (Foucault 1978:151-152). Given this proclamation and the inability to erase trans identities altogether, the discipline of science now must find a way to normalize the trans identity

[13] Foucault discusses "regulatory controls: a biopolitics of the population" as "focus[ing] on the species of the body, the body imbued with the mechanisms of life and serving as the basis of biological processes: propagation, births and mortality, the levels of health, life expectancy and longevity" (Foucault 1978:139). He references how in this process the body becomes a machine, "its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the disciplines" (Foucault 1978:139).

[14] Disciplines are "methods, which made possible the meticulous control of the operations of the body, [assure] the constant subjection of its forces and [impose] upon them a relation of docility-utility" (Foucault 1977:137). The science of the body, medicine, and healthcare are examples of disciplines (Foucault 1978:139-141).

through curing its pathological state.

The power of knowledge held by health professionals therefore works to control and discipline rather than to help and heal. It thus became someone else's, namely a doctor's, jurisdiction to decipher an individual's inner truth, thereby also claiming the authority to define and shape this inner truth. Foucault refers to this system of surveillance as "traditional fears [being] recast in a scientific-sounding vocabulary" (Foucault 1978:55). This evolves into a system of diagnoses and pathologizations derived from human confessions regarding sex. Foucault argues that confession "is so deeply ingrained in us, that we no longer perceive it as the effect of a power that constrains us; on the contrary, it seems to us that truth, lodged in our most secret nature, 'demands' only to surface" (Foucault 1978:60). This compulsion to confess leads to the association between confessions of sex and symptoms indicating pathologies. However, Foucault does not suggest that a person confesses their own pathologies, but rather that a doctor or authority figure defines the individual's pathologies based on the confession. Thus, "the one who listened was not simply the forgiving master, the judge who condemned or acquitted; he was the master of truth" (Foucault 1978:67). The relationship between the medicalization of sex and a societal obsession with confessions perpetuates a cultural conception of sex as "under the rule of the normal and the pathological" (Foucault 1978:67).

Butler's model of sex and gender provides a theoretical framework for the concept of "curing" the pathologized trans identity through a discussion of material and materiality.[15] She discounts sex and gender as linearly related, but in the process suggests that the two exist in a cyclical relationship where sex does not only create gender, but gender creates sex (Butler 1993:15). The link she draws between sex and gender deepens through renaming these two

[15] Material being a person's physical body, or sex, and materiality being the meaning ascribed to this body by society, or gender (Butler 1993:2).

concepts as material and materiality. She theorizes that material is something that only takes on meaning, and therefore comes to exist, through materiality (Butler 1993:2). The interwoven cycle of material and materiality explains the medical creation of sex from a trans individual's gender identity, because in curing incongruency medical professionals physically align the person's sex with the meaning the patient previously ascribes to it.

Butler draws on the overarching power structures Foucault analyzes to explain individual gender identity through the concept of gender performativity. She deconstructs the idea that gender is innate by claiming that gender is something each individual does, rather than something that each individual is, through a set of culturally constructed characteristics and behaviors that people are taught and policed through from a young age (Butler 2011). While this model distances gender from a biological given, it does not return agency to express gender to the individual. Rather, "In this sense, what constitutes the fixity of the body, its contours, its movements, will be fully material, but materiality will be rethought as the effect of power, as power's most productive effect" (Butler 1993:2). Butler's theoretical association between sex and gender is so strong that the concept of sex becomes nothing without gender; the very meaning of sex is created through gender (Butler 1993:5). In the absence of this association, bodies become the abject of society (Butler 1993:8).

The correction of the abject individual that emerges through this mismatch centers on the admission to "humanness" (Butler 1993:8) through "the approximation of realness" (Butler 1993:129), otherwise known as passing. Butler references passing in her discussion of drag, distilling drag down to an insufficient performance of gender that can be read as something other than the real thing, meaning the normative correspondence of material and materiality. She writes, "For a performance to work, then, means, that a reading is no longer possible, or that a

reading, an interpretation, appears to be a kind of transparent seeing, where what appears and what it means coincide" (Butler 1993:129). Two avenues emerge to avoid abjection and assume humanness. The first is to perform a materiality that normatively corresponds to one's material flesh at birth. The second is to perform a materiality so seamlessly that one's supposedly incorrect material is indistinguishable from the material that normatively corresponds to the aforementioned materiality. Butler describes this concept as the mimicking of heteronormative identities when a physical body, whether medically altered or not, and gender identity affect congruency (Butler 1993:16, 22, 231). This idea of reading as a failure and passing as a success forces gender embodiment into a binary paradigm where sex and gender, or material and materiality, must be congruent along a normative spectrum. The need for this congruency further necessitates the creation of sex from gender through medical meanings if an initial correspondence does not already exist.

The theories of Foucault and Butler provide a deeper understanding of how systems of power work to produce gender norms, offering explanations as to how the medicalization of trans identity functions. While these theoretical frameworks are the basis of poststructuralist thought and queer theories that problematize heteronormativity (Namaste 2000:9-23), they fail to offer an alternative to the mainstream in which they locate norms, making little room for resistance and individual authority. Foucault's contemplations on resistance are brief and convoluted. He interestingly claims that "it is the agency of sex that we must break away from" in order to resist (Foucault 1978:157). Instead he advocates for claiming "bodies, pleasures, and knowledges, in their multiplicity and their possibility of resistance" (Foucault 1978:157). He complicates his suggestion to claim one's own body further by reinforcing that in order to form an identity, encompassing both physicality and intelligibility, every individual has to pass

through sex (Foucault 1978:156). Ultimately, Foucault seems to suggest that claiming one's own authority is key to circumventing the larger structures of power he presents, however he does not give any idea of how to do this or where there is space to do this given his suggestions of perpetual and domineering surveillance that negates autonomy.[16] Butler suggests that agency can perhaps be found in "the appropriation of the regulatory law" (Butler 1993:12), but quickly challenges this option by saying, "The practice by which gender occurs, the embodying of norms, is a compulsory practice, a forcible production" (Butler 1993:231). Again, in her discussion of drag, she also suggests that the subversion of gender norms often reinforces them through mimicry and adherence to a heteronormative binary (Butler 1993:231). Therefore, her discussion of resistance is limited given the compulsory notion of assuming sex and gender through a totalizing system of norms and regulatory ideals as set forth by Foucault. It is this concept that is the foundation of the medicalization of the trans identity.

Methods

During the time I spent with my participants and in looking back over the stories they told me, there was an overflowing amount of profound examples depicting resistance against the power structures that Foucault and Butler cite as extinguishing individual authority. In discussing gender embodiment with these members of the trans community, cisgender and transgender activists, and trans specialized healthcare professionals, I did see individual authority in their own negotiations of sex and gender. Taking an ethnographic approach in discussing social and personal experiences with healthcare, embodiment, and identity actualization, I began this project with a mind toward trans inclusive and exclusive health insurance. However, in my

[16] Foucault locates his theory of societal control in the metaphor of the panoptic prison, through which he uses the fear of perpetual surveillance to explain a subsequent system of internal policing where individuals adhere to the normative categories of male and female out of fear of being rejected by society (Foucault 1977:201).

discussions I found that people steered the conversation toward how they claimed authority over their own identity and how those they interacted with had done the same. My results reflect segments of these conversations during ten interviews.

My sample consists of ten individuals who I interviewed individually for an hour to an hour and a half each from November 2013 to February 2014. Seven of these individuals self identified as within the trans community (Participants 1, 3, 4, 6, 7, 9, and 10), and three were healthcare professionals who had extensive experience working with the trans community (Participants 2, 5, and 8). To avoid generalizations, I will describe how every participant identifies individually, beginning with those interviewed as members of the trans community. Participant 1 identifies as transmale, referring to himself as "just a dude" (Interview, Participant 1). Participant 3 identifies as genderqueer and uses gender neutral pronouns.[17] Participant 4 identifies as a transsexual woman, using feminine pronouns. Participants 6 and 7 also identify as genderqueer. Participant 6 uses both gender neutral and masculine pronouns, and Participant 7 uses gender neutral pronouns. Participants 9 and 10 do as well, but Participant 9 specified that he is a "fluffy cat femme, nonbinary, because I feel like I present somewhat masculinely, but in terms of the way I define myself I would say it's more nonbinary" (Interview, Participant 9). Participant 10 also uses masculine pronouns, but identifies as nonbinary. Participants 1, 3, 6, 7, 9, and 10 were assigned female at birth and ranged from 19 to 29 years old, whereas Participant 4 was assigned male at birth and is 56 years old. The categories based on sex assigned at birth follow the same binary medical model detailed earlier and in no way represent each participant's gender identity, gender expression, or current physicality.

The health professional participants include a gender specialized therapist with an MSW

[17] I will use they/their/theirs for gender neutral pronouns in this paper. My genderqueer participants were comfortable with these pronouns.

(Participant 2), a director of a trans health program (Participant 5), and an insurance administrator for a plastic surgeon (Participant 8). Participants 2, 5, and 8 only serve to provide expert opinions and highlight general trends in their patients, not to share their own lived experiences with gender embodiment. In terms of other demographics, my sample exclusively represents current residents of Massachusetts, and all participants identified as white, except Participant 4 who identified as multicultural.

As I talked with my participants about sex and gender, my thoughts moved away from the dictatorial structures of power that mandate a link between material and materiality. I went into my conversations with an academic perspective on how medicine guides individuals, but was usually left sitting in coffee shops, where most of my interviews took place, confused and amazed at the strength of individual identity. The theory I had previously thought of as progressive failed to encompass the complexity of experiences told to me, and I often found myself asking a few guiding questions at the beginning of my interviews and then letting my participants guide me throughout the rest. My research serves as a synthesis of these powerful stories, but more than anything I hope to let my participants speak for themselves, relocating authority to the trans community in ways absent in Foucault's and Butler's works. In the chapters that follow, I will share the experiences of these ten participants in their own words to convey that through individual authority, gender and sex disassociate, acting as distinct concepts that each person negotiates within their own gender embodiment on their own terms. As famous trans activist Leslie Feinberg said in their book *Trans Liberation*:

> I was born female, and my gender expression is masculine. For that reason, my birth sex and my gender expression appear to be at odds. I believe this is a social contradiction that can only exist in a society that mandates—with coercive force—that gender expression must conform to birth biology. (Feinberg 1998:29)

In the remainder of my paper, I divide the examples my participants gave of resisting this conformity into three main areas: healthcare, individual, and social. Through these lived experiences I redefine preconceptions of the manifestation of authority in these areas, and therefore move away from trans medicalization and a top down analysis of state power. I conclude with a discussion of how this data both reinforces and problematizes Foucault's and Butler's theoretical framework through demonstrating the significance of individual authority in resisting and redefining societal norms.

Chapter I: Renegotiating Authority in a Healthcare Model

Healthcare is a key area in which to analyze the effects of trans medicalization because in order to redefine mainstream conceptions of how transitional care functions it is essential to approach the source of these conceptions. The experiences of my participants both confirm and refute the authority medical spaces claim over gender identity. The intake process and brief impersonal conversations with medical professionals categorized their identities at either end of the binary. I expected to hear these stories given the frameworks Foucault and Butler provide for understanding medicalization and gender policing. However, I was surprised to encounter an equally strong sentiment of empowerment through resisting the automatic allotment of authority to the medical professional. Participants resisted categorization and defined their own identity through establishing control in medical settings and demanding a relationship with equal power dynamics. This resistance exposed the possibility of gender and sex as more than the labels on medical forms and provided a model for how medical authority can better understand and accommodate the trans community.

Essentializing Identity in the Intake Process

As noted above, my participants emphasized the intake process as a site of medical simplification, where health professionals only created space for congruent identities. Two participants in particular attributed this reduction of identity to the process being "very form driven" (Interview, Participant 6). Questions regarding gender identity, or lack thereof, and questions regarding sexual activity were the main source of complication. Participant 6 describes his experience with a new Primary Care Physician at an LGBT health center in Boston between

2006 and 2007, saying, “She never asked me questions about gender. The intake forms at the time didn’t ask questions about gender” (Interview, Participant 6). The simplicity of the intake forms when it came to issues of sex, gender, and sexual activity became further apparent through my conversations with Participant 6 and Participant 3 as we discussed how even well-meaning doctors asked incorrect and assuming questions.

Participant 3 and Participant 6 expressed the sentiment that their primary care professional ask them what they meant, instead of jumping to conclusions about their body and sexual history based on the sex marker on their health insurance form. This desire for precise and clear language exposed binary assumptions made through form-driven medical care. As we sat in an empty restaurant in Chinatown discussing sex and gender over a casual lunch, Participant 6 talked calmly about his experience with medical trauma:

> She didn’t ask me or tell me what she was going to do. And then not to mention all the sexual history questions were very binary, and very penis focused. And I’m like, why don’t you ask me, ask me what will get you the information you’re looking for. If you’re looking for information about whether I’ve had sex, ever or recently, with a biological penis, factory assigned, factory manufactured penis, ask me that question. Because asking me if I have sex with men won’t tell you whether I have sex that involves fluids or semen. (Interview, Participant 6)

Similar themes came up in my discussion with Participant 3:

> My experience is that I’ve never met a doctor that gets it unless you search out the ones who say they specialize in it. I’m going to an OBGYN and they don’t even have paper work in their systems to not ask you the questions like are you pregnant? No, I’m never going to get pregnant; I hate to break it to you. Well are you sexually active? And I’m like yes, and then they’re like well do you have penetrative sex? And I’m like well yes, but usually the things do not have semen in them. And because I date a lot of transmen and masculine people I usually use male pronouns and boyfriend for my partners, and it just blows their mind. Like yeah, I have a boyfriend and he has a dick, but it doesn’t work the way you think it does. (Interview, Participant 3)

The heteronormative assumptions made by the doctors in these situations illuminate the institutional ignorance of relationships and identities outside those contributing to reproduction

that plagues mainstream medicine. The burden lies on my participants to educate their doctors. In the case of a truly equal power dynamic between patient and doctor, this mutual education has potential for a better understanding of sex and gender in medical settings. However, the absence of a space for the patient to provide this knowledge instead delegitimizes Participant 3's and Participant 6's identities. Doctors asking questions assuming a heteronormative, cisgender lifestyle forces identity to either fit a mainstream model or lose validity.

The silence stemming from this loss erases identity from medical models altogether in Participant 3's case. Participant 3 described a situation with their childhood PCP where the office used to be self-owned and their computer system had a notes section on the forms where the doctor or health professional could record an individual's preferred name, pronouns, gender identity, and sexual orientation. This allowed doctors who saw many patients daily to remember not to ask certain questions about sexual history and to refer to each patient with respect to their gender identity. When a larger company bought out the office and the computer system switched over, the notes section was erased: "My preferred name, my pronouns, and my identity, *just gone*" (Interview, Participant 3). Participant 3's identity disappeared from the medical realm when medical terminology and labels on intake forms could no longer capture their identity. The erasure of identity magnified with the introduction of larger institutions and economic incentives, a pattern which continues when I discuss the impact of insurance companies in the following sections. Even in this simple statement, though, my participant's experience conveys how institutional biopower attempts to control the individual through dictating when their identity is acceptable, alluding to Foucault's model of how the state polices populations by mediating the revelation of self through confession or repression. Assuming a person's gender identity and sexual history, all from their health insurance gender marker, demeans a person's identity to a

simple F or M, negating their ability to speak for themselves and claim their own individuality outside Foucauldian systems of power. The empirical nature of the medical industry, as seen through the essentialization of identity in intake forms, illuminates the claim this field has over mainstream notions of trans identities.

Participant 3 did express an understanding for this categorization, acknowledging the necessity of knowing what body a patient has to further diagnose and prescribe treatment for many non-trans related medical conditions. However, this understanding of medical science came with an expectation that the medical industry understand them as well:

> I completely understand that the medical community needs to know, sort of, whether you are male or female, and I mean intersex is a whole different thing. But the population in general fits into those two categories biologically, and it helps them figure out what's wrong with you and I get that. And I'm perfectly willing to be like I got a vagina, I got boobs, got these chromosomes, got these things but it just seems silly to me that they have so much data on you and they can't add more questions. (Interview, Participant 3)

This idea of adding just a few more questions about gender identity to already extensive forms begs the question of what the medical community sees as important and worthy of their attention. For certain doctors, as seen in Participant 6's experience with their initial PCP, the gender identity of their patients is wrongly perceived as not crucial to providing adequate treatment. The addition of these considerations to an individual's identity is a luxury. It also struck me that Participant 3's understanding of biological categorization lies in medicine's ability to decipher "what's wrong with you." This labels deviations from congruent cisgender identities as pathological and conveys that these biological categories allow for the state to judge who is intelligible and who is not (Foucault 1978:156; Butler 1993:2), and then fix those that are not through recommending treatment in the from of establishing congruency rather than discussing the potential for incongruency and ambiguity to exist within one body. Erasing this potential

reinstates unequal power structures between patient and professional, assuming one to be knowledgeable, and therefore dominant, and the other to be submissive.

Dichotomies of Knowledge in the Patient Relationship

The erasure of identity that is enabled through the inflexibility of medical forms turns trivial questions and assumptions into identity policing and stolen authority. The power that is thus transferred away from patients and to the medical industry enables unsafe environments where people are afraid to advocate for themselves. The dichotomy of knowledge that is therefore imposed on a situation where the patient should be considered the expert on their own identity hides the dissociation of sex and gender through silencing the individual. Participant 6 spoke to this feeling when he said,

> I was really annoyed and I didn't feel like I could stand up for myself. I didn't know I could ask questions. My experience with the medical industry was: I don't understand, I don't know, I'm scared from this trauma history, and they have all the power. (Interview, Participant 6)

He continued, speaking about the trans community in general, and how this mistreatment caused him to end his relationship with this particular PCP:

> We settle for non-abusive. Not thriving. Not actually getting our needs met, in a real way. So I left after a couple of years. I think the final straw was actually that I got a letter in the mail that was addressed to 'Ms. Smith,' and I was like, fuck, I'm done with this. (Interview, Participant 6)[18]

In interacting with a field that is designed specifically to care for individuals and increase their quality of life through fighting disease and health conditions, the idea of settling for non-abusive is striking, yet something that the trans community is all too familiar with.

Despite this sentiment, I did not find that an imposition of authority led to the structural dictatorship that postmodernists like Foucault and Butler suggest. My participants resisted the

[18] Name has been changed to preserve participant's anonymity.

state's biopower over sex and gender as identical categories serving to perpetuate population reproduction and regulation in their own bodies and identities.[19] The idea of the medical industry controlling and shaping trans identities is told repeatedly through a narrative focused on medically reinforcing the sex/gender binary, with undertones of Foucauldian structures of power and discipline. However, when told from an individual's perspective, the endemic control assumed to perpetuate this system of population productivity breaks down. To represent this resistance, Participant 6 told me about his friend who works at a health center in Massachusetts whose husband is a transman. His friend works in an office that previously had two separate intake forms for people medically categorized as F or M:

> She instituted a policy where she was like why don't we have a single double-sided [form], so that if you go in and the person's anatomy isn't what you expected, you could flip it over, instead of going away and getting a new form and coming back. And it actually happened to someone not long after, and they were able to say "Oh my god, thank you so much for having us do that because this happened to me, that I got into the room and I was like, oh, and I just turned over my piece of paper and it was fine. (Interview, Participant 6)

This resistance is slight, but significant to those it affects. The majority of my participants have talked about how incredibly invalidating and distressing it is when someone miss-pronouns them or does not treat them with a certain level of basic respect that all human beings deserve. Addressing someone as Ms. when they identify as transmasculine or genderqueer or using someone's birth name rather than their real name are the seemingly trivial acts that build on each other to create the intense distress commonly associated with trans identities. People excuse

[19] The disciplining of the human body manifests in "the parallel increase of its usefulness and its docility" and in "its integration into systems of efficient and economic controls," whereas the regulation of a population attempts to affect group productivity with a specific focus on "propagation, births and mortality" (Foucault 1978:139). Foucault refers to sex as being, "At the juncture of the 'body' and the 'population,'" and therefore becoming "a crucial target of a power organized through the management of life" (Foucault 1978:147). Sex is an individual characteristic that leads to population survival and perpetuation through a heteronormative, biological model, and therefore necessitates, "infinitesimal surveillances, permanent controls, extremely meticulous orderings of space, indeterminant medical or psychological examinations, to an entire micro-power concerned with the body" (Foucault 1978:145-146).

these violences by saying that they are trying or that it is too difficult to change their perception of someone (Interview, Participant 3). However, this violence continually pushes nonbinary identities out of the mainstream or coerces them into conforming to the mainstream (Namaste 2000:14; Butler 1993:2), contributing to the simplified correlation between sex and gender falsely assumed for all of society.[20]

While this silences resistance according to Foucault and Butler, the deliberate act of ignoring resistance strengthened self-advocacy for my participants. With his next PCP, Participant 6 advocated for himself, demanding the care he deserved and creating an environment where these violences where unacceptable. His mindset turned when he realized the significance these attempts to silence his identity held in his life:

> It's amazing how much of an effect it has when someone says Ms. It seems so small, and for a long time I was like what's wrong with me, it's not that big of a deal, just what do I expect. I did this whole downer thing. Now I'm like, no, actually this is something I get to ask for. This is a big deal. It really makes the difference between me wanting to pick up the phone and make an appointment or not. I've seen that in my own life, when I was like I don't want to go back to [my old healthcare provider] because I just can't deal, this was the last straw, and it meant that a year later I ended up having to pay $300 because I ended up at an urgent care walk-in clinic, which wasn't covered by my insurance, because I was sick and I needed antibiotics, and I could not go to [my old healthcare provider], I just couldn't do it. (Interview, Participant 6)

The consequences of settling for non-abusive proved to be too much, and when this participant found a new PCP they reclaimed the authority over their own identity. Again, these consequences are wrapped up in a system of economic control perpetuated by the state, further foreshadowing my discussion of the monetary role insurance companies play in mediating trans healthcare and eradicating incongruency. Participant 10's similar experience of taking control

[20] "[Sex] will be one of the norms by which 'one' becomes viable at all, that which qualifies a body for life within the domain of cultural intelligibility" (Butler 1993:2). Therefore anyone who does not represent this match threatens to destabilize the system through embodying the abject and lacking "humanness" and must be put back into place (Butler 1993:8).

also resided in this economic system through harnessing the power of the consumer and refusing to let doctors shape his identity:

> When I have advocated for myself in clinical settings I'll say well here are the pronouns I prefer. The appropriate pronouns for me are masculine pronouns. That's it. They don't have to get into how come and what does that mean to you. I'm a transgender person; here's the appropriate pronoun for me. You can't use my birth name. Oh, you're using the inappropriate pronouns, okay, I don't want to see you anymore, and by the way, here's a pamphlet. (Interview, Participant 10)

Participant 10 refuses to allow a doctor to become the expert on his gender by communicating with them on a need to know basis, connecting to Participant 3's experience with intake forms as a symbol of biopower over repression and confession. In abstaining from confession, Participant 10 creates a space for ambiguity in the sense that he allows for the unknown and removes himself from the judgment of his doctor. Through withholding the entire history of his gender identity and embodiment, Participant 10 assumes confidence in and authority over his incongruency, setting a standard for how medical professionals should act with him and limiting his interaction with them to the specific health issue at hand. Therefore resistance can come from both healthcare providers, as in the case of Participant 6's friend instituting a new intake policy, and from individuals advocating for themselves in a medical setting.

The combination of the trans community claiming authority over identity and gender embodiment and doctors' offices ceding authority to the patient through policies allowing people to define themselves work together to combat the structural enforcement of the binary and the policing of deviant identities that Foucault discusses. Just as Participant 10 did, Participant 6 claimed authority over his own genderqueer identity when he, with the help of his partner, told his new PCP, "This is what my needs are, this is who I am, if you can't respect my needs around how we talk about things, then I'm going to have to find somebody else" (Interview, Participant 6). This is a powerful statement and example of how authority can be transferred into the hands

of the consumer. However, Participant 6 still acknowledged that his advocacy in part comes from his privilege of being comfortable with his female body:

> It is easier for me to navigate these systems because of the fact that I don't have the same issues that a lot of folks have in terms of mismatched documentation and gender markers and stuff like that. It's not a problem for me. Really I just want to be seen as who I am, and have people use language that reflects my own experience. (Interview, Participant 6)

Participant 3, Participant 6, and Participant 10 have not changed any of their legal gender markers, and therefore they experienced a different type of negotiation of authority over gender embodiment than my participants who did legally change certain documentation.

Basing Insurance on M's, F's, and Checklists

With inconsistent documentation, which in my participant sample was typically accompanied by undergoing aspects of a medically facilitated transition, new issues of authority arose regarding who defined the appropriate care for each individual. These experiences incorporated the legal binds of accessing care that does not correspond with a person's health insurance gender marker, initiating health insurance as one of Foucault's disciplines of power. This introduces an overarching economic structure that does not only work to categorize and control the individual through biopower, but even regulates the medical offices previously referenced as institutional authorities. The care deemed medically necessary by health insurance providers assumes that whatever gender marker identifies the individual on their insurance documentation corresponds to the "correct" normative body. Therefore, the person's health insurance holds authority over gender embodiment by assuming that a simple letter dictates a person's body, compromising a medical facility's ability to provide adequate care without distilling identity to sex assigned at birth. After alluding to it at the beginning of our interview, Participant 4 finally opened up about the horror story of their experience with MassHealth:

> [They] won't cover an orchiectomy for a genetic male unless it's cancer or testicular pain, and because my gender marker says female they don't believe that I have those parts. So I had to change my gender marker back to male, and it was really hard and traumatic for me to go through this to change my gender marker back to male. But because I didn't have testicular cancer they denied the procedure, and I had to change my gender marker back to female. It's humiliating going back and forth like that. (Interview, Participant 4)

Participant 4's experience demonstrates the rigidity with which insurance companies operate. The fact that an individual is only covered based on the body that their insurance assumes they have given their gender marker fails to acknowledge the complexity of human biology and the nuances of identities. Participant 10 also expressed anger over this ignorance of the nuances of appropriate medical care:

> I think society is too obsessed with gender. I don't see why. For the most part, it seems irrelevant. I just don't understand. You go to the doctor, your doctor says, "Oh, you have this thing." If you go to the doctor and you have a lump in your breast, obviously you have breasts...Or if they say, "Hey this person needs a mammogram," then they need a mammogram. Does it matter if they have ovaries or if they are taking exogenous estrogen? If their doctor says, "I'm a medical professional. I've evaluated them. They need a mammogram," give them a mammogram. Or if this person has a problem with their testes, what do you care? They obviously have this tissue that needs something. So I don't understand why they need to categorize it like we've checked off the M box so these must be the body parts you have, and these must be the body parts you don't have. Why? You're [the insurance company] not there. You're just this crazy bureaucracy. Why don't you just listen to the doctors that are there? (Interview, Participant 4)

Participant 10 felt that the only real purpose of this categorization was discrimination. The insurance companies' lack of justification for such black and white groupings indicated that their real motives lie in denying coverage for the purposes of making a profit (Interview, Participant 10). He alludes to the control insurance companies have over doctors and medical facilities, calling for more authority to be placed in the patient-doctor relationship than in overarching, profit-driven industries. The authority of insurance companies dictates when and where sex and gender are linked, taking monetary control over the individual and the doctor's office, which then become a potential space for resistance.

The introduction of insurance companies as an overarching, profit-driven authority relocates doctors' offices as potential sites of allegiance between health professionals and trans individuals. In my participants' experiences this allegiance in resistance to the larger economic powers driving state regulation only formed with health professionals specializing in trans health and gender variance. This creates a complex system of negotiating when and where to reveal the trans status of a patient, or one's own trans status to a doctor, in order to subvert the economic powers of the state. Participant 5 discusses the ICD code used to get coverage for hormone therapy, saying, "The ICD code for hormone imbalance is 259.9. That's what's being used for the majority of them because it's the treatment of the hormone imbalance. The 259.9 is not linked to any behavioral health diagnosis, any mental illness" (Interview, Participant 5). Participant 5 is a psychologist at an LGBT focused healthcare center, and therefore, like many other doctors with trans clients, he knows that in order to get uncontested coverage, ICD codes that are not directly linked to trans identities are the most successful. According to Participant 5, the use of ICD codes not connected to the behavioral or mental health diagnosis of gender identity dysphoria is not for the purpose of covering up the trans identity, but rather for accurately representing a treatment for what it is, free of mental health stigma. As I sat in his dimly lit medical office, Participant 5 matter-of-factly explained to me that, "It is appropriate treatment for hormone imbalance to treat it with hormones...you know they're not treating mental illness, they're treating a medical condition, and so we just don't even bring [a mental health diagnosis] into the mix" (Interview, Participant 5). Thus, by simply using ICD codes for hormone imbalance, doctors recognize that trans identities and bodies do not have to be pathologized. In a way, this cedes the authority over gender embodiment back to the individual,

who can now choose whether they have a hormone imbalance based on their internal gender identity or not.

Returning authority to the trans individuals in a medical setting requires that all parties are accurately educated on the subject and understand the negotiation of gender embodiment that goes on between trans individuals and health insurance. When a doctor is unaware of the specific ICD codes that must be processed in order to grant access to coverage for their patient, insurance companies can once again assume authority over the body of a trans individual. Participant 6 told me a story of a friend who identifies as a transman, with corresponding masculine legal gender markers, who tried to get fertility treatments for himself and his wife:

> [The doctor] told the healthcare insurance what the situation was. He didn't realize that that would potentially be a problem. If he had just coded it, if he had just put it in, you know this guy, all his documentation lines up. He's got M's everywhere. It's not like there's some kind of mismatch. In terms of coverage, it probably would have been fine if [the doctor] had just put it in and coded it for infertility, which is true. It wouldn't even be a lie, but instead he told them, and they were denied, because they have a policy that can't cover anything trans related...and it meant that they ended up spending thousands and thousands of dollars on infertility, and they ended up giving up because the first three or four tries didn't work, and they ran out of money. So they weren't able to have a kid. (Interview, Participant 6)

What I find most interesting about this story is the emphasis on truth. It would not have been dishonest to put a code in for infertility because this is the problem that the couple was experiencing. However, out of the care of a doctor knowledgeable on trans health, the insurance company assumed authority over gender embodiment by excluding an individual from coverage solely on the basis of their gender identity. The physician's confession of the patient's irrelevant medical history enacted a series of judgments on the part of the insurance company, leading to the delegitimization of the patient's needs. This emphasizes the necessity of knowledge, rather than just good intentions. The lack of information in the mainstreams is dangerous when well-meaning assumptions fail to properly navigate larger economic structures.

The response from my participants when doctors did work to form this allegiance and educate themselves on trans issues was overwhelmingly positive. Participant 4 called the experiences she'd had with her doctors "beautiful," saying that they had all "transitioned with her" to mean that they had learned and educated themselves as much as she had throughout her transition (Interview, Participant 4). As I sat and sipped tea in the common room of her apartment building, I could not help but be in awe of the lengths her doctors had gone to to resist with her:

> I said to myself how can I live with a male gender marker as a woman with a female name? So I legally changed my name and then I talked to my endocrinologist and said I got to figure out a way to change my gender marker. I couldn't change my gender marker on my driver's license unless I had my birth certificate changed and then changed my SS card because you needed documentation that you'd gone through the surgery. Massachusetts, as long as you've had the surgery, is one of the easiest states to have your birth certificate changed, if you are born in Massachusetts. It took three times with my endocrinologist and the third time it worked out pretty good. All it was, was a simple letter because the hall of records down in Boston told me what their requirements were and all I needed was a letter saying that I'm going to have a change. So my endocrinologist and I put a letter together and all the letter said was that Participant 4 is a patient of mine and has undergone gender reassignment and is a complete woman. It's just a play on words. So they changed my birth certificate. My birth certificate is female, so if I die before my mother she can't bury me under my birth name as a guy. (Interview, Participant 4)

It is important to note the fact that Participant 4 has not undergone gender reassignment surgery. However, Participant 4's story symbolizes a moment of truth and revelation of identity without confessing the private details regarding her body, which would allow the state to control her. Her endocrinologist wrote an honest statement when he said that Participant 4 "has undergone gender reassignment and is a complete woman." She has gone through gender reassignment, but she has not gone through surgery. Participant 4 is a complete woman, but not according to the congruency mandated by health insurance and state regulations, which only define true gender reassignment as an alteration of the body in order to achieve a normatively male or female

appearance ("Medical Policy: Transgender Services"). The allegiance of her endocrinologist demonstrates the power of health professionals recognizing a patient's truth. This relationship of equal and individual authority allowed for a moment of resistance that deconstructs the power of the state and the internalized lack of autonomy attributed to individuals like Participant 4.

In the current health insurance climate of Massachusetts the need for these types of resistance seems to be dwindling as more and more private insurance companies begin to cover transitional care (Interview, Participant 8). This allows for doctors to be able to confess to insurance providers the status of their trans patient without entirely compromising the potential for coverage or differential treatment based on gender markers. However, according to Participant 8, an office manager and medical esthetician for a plastic surgery office in Boston, this expansion of coverage does not minimize the hoops she has to jump through when filing claims for the office's patients. The plastic surgeon she assists began taking trans patients in the late nineties, focusing mainly on performing chest reconstructions for the transmasculine community. Participant 8 said that this patient base started out small, "but within the last three years, our patient base has grown tremendously, as well as the insurance coverage. Where we were only doing a few cases a year, now we're doing twenty to fifty cases a year" (Interview, Participant 8). But the influx of patients due to the increase in trans inclusive health insurance plans does not indicate a lack of discrimination against incongruency. Participant 8 talked about the essentialization of identity reinforced in the process of applying for coverage:

> It's very bizarre, and almost kind of sad, because they just have these check boxes for everything, and some patients are very sensitive in the matter. So when we're trying to get the information, we have to be really careful in how we go about it, and how we say it because they can almost take offense to certain questions that we ask them, which we totally understand. And we get it, there are things like documented gender identity disorder. It's an insurance company thing that's sort of trying to be phased out in a lot of communities and groups. (Interview, Participant 8)

The language that doctors must use in order to claim trans related procedures clashes with the language used in the trans community to accurately represent varying identities, relating back to the inadequate simplicity and terminology of intake forms.

The issue of proper language further complicates treatment when insurance companies draw a distinction between a "normal" mastectomy and a trans related mastectomy. Participant 5 previously specified that hormone therapy was covered without contestation from the insurance companies if it was not linked to a trans patient, and Participant 6 discussed a similar phenomenon with fertility treatments. From the perspective of someone filing the insurance claim, Participant 8 reinforced the discrimination associated with this differentiation:

> A patient might call up [an insurance company], and say, "Do you cover mastectomy?" and they'll say, "Yes, of course," because it's usually cancer related. But what they actually have to call and say in very specific wording is, "Do you cover gender reassignment surgery. Is it a covered benefit with my contract?" because they call and they get the wrong answer. And then we call and they say, "No, it's not a covered benefit with this patient's plan," and then we are giving them the bad news. (Interview, Participant 8)

Participant 8 talked about how this process was further complicated because most of the time she would get someone on the phone who did not even know what she was talking about, "so sometimes what we have to do is hang up, call back, and try to talk to a different person" (Interview, Participant 8). The lack of knowledge on the part of the insurance company coupled with the authority they hold creates a dangerous situation in which people's mental and physical health is at stake. This ignorance also puts the burden of acquiring the knowledge needed to effectively resist coverage limitations heavily on the individual and their medical provider, a burden that will fall solely on the individual outside of trans friendly medical offices.

The use of rigid checklists and confusing terminology barely support coverage for transitional health care within the confines of the gender/sex binary, but hardly at all when

addressing identities and transition pathways outside this binary. Participant 8 confessed her struggles with the insurance companies and within her own medical office in providing treatment for nonbinary identified individuals. Here, her views demonstrate a certain contradictory sentiment in that she criticizes insurance companies for distilling identities down to a checklist, but states that ambiguity is a "red flag" in providing treatment. She says,

> We've had a small number of [more ambiguous] patients, and that's kind of a red flag to us, because in our eyes we're wondering if, first of all, this is something they really want to do, if they've made a fully informed decision on it, and where they sort of stand in this...it sounds like you really don't know which one you want to be. (Interview, Participant 8)

But then she goes on to say,

> It's really interesting and strange to me that sometimes [insurance companies] can be so easy and so difficult, and again it's a checklist, and not every patient is going to fulfill that checklist, but they might really need that medication or surgery. So it's kind of sad, and it's this whole algorithm. (Interview, Participant 8)

In the first statement, Participant 8 portrays ambiguity as indecisiveness, but then goes on to defend patients who do not fit into a preset checklist. This discrepancy demonstrates the effect of the rigid insurance structure healthcare providers operate under. Healthcare offices operate in the liminal space caught between the authority of overarching power structures like the capital-driven health insurance industry and the authority that is being reclaimed by the individual, creating a prime site for examining how these negotiations of authority impact the association of sex and gender.

Participant 8 delves further into these negotiations in discussing the term "medically necessary." Regarding coverage for a FTM mastectomy, insurance plans only consider certain aspects of the procedure medically necessary, and will only cover these aspects. Participant 8's knowledge of these procedures exposes this system as a means of gaining profits through discrimination rather than being based on legitimate findings. When I asked about medical

necessity she paused briefly, juggling the many hats she said she wears in the office, some personal and some professional. I identified with her because it is hard not to get emotionally invested in this work. Eventually, with a frustrated tone, she commented,

> You know it's a huge topic, especially with these surgeries right now, and how insurance views it, because they are so behind, is that this is all experimental. Well, why is it experimental? If you are going to approve the mastectomy why isn't the liposuction approved? That's medically necessary treatment. It's all part of the package. Patients don't get the care that they deserve, as far as insurance coverage, because they are just so behind with certain things, the whole medically necessary crap. (Interview, Participant 8)

Earlier, she detailed why liposuction is crucial to the procedure:

> Like I said, there are all these checkboxes, so how can Dr. Wilson do a full mastectomy without the use of liposuction? It's fatty and glandular. So it's very complicated, and there's also usually a cosmetic aspect in what he does anyway because, for example, with just the incision around the areola he has to remove tissue that has to extend all the way into the underarm. And that's something that could be done by a general surgeon in an hour if they cut you from side to side. So there is sort of a cosmetic aspect involved in the insurance aspect. (Interview, Participant 8)[21]

The discussion surrounding medical necessity is simply another way through which to use medical categorization to deny surgery. As Participant 8 asks, "Why is it experimental?" This relates back to Participant 10's observation that insurance companies do not justify why they cover certain bodies and procedures, but rather they base these decisions on a system of binary divisions and identity categories in order to exercise biopower. Participant 10 says,

> I just don't see the point, unless you are trying to discriminate...That's how their math works, but it seems like it's used to oppress people needlessly. I don't think it helps them economically that much to deny care to the 2% of people that have issues with this. (Interview, Participant 10)

Therefore the seeming economic justification for exclusively covering what is medically necessary becomes a system of structural power renegotiated within each patient's relationship with their healthcare provider. These convoluted interactions between the individual and state power illuminate Foucault's theory of biopower as something that insurance companies actively

[21] Name has been changed to preserve participant's anonymity.

try to harness. However, these instances of resistance question Foucault's lack of attention to the avenues through which individuals circumvent this institutional power.

Through the discussion of these relationships, there was a consensus among participants that more health professionals need to educate themselves about trans related healthcare, and that the professionals that are not well educated need to seek out supervision if they have a trans patient. Treating trans patients without the proper awareness led to inadequate services and even abuse among my participants. The compromising position this lack of knowledge puts trans individuals in regarding health insurance coverage and personal safety from harassment and abuse demonstrates the complex negotiation of authority over gender embodiment that goes on in healthcare. Without the authority to draw or break the connection between sex and gender, trans individuals lose this authority to overarching structures of power, enabling the same binary-driven Foucauldian discipline that dictates mainstream representation of their identities. These representations condemn incongruency and suggest that it must be cured through medically creating congruency to ensure state productivity. With education comes a more nuanced process of health professionals ceding authority over gender embodiment to trans patients, and serving as a resource rather than a mediator of trans related care. Heavily incorporated in this cessation of authority is the idea of self-labeling, withholding confession, and therefore refusing to be judged. This allows trans individuals to claim their own terminology and define what the terms they use to represent their identity mean rather than allowing medical jargon to do this for them, a concept I will further discuss in Chapter II.

Chapter II: The Meaning of Claiming a Trans Identity

Self-labeling allows for the representation of incongruency and resists medical models that pathologize the disassociation of sex and gender, seeking to eradicate incongruency from the moment it manifests in an individual. The narrow scope of medical jargon does not encompass the diverse terminology used within the trans community in representing each individual's identity, whether binary identified or not. Justifying and embracing incongruency in the actualization of an individual's authentic self enabled my participants to escape medical models of trans identities solely based on congruency and subvert the biopower attempting to create this congruency. The introduction of incongruency as an acceptable and authentic state in which to exist, rather than one representing liminality or indecisiveness (Davis 2008:101), further confirms that sex and gender are not inherently linked (Interview, Participant 6, Participant 9, Participant 10). Sex and gender may correspond within a given individual, but the lack of this correspondence in others contests the idea of the inherent cycle of material and materiality. In claiming a trans identity, my participants redefined the concept of transition and used self-labeling to establish authority over their gender embodiment and prove that congruency is not always the key to self-actualization. This concept came up throughout my participant interviews, as well as in discussions of terminology by trans scholars.

Defining Trans as Defining Incongruency

Language's role as a complex tool for liberating and constricting identity reflects a paradoxical relationship between trans definitions within the community and trans definitions in normative society stemming from medicalization. Language is an integral part of writing about

the lived experiences of those in the trans community because of both the positive and negative influence labels have on conceptualizing identity and representing it to the public and to oneself. Since the early 1900s, the language used to represent this community has evolved immensely, from words like "transvestite" and "transsexual" to more politically correct terms like transgender (Cohen-Kettenis 2009). These earlier terms are now dated; they are considered offensive, validating, and progressive all at once, depending on who is claiming them. The issue of claiming is crucial to the correct usage of these words. Mislabeling or using a term to generalize the unique experiences of many is essentializing and invalidating. Claiming a term to accurately represent one's authentic self is difficult given the sweeping generalizations that accompany labels, making self-labeling crucial and liberating, and medical labeling constrictive and even discriminatory at times.

Fenway Health, a Boston community health center at the forefront of LGBT healthcare, defines transgender as "An umbrella term for people whose gender identity and/or gender expression differs from their assigned sex at birth (i.e., the sex listed on their birth certificates)" ("Glossary of Gender and Transgender Terms" 2010:3). The definition WPATH uses in the newest edition of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* is an "adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth" (Coleman et al. 2011:222). Despite the fact that these definitions come from organizations whose mission statements pertain to actively supporting the wellbeing of the trans community, they do not encompass the full spectrum of labels and identities someone can use to represent their authentic self.

Binary-based definitions of trans identities are exactly what transgender activists like Feinberg and Stryker, many of my participants, and some more progressive LGBT health initiatives attempt to move away from. In opposition to binary definitions of trans, Stryker says, "it is the movement across a socially imposed boundary away from an unchosen starting place—rather than any particular destination or mode of transition—that best characterized the concept of 'transgender'" (Stryker 2008:1). In defining the term trans and depicting those who can claim it, this definition is key. The emphasis on an "unchosen starting place," refutes the discourse of trans people being a man born in a woman's body or vice versa. Instead this definition highlights that the gender assigned to a person at birth merely based on the appearance of their genitals was not chosen and not necessarily representative of their authentic self. Further, the discrepancy between this definition and medical definitions questions what can even be called a man's body or a woman's body. Stryker goes on to detail that a person's transition to embody their authentic identity does not have a socially defined endpoint. This contradicts medical models dictating that the best way to treat gender identity dysphoria is to follow a treatment model aligning a person's physical self to normatively match a binary gender identity.

A Journey With No Endpoint

As detailed in Chapter I, simplifying the transitional journey in a linear medical model reproduces the same essentializing narrative as assuming congruency to be the only desired state of existence. Congruency is normal, logical, and assumed, and therefore seems healthy. When a child is assigned female at birth and then does not become a little girl, societal expectations problematize this incongruence with the reinforcement of years of biomedical definitions and

norms.[22] Feinberg expresses this gendered oppression as something that even expands outside of trans identities: "Your own choices as a man or a woman are sharply curtailed. Your individual journey to express yourself is shunted into one of two deeply carved ruts, and the social baggage you are handed is already packed" (Feinberg 1998:6). Congruent and acceptable cisgender individuals only occur when female-bodied people are assigned female at birth, identify as women, and have a feminine gender expression, or when male-bodied people are assigned male at birth, identify as men and have a masculine gender expression. This allows for many points for incongruency to arise, not just in terms of transmen who are assigned female at birth or transwomen who are assigned male at birth. The path to actualizing a trans identity cannot be this simple either. Generalizing all transitions to a switch from male-bodied to female-bodied to establish congruency fails to encompass the multitude of different ways to negotiate gender embodiment and expression in accurately representing authentic gender identity.

The desire for individual-driven transitions surfaced in my discussions with mental health professionals specializing in trans issues, demonstrating knowledge of more nuanced trans identities among educated health providers. Participant 2, a social worker, captured the variations in each of her patients' transitions as we chatted in the very room in which she helps her trans clients define their own experiences:

> I generally treat it like any other issue that people come in with. I'm curious. I want to know as much as they can tell me about it. A lot of times, if someone comes in at the very beginning, a lot of it is managing the shame that people feel and once we can diffuse some of the shame we can figure out what, if anything, people want to do with those feelings. It's a process and a journey. People arrive at different end points. I think it's just important to be open to the process and not make assumptions about where people are or where they are going, or end up, because gender and sexuality manifest in multitudes of different ways. You have to be sure that you meet your client where they are. (Interview, Participant 2)

[22] In regard to sex, medicine and scientific truth emerged as one of Foucault's controlling disciplines, spreading the concept of truth and neutrality though the "medical norm," which grounded prejudice in truth (Foucault 1978:53-54).

Participant 2 allows for her patients to dictate the process of negotiating their gender identity and coming to an embodiment that speaks to their own lived experience: “I usually try and let the client lead” (Interview, Participant 2). Participant 5 voiced similar variations in his patient evaluations: “We often see people’s visions of how they want to see themselves and their bodies change over time, and we’re completely open to that if we ever find there’s a shift. So I leave a little room so they don’t feel too embarrassed to come back later” (Interview, Participant 5). Participant 5 deals mostly with writing referral letters for the trans patients of a larger LGBT focused health clinic. In his intake appointments he creates an open environment, allowing for flexibility and understanding that the goal of a transition can change over time.

My participants exemplified these changes over time by identifying differently at various points in their lives. Participant 1 began identifying as genderqueer in high school, but now identifies as a transmale. He told me that early on in his transition, when he was not even really thinking of himself as trans, he “started going to a trans group because I was just interested, but then I started realizing that I connected with the guys more than girls in women’s group. And then mid freshman year I started binding because I liked the appearance but didn’t think anything of it” (Interview, Participant 1). This contrasts with Participant 9’s experience of identifying as more binary at the beginning of his transition and now identifying as genderqueer (Interviews, Participant 9). These experiences illuminate a transitional narrative highly influenced by individual authority. Through the flexible and non-assuming environments created by Participant 2, Participant 5, and health professionals like them, nonlinear relationships between sex and gender emerged in incongruent and acceptable identities. These pockets of resistance delegitimize the need for normative categories. The stability of these medical environments in fact stems from their acceptance of fluid identity.

Participant 2 and Participant 5 both work in practices that are specifically geared toward progressive trans healthcare. The lack of knowledge surrounding trans issues in other clinical settings led to well-meaning professionals attempting to dictate patient transitions, re-establishing rigid, normative standards. Participant 3, who identifies as genderqueer and does not plan to medically transition, talked with me about such an experience:

> With therapists they can be like what does queer mean to you, so it's not really an issue. Doctors and medical professionals on the other hand are like have you considered going on hormones or what's your trajectory? Can you tell me a little bit about where you want to go? And I'm like, uh no. (Interview, Participant 3)

In addition to commenting on medical settings, Participant 3 elaborated on their experience with therapists:

> I find that a lot of gender therapists, if they're focused on gender they're focused on gender. They don't have a lot of other specialties...everything had to lead back to gender, and although they tried really hard to not push me into a category or an arc of transition, they were doing it a little bit anyway. They didn't really know what they were trying to accomplish if I wasn't transitioning. (Interview, Participant 3)

The constant reference to a trajectory or arc of transition adheres to a medical model of binary transitions that functions to rebrand trans individuals as congruent, and therefore avoid destabilizing the productivity of society. In reality, most of my participants established a path unique to their own identity, creating space for ambiguity and incongruency throughout society and redefining productivity as not simply linked to reproductive potential.

Participant 1 spoke to the individuality of transition and the evolution of his transition over time, while simultaneously clarifying that this evolution did not indicate the indecisiveness or lack of self-awareness assumed by medicalized notions of transition. When I asked him about future plans, Participant 1 said,

> I'm not sure. I can never really say for certain if I am or am not going to do something, because when I was coming out to my mother, when I was 14, a freshman, I was all, "I'm not going to go on T. I'm not going to get surgery." So now I kind of realize when I look

> back at myself. Things can change, so I can't really give any guarantees for my transition or what my next step is. (Interview, Participant 1)

The evolution of Participant 1's journey, however, did not compromise his sense of self:

> For someone else it might be internal stuff, but at some point I would have realized that this is what I'm supposed to do. Even though I wasn't presenting as feminine [prior to physically transitioning], I was still very feminine in terms of what my body was, so at some point I still would have wanted to change that. (Interview, Participant 1)

Participant 1 identifies as a transmale, and he expresses that his gender embodiment highly corresponds to his physicality and identifying as "just a dude" (Interview, Participant 1). His simultaneous recognition of the variations within his own transition and his "defensive[ness] of genderqueer folks" (Interview, Participant 1) demonstrates that his evolving decisions to physically transition to male do not negate the position that being trans and transitioning cannot be defined by anybody but the individual experiencing it.

Despite the need for individual definitions, I came across multiple individuals who had experienced immense pressure to eradicate incongruency and conform to societal gender norms in order to follow a binary transition, to justify the legitimacy of their trans identity to others. Although this pressure led to perceived conformity in certain situations, it did not compromise the individual's authority over their own transition and embodiment. Jason Cromwell discusses his own experiences with this pressure to create congruency between his body and identity through surgery in his book *Transmen & FTMs*. He says that if his incongruency was medically corrected then he would become a "'real' man" according to others: "I was 'less than a man' because I did not strive for a 'manly' occupation, ironically because I wanted to be a writer. I was once again not really a transsexual because I was not obsessed with having genital surgery" (Cromwell 1999:5). Cromwell details how his gender expression and his physical body intertwined to make him socially "less of a man" than the way he thought of himself. Being a

transsexual man would imply that he had undergone gender reassignment surgery to bring his body into congruence with normative ideas of socially "correct" men's bodies. It is crucial that Cromwell personally did not think of himself as "less of a man" because of this perceived incongruency in his gender embodiment. Despite the accusations against him, he did not fall under a pervasive and inescapable societal power structure mandating a match between material and materiality.

Participant 9 talked about a similar pressure in their attempt to receive hormone therapy and a mastectomy while identifying as genderqueer:

> It sucks to work within that system because if I were to express nonbinary kind of stuff in that setting, it would be, at that time, it would be perceived more as [Participant 9] doesn't know what he wants. [Participant 9]'s not sure. It would be too extreme for him to get this. (Interview, Participant 9)

In order to safely access the medical treatment Participant 9 needed to actualize their gender embodiment, they had to frame their transition in binary terms to their doctor. This did not result in a total loss of authority over their own identity, as they still hold claim to their expression and embodiment outside of a medical realm. Post-medical transition, they expressed an ability to avoid the assumption of congruency between sex and gender in talking about their body:

> So in that way it felt like more of a blank canvas sort of, that I could build upon rather than call these things that already had meaning attached to them. So it just felt easier, like I would feel more comfortable wearing a dress now because it wouldn't be me as a woman, it would be me as whomever in a dress. (Interview, Participant 9)

Therefore, the medical model that confined them to the binary during their acquisition of medical resources did not dictate or alter their authentic self. An individual's trans identity cannot be erased. Rather, the persistence and validity of the incongruency at times implicative in claiming this identity does not fit into normative medical definitions.

Participant 1, who did wish to complete a more traditional FTM transition, still contradicted these rigid definitions of what it means to be trans and address one's body dysphoria. He talked at length about his acceptance of his body prior to getting top surgery, and how this did not fit with a traditional gender identity dysphoria narrative:

> There was the issue of my breasts because I've always been accepting of my body. So I was very accepting of it, but didn't identify with it. It just kind of existed on my body. I felt very connected to them so that was one of the last things I was struggling with, cause you know, I'd lived with them my whole life. It was a push pull between I was going to be happier when they were gone but it was a letting go. They are still part of me, but I need to let them go. (Interview, Participant 1)

This acceptance, and therefore deviation from pathologized notions of transition, made others question their identity as a "legitimate" trans person:

> People were actually really confused about that because in the trans community and at school they were like well you're accepting of your breasts, what's going on? That's related to the whole not being trans enough thing, cause I was so open about not having my clothes on. But that's how I was coping with my dysphoria, by facing it head on. (Interview, Participant 1)

Participant 1's divergence from a traditional trans narrative of physical and mental pathology, despite their identification with the masculine side of the gender binary, suggests that only personal authority can shape an individual's true trajectory. This breaks open even seemingly binary identities and demonstrates that gender is much more complicated than a simple spectrum drawn between two biologically sexed categories. Where Butler suggests that a person's sex takes on meaning through overarching societal norms, Participant 1's experience contradicts the idea that breasts must be feminine and do not fit on a masculine body. The cycle of material and materiality does not account for this complication, though it did contribute to Participant 10's thought process when starting hormone therapy.

Participant 10 expressed that they delayed going on testosterone because they did not feel that their desire to be a male was as strong as that of their other friends who identified on the

transmasculine spectrum. He did not want to kill himself and did not feel the need to make a complete physical transformation from female-bodied to male-bodied either, therefore leading him to delegitimize the use of testosterone in his gender identity:

> I went through a long time debating with myself about hormones. I was really feeling like I couldn't become an adult. I didn't feel like I could grow up the way I wanted to without taking hormones. And it was just really upsetting seeing everyone I knew who was trans start hormones and being really jealous. It's just upsetting. *I was like, it's not fair that you identify as a man so you get to go on hormones. I don't identify as a man so I'm not allowed to go on hormones*…I felt like I shouldn't do that kind of drastic thing if it wasn't really *necessary*. For some reason most of my close friends that are trans, I mean I really only have three friends who are trans and they were all very binary identified. Two of them were acutely suicidal. So I felt like it was this thing like that's how it's supposed to be. You're supposed to know you are a boy when you are three and you're supposed to be suicidal when you hit puberty and then you go on and transition and get a sex change or else you will kill yourself. And I was like well I'm not like that so I don't have to do it, so I shouldn't, and it's really unfair that they get to do this. I think that you should evaluate the risks for yourself as best you can *and you should be allowed to make your own decisions about it.* (Interview, Participant 10)

Participant 1 voiced a similar trend:

> Within the trans community, mostly the FTM community, a lot of guys have this rigid idea of what transitioning is. You have to start testosterone, you have to get top surgery, you have to do this, this, and this to be trans and the thing is that not everyone fits those criteria. There are also genderqueer folks. Like one of my friends…He identified as genderqueer, didn't start testosterone but got top surgery. (Interview, Participant 1)[23]

This same participant defined trans as, "You don't identify with the body you were born in. Your gender differs from your sex" (Interview, Participant 1). This definition mirrors Stryker's definition in the sense that it does not specify an end point, a "correct" actualization of the trans identity. Instead, they both identify an incongruent start point, where sex and gender do not match. Participant 10's experience problematizes the ownership of certain bodies by certain societal categories and reinforces that material and materiality are not always cyclically influential and dependent on norms. In his description of his genderqueer friend, Participant 1

[23] In this scenario, Participant 1 uses trans not to indicate trans* as I do, but to refer to transgender and not encompass genderqueer identities.

specifies that a normative match between physical self and gender identity do not have to be reached for an individual to feel that they have embodied their authentic self. This diverges from the mainstream medical models of sickness and health where medicine solves problems through a definitive cure at the end of which the initial "problem" no longer exists.[24]

Justifying Identity through Terminology

The concept of a transitional journey with no distinct endpoint or rootedness in congruency, while valid, leads to complicated social interactions where an individual has to constantly reaffirm their gender identity verbally to be visible in a normative society. Participant 3's internal resolution and acceptance of what society would perceive as an incongruent gender identity was not reflected in their interactions with others. This necessitated constant justification of their existence through vocalizing a congruency between their gender expression, gender pronouns, and appearance: "Unfortunately when I ask for gender neutral pronouns I quickly follow it with the, 'I identify as genderqueer,' so people have a basis for why I'm asking for them. Otherwise, I find that people fight me on it" (Interview, Participant 3). Their response to this pushback further illuminates society's obsession with congruency:

> When I get people who do pushback on pronouns and my identity, I'm like well I'm sorry but how do you know what I have between my legs? And they're immediately like *do you have a penis?* And I'm like I don't know. *But you have boobs?* How do you know these aren't stuffed? (Interview, Participant 3)

This need to constantly legitimize a trans identity through binary definitions of sex and gender that separate congruent bodies from incongruent bodies, and furthermore, problematize those incongruent bodies, demonstrates the perpetual delegitimacy imposed on non-normative gender

[24] This concept of curing, and therefore erasing, a problem to bring a person back to health relates to the medical depiction of bodies as machines: "The Cartesian model of the body as a machine operates to make the physician a technician, or mechanic. The body breaks down and needs repair; it can be repaired in the hospital as a car is in the shop; once 'fixed,' a person can be returned to the community" (Martin 1987:56).

embodiment. In diverging from a mainstream model of sex and gender, Participant 3's resistance was constantly met with questioning and social gender policing.

This creates an interesting paradox where society imposes normative labels on individuals and individuals attempt to counter this imposition with self-labeling to justify their identity. Participant 4 talked about this in relation to her name, and the negative responses she got from certain family members and friends: "This is my real name. I've lived the way everyone wanted for 50 years. If I live another 50 years, it will be on my terms" (Interview, Participant 4). This theme of realness flowed throughout my various interviews. Participants emphasized that their self-labeling represented the real them to the public. When physical appearance and subtle hints did not convey the truth behind their authentic self, these vocal justifications got louder. Participant 1 said,

> I wasn't a very internalized dysphoric person, but my dysphoria was expressed outwardly. I was just kind of a dick. I was just constantly trying to be like, "Yo, I'm trans," yelling and screaming from the rooftops, because people didn't really understand that if I was really quiet about it. I was just really loud and proud about it. It wasn't particularly internal. I didn't really cry about it a lot. It wasn't that kind of stereotypical internalized dysphoria. (Interview, Participant 1)

Participant 1's vocal justification of his identity to others and to himself allowed him to express his dysphoria outwardly, instead of internalizing it. In making others aware of his true self, he avoided the distress associated with hiding one's identity. Participant 1's openness contradicts Foucault's supposed system of internalized norms leading to the repression of the true self. He fights the erasure of his individual identity enacted by societal institutions because the stress of closeting his identity overwhelmed the fear of potential ostracization from the mainstream (Foucault 1977:198-199).

Other participants used pronouns to resist societal norms and avoid erasure, bringing about continual tension with the systems they worked to subvert. Participant 6 explained to me

how in the process of representing themselves through non-gendered language others became uncomfortable:

> I identify as genderqueer. I also identify as transgender. I don't see myself as a man or a woman, and I use the pronouns he/him or ze/pir, or just [Participant 6], repetitively, which is actually delightful and really awkward for other people, but delightful. It works really well. I think a lot about the fact that we are ingrained to feel we have to use pronouns, and that repeating someone's name over and over again feels awkward to us because of how we've been socialized, but it's not actually grammatically incorrect. In fact, in contracts and legal documents it happens a lot. (Interview, Participant 6)

The learned grammatical structures that feel appropriate in normative conversations in fact turn the system of internalized behaviors onto the mainstream. Instead of Participant 6 internalizing the medicalization of their identity, it was the rest of society that felt uncomfortable due to the internalized biases represented in mainstream language. The simple substitution of a gendered pronoun with Participant 6's name creates a small difficulty for others, but is the difference between Participant 6 feeling respected and represented in a conversation. Rather than being controlled by them, my trans participants have challenged Foucauldian internalized societal patterns by establishing authority over language. The awkwardness that the larger society feels in accepting, or even accommodating, trans individuals in everyday conversation conveys that the mainstream is the sector of society controlled by these overarching structures of power rather than the individuals that have already broken out of this cycle and formed their own definition of existence.

In defining oneself and finding a transitional pathway to embody this definition, the individual reclaims authority over negotiating gender and sex. As Participant 7 pointed out, the key is "finding ways of feeling strong and confident and not letting other people define you for you" (Interview, Participant 7). Due to the pervasiveness of the binary-based medical jargon, the

development of alternative terminology is slow to catch on in the mainstream. However, Participant 2 made a final comment on the impact of language on the medicalized trans narrative:

> Even people who struggle with the idea of trans stuff, it's harder for them to understand that gender is not a binary so they could kind of get their head around a man trapped in a woman's body or a woman trapped in a man's body. But the idea that gender is not a binary is kind of a stretch for people, and there's no language to describe it. And that's also a problem, but I think if more people begin to live that way then the language will flow from it. We've struggled to find language and pronouns and none of it feels exactly right but I think just having people live it will truly lead the way. (Interview, Participant 2)

Participant 2 conveys that through language comes the ability to self-define and defy medical norms, pushing societal conventions further away from a rigid and congruent connection between sex and gender. Control of language allows an individual to confess the aspects of their identity that they want to be visible in society while still maintaining privacy. Lacking this control leads to a simultaneous invisibility and vulnerability to external labeling and judgment. Verbal manifestations of authority establish control within the individual, but mainstream societal norms largely rely on visual representation to assess identity. Therefore, along with verbal self-labeling, the concept of visually passing is imperative to claiming individual authority in social settings.

Chapter III: Implications of Passing

"Anytime I walk on the street my gender is visible. I am a woman. People see me and take me as a woman. And that's not passing, that's me just being." – Janet Mock

The concept of passing implies that there is something to pass as, a normative category to neatly fit into or embody through medical intervention. My participants did not want to pass as these categories. Instead, they wanted to pass as themselves. They wanted to have the resistance they demonstrated in taking control of healthcare and defining their own identity validated in their social interactions through an acceptance of incongruency. They refuted the idea that passing only occurs after a medical professional has bestowed the ability to belong in acceptable societal categories onto a previously incongruent and abject individual through medical intervention. In a brief video interview, trans author and fierce advocate Janet Mock discredits the concepts of passing, saying that it suggests a degree of inauthenticity or deception. She is not passing as a woman; she is a woman (Janet 2014). However true this comment may be, it does not encompass the experiences of trans people embodying incongruency, and therefore unable to achieve Butler's acceptable "approximation of realness" (Butler 1993:129). Fenway Health defines passing as "When people are perceived as the gender they are presenting in (e.g., based on their dress and mannerisms match according to social norms)" ("Glossary of Transgender and Gender Terms" 2010:10), and therefore identities that do not fit into binary definitions of sex and gender compromise an individual's ability to pass and thereby become viable at all in the mainstream.

The concept of needing something to pass as invokes the distinction between embodying congruency and resisting congruency, directly correlating with negotiations between material

and materiality. To pass conveys that the normative meaning of an individual's material correctly signifies their materiality, or gender identity, to those around them. When these assumptions of correctness contradict how an individual personally identifies and ascribes meaning to their body, regardless of their material, the connectedness of sex and gender disappears and the idea of being congruent with your internal and external self rather than societal definitions gains importance. Although passing may be a valid concern for many trans individuals whose identities adhere to binary gender structures, this concept discounts those who wish to *just be* outside of these preset categories. It takes away the credibility of existing as a female-bodied man who does not undergo a medical transition or identifying as genderqueer and other nonbinary identities. Passing inherently connects the concepts of gender and sex, or materiality and material, a correlation that many trans identities actively resist through embracing incongruency.

Living in the Middle

Through the concept of normative passing, genderqueer identities are an unaccepted space to exist in because there are no paradigms for passing as genderqueer. When discussing nonbinary identities in her patients, Participant 2 said,

> [The middle] is a very hard place to live. You have to have a lot of confidence to live in the middle. It's a very lonely place because for younger people there's more support around that, but it's hard to find other people living in the middle. (Interview, Participant 2)

The confidence that Participant 2 discusses as necessary for existing in the middle relates to concepts of identity validation.[25] When there is no existing category to pass as, and thus a lack of societal reinforcement, inner self-assurance plays a crucial part in identity. The incongruence perceived by others due to a lack of adherence to binary-driven gender norms, largely based on

[25] I use the middle as a symbolic spatial representation of the incongruency associated with not existing at either end of the sex/gender binary.

one's physical appearance, necessitates a strong sense of self and inner confidence that negates a need for external validation. For some this is an extremely lonely place to exist because others often do not see a person as they identify. These people live outside of societal intelligibility and legitimacy according to Foucault and Butler, an experience the pushes people to the margins in the absence of resistance (Butler 1993:8). This results in the constant need for non-normative individuals to assert their identity by countering others' assumptions as discussed in Chapters I and II.

On the other hand, society legitimizes identities that demonstrate a visual congruence between sex and gender. The assumptions made when categorizing outward traits as feminine, masculine, or androgynous convey mainstream ideas of what gender identity corresponds to what body. The confusion my participants cited when reflecting on others' perceptions of their genderqueer identities called into question what is so inherently troubling about incongruency for mainstream society. Participant 2 and I discussed the relevance of this point in her own work:

> There's a lot of worry about people being able to pass. Like, I don't want to be seen as a man in a dress. People have sort of a horror of that being people's perceptions. So there's a lot of worry about that, internalized transphobia. What is exactly wrong with a man in a dress, number one? Why is that such a horrible thing to be? And then number two, exploring all the ways they might be more feminine. Self-acceptance is a part of it because for a lot of people they are not going to pass. (Interview, Participant 2)

If a person's internal gender identity is a man then in order to "pass" as what society deems an authentic man, a cisgender man, the individual's outward appearance must adhere to cisgender ideas of male bodies. The negotiation between physical body and gender expression for the accurate embodiment of gender identity in a way deemed congruent or incongruent by mainstream society came up repeatedly throughout my conversations with participants. Participant 1, a transmale, said, "I want to be seen as a dude but when I enter certain spaces I want to be seen as a transguy" (Interview, Participant 1). This statement reflects a desire for his

authentic self to be seen and accepted by society regardless of the various social contexts he enters. He wants to be seen as a "dude" in order to validate his masculine identity. However, in social contexts where others assume that masculinity corresponds to being cisgender, Participant 1 wants to be acknowledged as a "transguy" to avoid the erasure of an important aspect of his identity. He does not want his binary gender identity to isolate him to a cisgender narrative. In actualizing his gender identity as a man, Participant 1 did not want to mimic a hegemonic paradigm; he simply wanted to represent himself accurately in his social and personal interactions. The desire to represent a degree of incongruency resists Butler's claim that subversive acts serve to reinforce heteronormative agendas. Throughout the different contexts my participants exist in, they negotiate an individual gender embodiment for the purpose of making visible their authentic selves.

For my genderqueer participants, being seen as their authentic selves did not negate their trans identity. Instead it subjected them to the social criticism associated with the visual incongruency of sex and gender. Participant 3 voices frustration over this issue:

> For some reason my gender identity is in the gender expression, which is mostly why I want to use gender neutral pronouns. It's not even that I feel that uncomfortable with male pronouns or female pronouns or whatever people choose to call me. It's that people default to female. They immediately see me, and they read me as female. And it's like, okay, what part of I buy all clothes from the men's department and have short hair did you not understand? Probably partially because of just the way my body is I immediately get read as female. (Interview, Participant 3)

Defaulting to the gender commonly ascribed to a certain sexed body negates the genderqueer, gender neutral, and other nonbinary trans identities of several of my participants. For others who have undergone medical transitions to actualize their gender identity this defaulting is a validation of passing as their true gender identity rather than their assigned sex at birth. However, Participant 3's attempts to express their gender in more masculine and neutral ways to

embody their genderqueer identity do not stop others from reading them as female. They are not trying to pass as a man because that is not their gender identity, but they do not identify as a woman either. This leaves them in the middle where there is nothing to pass as, causing people to default to female pronouns and assume they identify as a woman under normative presumptions.

Participant 3 attributed their difficulty passing to having larger breasts and unchosen secondary sex characteristics that medically would deem them a woman by association with their female-bodiedness, linking sex and gender. In mainstream society medical norms constantly enforce this false link in people's minds, making it difficult for Participant 3 to counter these assumptions with a masculine and androgynous gender expression. Participant 3 hopes that one day society will reach a point "where someone looks exactly like the sex they were born as and people still ask them what their pronouns are" (Interview, Participant 3).

Participant 3's wish to allow self-identification in spite of physical form relates back to the concept in Chapter II of what makes a male body a man's body and a female body a woman's body. A person's sex is based on their anatomy, genitals, chromosomes, and hormones whereas a person's gender is based on their "deeply felt psychological identification as a man, woman, or something else" ("Glossary of Gender and Transgender Terms" 2010:3). "Gender is a culturally constructed process" (Interview, Participant 2), yet the concepts of sex and gender are forced together through ideas of passing and appropriately embodied congruency. Janet Mock may refer to her gender as "being" and not "passing," but her specific gender identity and the embodiment of that identity does pass as a cisgender woman. For others, their embodiment is just as authentic, but does not involve passing as cisgender. It is also important to note that for others still, their desired gender embodiment would involve passing as cisgender, but they do not

have the resources to do so. There is certainly a threat of not passing in a binary world, as Participant 2 discusses. People have to consider "what impact there will be of being visibly trans in any way, if it will impact their relationships, work, family, friends. Shame, internalized transphobia, and how they will be perceived if they express the way they would like to be seen" (Interview, Participant 2). For the genderqueer community, the incongruency associated with the desire to not fit the binary or pass as cisgender makes the issues associated with being visibly trans very real.

This separation of sex and gender in my genderqueer participants' visual expressions of identity incited awkward, and at times hostile, social interactions that illuminated the difficulty society has when material and materiality do not depend on each other. Participant 6 spoke of his experience identifying as genderqueer and transgender while being comfortable in his female body:

> I don't use tradition to speak to my experience whatsoever. I am female-bodied, female assigned, and don't actually find that to be incongruous with my gender identity. My gender identity is genderqueer, and I tell people that I'm basically a gay boy pleasantly ensconced in a female form. And it's totally fine. So obviously then I run into trouble in society because *that's not really allowed*, but I don't experience internal trouble with my biology. (Interview, Participant 6)

Despite the disallowance of Participant 6's non-normative identity in his experiences with healthcare, mentioned previously in Chapter I, he actively resists societal congruence because conforming to it would only give him the appearance of existing in a healthy, normative body. In reality, this false manifestation of self would be incongruent with his authentic identity. Foucault's system of biopower does not acknowledge that internalized norms and discipline through fear only create the façade of state stability and productivity. Participant 6 says his identity is not allowed, but the societal norms that do not allow it do not erase his self-

determinism. Biopower does not hold ultimate control in the personal realm, as my participants' experiences demonstrate.

Participant 6 has not undergone any steps associated with a medically facilitated transition, but uses male or gender neutral pronouns and sings in the Boston Gay Man's Choir as a tenor. These actions fit seamlessly with Participant 6's sense of self and demonstrate a larger resistance against societal expectations of gender identity. Participant 7, a professional violinist, found a similarly nuanced gender expression to embody their genderqueer identity, again rubbing up against social acceptability:

> I've found the comfortable gender expression for myself on stage. I'll just wear a black suit, black shirt, black tie. But I found that that brings up all these issues where everybody's like well we don't know what to wear or where to put you or how to interact with you. With some colleagues I can really feel the tension. (Interview, Participant 7)

Both of these participants defy classifications of who is allowed to claim what gender identity based on their physical body. By segregating sex and gender in their own life and identity, not needing one to validate the other, they have forgone the need to pass as anything but themselves. Throughout our conversations, Participant 6 and Participant 7 seemed to possess the confidence that Participant 2 said was crucial to living outside the gender binary. They did not express feelings of dysphoria, but rather a comfort with their incongruency. The only exception to this for Participant 6 was the memory of certain childhood characteristics that had not continued into adulthood, such as a high voice, which dropped during puberty. He did however wonder:

> If my biology had been different, I might have already chosen to take some steps that might otherwise be, you know, considered transition-related steps. Like if I had been unfortunately endowed with a D cup chest, I don't think I would have been able to make that work. (Interview, Participant 6)

He expressed the sentiment that "things worked out well for me in terms of how my biology can actually support my gender identity" (Interview, Participant 6). His lack of physical female

signifiers in part allows him to incorporate a mix of masculine and feminine elements into his gender identity and embodiment without people assuming him to be either/or.

Participant 6 further delves into the separation of sex and gender, discussing physical form as something completely distinct from gender expression. He commented on his experience in the Boston Gay Men's Chorus:

> I actually blend in pretty well in terms of gender expression to the Boston Gay Men's Chorus for example, which is full of effeminate divas. Not all of us are effeminate divas, but a lot of us are. And I present my gender in that way very authentically, which is odd for people who are like wait a second, but you're not male, how is that possible? I'm like, well actually it's different. You can have that kind of gender expression of a female form, it just doesn't happen that often because we're not allowed. (Interview, Participant 6)

Participant 6 therefore creates a new and complex gender embodiment that does not ascribe to the binary. Again though, this puts Participant 6 in a position where he cannot pass because there is nothing for him to pass as. Nor is there anything he would want to pass as because he views his gender identity as a nuanced combination of both feminine and masculine, woman and man. He did not view this combination as an embodiment of androgyny though, which is an assumed visual classification of genderqueer depicting a mix of the two normative categories ("Glossary of Gender and Transgender Terms" 2010:5,7). When I asked Participant 6 about androgyny, he quickly corrected me by saying,

> It's not necessarily neutrality as much as it is complexity. I feel like I'm an interesting mix of feminine and masculine. I'm not androgynous whatsoever. I am very flaming and effeminate, but I'm female, and that's really hard for people to wrap their heads around. (Interview, Participant 6)

They are effeminate in a sense that is typically ascribed to male-bodied individuals, drawing a distinction between feminine and effeminate. The separate connotations of these two terms further suggest that only certain gender expressions are "allowed" to belong to certain bodies in mainstream society. As Participant 6's experience demonstrates though, resisting rules and

regulations of who can exist in what way and in what form allow for something entirely different: the expression of authentic self through separating sex and gender as distinct components to one identity.

Bodily Assumptions

The assumptions made by others when my participants expressed their authentic selves revealed a deeper analysis of how only certain identities are "allowed" to exist, as Participant 6 touched on above. Some of my participants recalled lived experiences when they were able to float back and forth across the gender line dividing man and woman, while others felt that they were consistently assumed to be female-bodied regardless of their gender expression. Interestingly these default assumptions or lack thereof typically related back to each participant's physical body and how much their secondary sex characteristics accentuated their female body.

Participant 6 focused on his voice in terms of the physical characteristic that contributed to assumptions and therefore his dysphoria. As noted previously, he experienced body dysphoria as a child, but this feeling did not continue into adulthood. In recounting his experience with vocal change and dysphoria, he said,

> I don't have what is considered to be a standard narrative around body dysphoria. There's certain stuff, but mostly is has to do with how I bump up against society's expectations and cultural expectations. For example, when I was a kid I remember the first time I heard a recording of my own voice, and it was deeply distressing for me because my voice was so much higher than I thought it was in my head. And I tell that story later and my partner's like oh gosh, how can you say you don't have body dysphoria when you have these kinds of stories? And basically what it is I felt like I couldn't be my authentic non-girl self. The expectation was because I was assigned female I would be a girl, and that because I was a girl I'd have a high voice and all this other stuff. (Interview, Participant 6)

When I asked if he was comfortable with his voice now, he said, "Oh yeah, so grateful that it dropped when I hit puberty!" (Interview, Participant 6). Participant 6 specifically focused on

colliding with societal expectations. Through commenting on authenticity and being his "non-girl" self, he conveyed that his dysphoria came from a physical characteristic that caused others to automatically label him as a girl. He referenced this as an "expectation" that a certain gender identity would result from being assigned female. He is not uncomfortable with being female-bodied, but instead with the assumption that this assignment comes with a "female" gender identity and "female" pronouns. This participant does not have an otherwise feminine form, and thus his voice was the characteristic that led people to these assumptions. The lowering of his voice during puberty signaled the removal of the secondary sex characteristic that indicated his female body to others. With the removal of this default classification, his dysphoria dissipated.

Participant 3 expressed a similar dysphoria related to their secondary sex characteristics leading others to mislabel and misunderstand their genderqueer identity. Instead of voice, this person focused mainly on the size of their chest and their inability to bind. They commented on the frustration of having a large chest in reference to how they "happen to like fashion that would be much easier if I didn't have large breasts" (Interview, Participant 3). Participant 3 wears men's clothing and finds fashion key in representing their authentic gender identity. However, the size of their breasts conflicts with this expression. They told me stories about being miss-pronounced with feminine pronouns (she/her/hers) in doctors' offices and constantly having to correct people and justify their identity. We talked about their gender expression and how it is clouded by physical form: "If there were a better spectrum for seeing the expression and to really see, oh they clearly did not want to be feminine, whatever they want to be, it's not feminine, and reacting accordingly, that would be great" (Interview, Participant 3). Participant 3 added that, "Probably, partially because of just the way my body is, I immediately get read as female" (Interview, Participant 3). Unlike Participant 6, Participant 3 cannot shed this physical

characteristic without medical body modification to break the link between sex and gender that society imposes on them. These experiences correlate to what identities are allowed in a Foucauldian society and therefore assumed to occur. Participant 3 wishes that more people could resist the mainstream as they do and therefore see the truth behind their gender expression, rather than forcing a normative identity on an incongruent appearance.

Participant 6 and Participant 3 both exemplify cases in which physical attributes associated with female bodies confined their identities, while Participant 7 experienced the opposite. Participant 7's height allowed them to step outside the rigid gender identity imposed on female-bodied individuals. Participant 7 also identifies as genderqueer and accepts female, male, and gender neutral pronouns. In reference to their height's contribution to the more masculine side of their gender identity, they said,

> Even though I'm biologically female, I'm 6'3". So that is one aspect of my physical self that is more like a man's experience. And kind of digging into that and finding ways connecting with all kinds of gender expression and that's one aspect that kind of lends itself to a different experience with strangers. (Interview, Participant 7)

Participant 7 connects the gendered experience of being a man to the physical experience of being tall, drawing another socially constructed parallel between sex and gender. The association of height with a "man's experience" allows this participant to pass in certain social spaces. Their gender expression, including the way they dress and their short hair, corresponds more with the masculine side of the spectrum as well. Thus with only their voice being high, others often take them as male-bodied. They described people calling them sir before they speak and then apologizing once their voice suggested a female body. Participant 7 specifically highlighted the joy they found in passing as male-bodied in these instances, as well as when they went out to gay clubs in Boston. When going out with their gay, cisgender male friends to spaces they also

identify with and feel comfortable in, they use a more masculine version of their name to avoid confusion and exclusion solely based on their sex.

Participant 7's focus on strangers' perceptions draws a link between their height and the societal misapplication of a male gender identity to a male body, alluding to the connection Butler draws between material and materiality. Participant 7 discussed this further when they said, "Sometimes when people don't know who you are, and they're going on their gut and assumptions, you learn almost a little bit more from that about how people understand gender in ways that they are not conscious of" (Interview, Participant 7). The fact that their height was so highly correlated to their success in passing as a male-bodied individual reinforces the norms that people use to determine whether someone qualifies as passing or not passing. These norms have a foundation in Butler's theory of the validity that comes with embodying alignment, or a match between material and materiality. The correspondence between Participant 7's experience and Butler's theory seem to suggest Participant 7's conformity to the mainstream, however the incongruency of their gender identity and the enjoyment they take in flowing across gender lines does not support their assimilation to a heteronormative discourse. Instead, their analysis of the gendered assumptions they experience based on their height demonstrates a deeper understanding of these systems and how to subvert them.

Participant 7 also talked about perceptions related to their short hair. In reference to a female coworker commenting on the fact that Participant 7 did not have any hair though they are female-bodied, Participant 7 said, "Everyone knows I'm gay, but they didn't really understand that that didn't mean that I was cisgendered, and that's sort of the foundation of my interactions" (Interview, Participant 7). This demonstrates how the combination of gender expression and a person's physical body dictates how others perceive their gender identity and what interactions

others assume are appropriate. Social perceptions indicate a system of short cuts with which many of my participants expressed annoyance, but which Foucault discusses as deriving from social categories that stabilize society (Foucault 1978:139). They wanted people to ask or say what they meant rather than using terms like woman and man when they actually meant female-bodied and male-bodied, definitions that those who participated in my study knew to be untrue. These social interactions signal how the mainstream links sex and gender in any given individual without their consent. Therefore the issue of passing comes back to gender embodiment and the proper correspondence between gender expression and physical form to depict what society deems a congruent individual.

Passing as Oneself

Though these three participants have not pursued medical body modification to alter their physical appearance of being born either male or female, the assumptions made by others when someone lives in the middle have resulted in body modification to embody a more androgynous form to dispel assumptions. Partial transitions and medical body modification alleviated the assumptions made about gender identity and physical sex for several people my participants referenced in their interviews. Participant 3 talked about a person they had seriously dated previously:

> Part of the reason he is transitioning is because, if the world simply didn't see him as female he'd be fine, like if the world saw him as something that doesn't have anything to do with female at all in any way he'd be fine. For me if the world sees me as anywhere in between I'm great, but for him it's really just like I don't like anything to do with female, feminine, anything F. And if the world saw him that way I'm sure it would be better. (Interview, Participant 3)

This same sentiment also came up with Participant 5, regarding his patients:

> This person said it well, it just kind of framed it beautifully: Well I've been in this college and it's an all women, all female-bodied, and kind of been able to do whatever I wanted to. But this summer I had to take classes at a major university, summer classes in Boston, and there aren't any gender neutral bathrooms and there's not any of these safe neutral spaces. And I realized at the moment when I was faced with these segregated spaces that I was really really deeply uncomfortable with being assumed to be female in every way. And so it was that forced developmentally appropriate experience of the society being based on a binary. And so if you are not firmly in the middle somewhere, that society is going to push your buttons, and you will have to discover and own at some level what you are uncomfortable or comfortable with. (Interview, Participant 5)

The push felt to undergo a medically facilitated transition to avoid assumptions and categorizations demonstrates the complex negotiation between societal perceptions (passing) and self-definition (gender identity), as manifested in an individual's unique gender embodiment. However, the idea that this gender policing condemned the person to a binary transition is false. Participant 3's ex and Participant 5's patient began hormones to embody an androgynous gender identity, not in an effort to pass as cisgender men. In fact, Participant 5 clarified that most of his genderqueer patients seek surgery without hormones, or only seek extremely low doses of hormones, "so that there's a little bit of an effect, but not enough to quickly alter who they are" (Interview, Participant 5). These statements problematize the idea that every individual strives to match their material and materiality in order to enjoy societal viability. The assumption that social influences completely strip an individual of their own self-determination perpetuates a misconception that everybody exists comfortably at one end of the binary or the other, when in fact Participant 3's ex transitioned to reinforce their identity's existence in the middle.

Passing as oneself conveys that incongruency is in fact the essence of congruency for people living outside the binary. Their incongruency embodies their innately felt self, representing a different kind of congruency with one's own identity rather than societal norms. Participant 7 has reached a place where they feel this incongruent congruency:

> Here I am wearing a wig and now I finally got to the point visually where if I wear a wig I look like a man wearing a wig. And that's good. That's what I want. That's accurate, and that's more accurate than anything that I have ever been able to do physically and that makes me really happy. (Interview, Participant 7)

Participant 7 felt strongly about striving for self-assurance rather than societal acceptance, accepting incongruency, and getting to a point where "when people don't understand, you can dismiss the people who don't matter and engage the people who can engage back with you" (Interview, Participant 7). In this way, internal intelligibility emerged as a greater force than societal intelligibility.[26]

[26] I use internal intelligibility as a synonym for incongruent congruency that allows an individual to make sense to themselves rather than fit with societal norms.

Conclusion

Portraying sex and gender as inextricably linked demonstrates a societal oversight of life's complexity. In listening to the lived experiences of people from the trans community, I found that their varying gender embodiments resisted the medical mockups of their identities in the mainstream and complicated Foucault's and Butler's theories on the societal production of sex and gender. These unrepresentative depictions rely on Foucauldian definitions of biopower and a cyclical construct of mutually dependent material and materiality. In the mainstream, the acceptance of trans identities largely relies on a superficial idea that although someone was "born in the wrong body" doctors can right this wrong through medical intervention. The pervasiveness of this model blurs the reality of sex and gender as two distinct classifications that an individual negotiates uniquely in their own embodiment. Using the resistance demonstrated by my participants, I contest the theories of Foucault and Butler, arguing for the independence of sex and gender through an analysis of individual, not structural, authority over gender embodiment. My contestation of previous postmodernist theory lies in the existence of resistance, the intersectionality of sex and gender as distinct axes of identity, and finally the ungendering of sex and unsexing of gender found in healthcare, individual, and social spaces.

Resisting Foucauldian Society

Foucault's suggestion that there is potential for resistance fails to recognize that resistance is already happening within his disciplines in spite of overarching structures of power. The authority held by medical norms and insurance pathologization represents only one site of authority. It is not my intent to trivialize people's experiences with this authority, as it has caused several of my participants medical trauma and abuse. However, this trauma did not compromise

their individual integrity, making them an automaton. The problems of healthcare and health insurance are disgraceful, but to distill an individual to a machine operating as a puppet of society is just as grievous as the physical abuse these power structures enact. A clearer and more complex understanding of trans experiences emerges when authority is relocated in the individual. Attempting to understand trans identities and the implications of gender embodiment from an oversimplified dominant narrative offers little validity compared to truly listening to the lived experiences of this community. In synthesizing the information in my three prior chapters, I found that many of my participants resisted the medical norms and classifications attempting to define them through identifying incongruency in their own gender embodiment and bringing this incongruency into a clinical setting. This resistance particularly surfaced in the incorporation of self-labeling in clinical settings, the refusal to negotiate discrimination, and the formation of alliances with health professionals.

Foucault discusses the elimination of nonproductive identities through medical norms and the pathologizing of these identities in order to funnel them through a binary cure, but in his argument he is blind to the ineffectiveness of imposing medical definitions and labels on the authentic self. Participant 6, Participant 9, and Participant 10 strongly exemplify this maintenance of a true self despite medical trauma. In the face of uneducated doctors performing invasive pap smears, physician attempts to take control of transitions, and mental health professionals treating them as if they were a zoo exhibit, these individuals stayed true to their nonbinary identities (Interviews, Participant 6, Participant 9, Participant 10). Their unique embodiments, despite their common identification as genderqueer and nonbinary, negated the claim that overarching authority shaped them even given these traumatic experiences. Participant 6 identifies with his female body, but not as a woman; Participant 9 made a medical

FTM transition through which they felt more at ease expressing femininity and presenting as their authentic, nonbinary self; and Participant 10 identifies as genderqueer, but not ambiguous, and has undergone hormone therapy (Interviews, Participant 6, Participant 9, and Participant 10). In solely addressing institutional sources of power, Foucault overlooks these distinct embodiments that resist gender binaries through their mere existence. This is not to say that the overarching structures of power are nonexistent or do not influence the individual, but these three participants complicate Foucauldian ideas of a lack of autonomy and self-definition. Foucault argues that individuals are the product of power and that internalized norms shape behavior and identity (Foucault 1977:201). The mainstream represents this model, seemingly rendering individual authority nonexistent. However, the complex identities of these participants convey that the mainstream is not an accurate representation of the complexity of sex and gender.

Butler also approaches sex and gender as products of societal structure, and discounts the existence of valid resistance. She claims that resistance follows the very structures of power it attempts to subvert, but this argument only analyzes life through a binary-driven trans narrative. The existence of binary trans identities does not negate the incongruency Participant 9 incorporates in their authentic self. Neither do the supposedly traditional transitions undergone by Participant 1 and Participant 4 suggest that they assumed an entirely congruent material and materiality upon physically embodying the sex opposite what they were assigned at birth. Participant 1 actively discloses his trans status in order to escape a heteronormative narrative despite identifying as a man. Participant 4 also openly shares the story of her transition: “This is me. My life is out there because I live my life by what I believe and my life is out there as an open book for the world to see” (Interview, Participant 4). Participant 4 is a complete woman:

"I'm built like a woman. I've got hips like a woman. I've got cheekbones like a woman. There's no way I can feel masculine in how I am. I don't even look at my birth defect as a masculine trait. I look at it as a birth defect, nothing more, nothing less" (Interview, Participant 4).[27] Her statement demonstrates an adherence to the gender binary in the sense that she identifies her female sex and gender as congruent, but her conception of her body as feminine delves past medical transitions and cures. She sees femininity in her body on her own terms rather than looking to institutions to create it for her. Yes, Participant 4 does hope to get gender reassignment surgery one day to remove her birth defect, but she does not see it as shedding a masculine trait to increase her femininity. Rather, she sees it as reinforcing the female that she already is and already embodies. While Butler suggests that people can only behave through the social avenues presented to them, the pattern seen in the experiences of Participant 1 and Participant 4 dismantles this point. They embody an authentic physicality that expresses the body they identify with and they label themselves to convey their own individual gender identity. In these cases this manifests in superficially heteronormative ways, but it is clear through the meaning my participants ascribe to their gender and sex separately that they resist normative avenues by dissecting and rearranging them to embody their own narrative. They therefore negotiate material and materiality as separate concepts rather than two parts of the same interwoven cycle.

As stated earlier, these forms of resistance are absent in the theory of Foucault and Butler. In less progressive times and geographical areas, this absence has extended to the clinical setting due to limited space for self-recognition. The terminology used in trans healthcare strictly adheres to a definition of trans as binary-solved and linked to mental illness. The need for a gender identity dysphoria diagnosis to access trans inclusive health insurance reinforces a

[27] Birth defect refers to the genitalia with which Participant 4 was born.

Foucauldian medical dictatorship over identity, but the emergence of trans friendly, well-educated health professionals subverts this system in ways that Foucault did not predict. Participant 2's patients have the authority to set their own transitional journey. She does not believe in a gender binary and therefore looks to her patients to define themselves and lead the way in treatment. She only seeks to provide her therapeutical resources as assistance rather than a set model for treatment. The information on alternative intake forms provided by Participant 3 and Participant 6, and the call for more widespread policy regarding this, further establishes a clear space for nonbinary representation in healthcare. As a health professional, Participant 5 calls for a degendering of health insurance altogether through removing the sex edits that dictate what care an individual can access based on an assumption of what body they have. These experiences demonstrate that there is space for resistance to expand out of the personal realm and into the clinical realm.

The permeation of resistance into the medical field occurs with the refusal to negotiate discrimination in mainstream settings. Deciding when to confess and when not to confess the incongruencies in one's embodiment restores authority to the individual, dispelling notions of health professionals as the expert on patient identity. Participant 3, Participant 6, and Participant 9 use their status as healthcare consumers to dictate the terms of their interactions with physicians. These participants set strict rules for what name and pronouns to use and assert that if these conditions are not met they will take their business elsewhere, putting them in control of the situation. This rejection of the impulse to confess through preempting invasive and assuming questions and setting a standard for future medical interactions protects these participants from the judgment of others. Butler suggests that this deviance will lead to societal rejection and unintelligibility (Butler 1993:2). However, the fear of experiencing trauma at the hands of health

professionals, as well as the trauma experienced through not being their authentic selves, exceeded that of potential societal rejection. Being unintelligible to themselves posed a greater threat to their life than being unintelligible to mainstream society.

This deliberate lack of confession is contrary to Foucault, who claims that the urge to confess is so great that individuals incorporate it into their natural existence and do not ascribe it to societal influence. Instead, the results of allowing another to dictate my participants' internal truth brought about a forced idea of embodiment connecting sex and gender that they did not see as reflective of their authentic selves. The severity with which they did not fit into this narrative was great enough to contradict the inner compulsion Foucault details. As Participant 5 points out, it is the diagnosis of gender identity dysphoria that often leads to discrimination in healthcare and health insurance. The individual's confession of the DSM-defined symptoms of gender identity dysphoria ultimately lead to the discrimination many trans individuals face: "Federally we do have laws against discrimination based on a medical condition and it seems to apply to everything except the diagnostic ICD code for gender identity dysphoria. That code gets kicked out and, federally, I would like to see us apply that law equally" (Interview, Participant 5). It is the medical double bind condemning trans people while promising to help them that leads to the need for individual authority, introducing clinical settings as another space for trans resistance and advocacy in defining an individual's desired embodiment.

An alliance with educated, trans friendly health professionals emerges out of this need for individual authority, one through which mental health professionals, doctors, and trans individuals work to subvert the biopower exercised by larger capitalist industries like health insurance. In this sense, individual authority over gender embodiment stems from an alliance with a more mutable sector of the overarching power structure. The health professionals that I

spoke with did not have an interest in collaborating with insurance companies, but rather in collaborating with their patients to fight insurance companies. Specifically, Participant 8 felt animosity in her correspondence with insurance companies while making claims for her patients. She said, "They don't always know what they're talking about," and "sometimes they try to make it hard and confusing because they don't want to pay any money" (Interview, Participant 8). Participant 5 speculated about the dangers of working within these power structures: "How much do I want to make insurance companies aware of what's happening? Are they going to then as a class start evaluating these folks with hormone imbalance coding? Suddenly that's going to be added to the list of things that they won't provide treatment under. I could see them doing that" (Interview, Participant 5). This resistance to forming an alliance with the reigning mainstream source of authority from a lesser, but still powerful, mainstream authority gives validity to the experience of trans individuals. Information trickles up the structures of society as individuals reclaim authority and refuse to negotiate their sex and gender as assumable and congruent.

The incorporation of this preexisting resistance into the medical field refutes the link between sex and gender that the medicalization of the trans identity falsely produces. In bringing self-definition and determination of embodiment and transition into a clinical setting the individual's reclamation of authority establishes a space for incongruency. Contradicting Foucault's panoptic model of total surveillance, the experiences of my participants convey a source of resistance and a subversion of the medical norm that is gradually seeping into the mainstream, at least in the Boston area. Active resistance without reinforcing pre-existing binary models of congruent sex and gender demonstrates that there is space for incongruent identities to shed light on greater societal misconceptions of these two aspects of identity. Foucault's analysis

of society is superficial in its lack of attention to the individual authority that already challenges the power of the state. By analyzing society solely through a mainstream institutional lens and not looking deeper into the lived experiences of the individual, Foucault proves himself to be under the regulatory control of the disciplines he names. The extrapolation of this loss of autonomy to every individual in a society suggests that he cannot think outside of his own experience rather than demonstrating validity in his theory of overarching power structures as the sole source of authority over identity and embodiment. As institutional power becomes one aspect of a multi-faceted web of authority, sex and gender emerge as distinct axes of identity rather than intrinsically interwoven components of an individual's material and materiality.

Distinct Axes Rather than Cyclical Interdependence

Sex and gender are two separate classifications that intersect, much like other identity categories do, but that cannot be constantly assumed to exist in tandem as Butler frames them. While second wave feminism drew a similar distinction, in the process of doing so it mislabeled sex and gender as immutable. Postmodernists like Butler reestablished interconnectedness between material and materiality to refute this immutability and the binary to which it subscribes. Rather than solving the essentialization of previous definitions, Butler's approach erases gender as an experience by lumping it in with sex and sex performativity.[28] She provides a framework for transitioning in which sex is made from gender when these two concepts are not congruent at birth, situating them in a constant state of interrelatedness. In distilling sex and gender into the concepts of material and materiality, Butler evades binaries but replaces them with a self-perpetuating cycle of ascribing meaning to the physical through heteronormativity.

[28] According to Butler, the concept of sex is nothing without gender, and therefore sex derives both its meaning and existence from gender through materiality: "gender emerges, not as a term in continued relationship of opposition to sex, but as the term which absorbs and displaces 'sex'" (Butler 1993:5).

In my participants' differing embodiments it became evident that physicality and gender identity intersect, but do not wholly correspond, in gender embodiment. This intersection spoke to the intersectionality seen in all identities regarding the multifaceted experiences of an individual. However, saying that sex and gender are a special intersection because of the meaning they ascribe to each other defines an individual through the perspective of others' judgments on the congruency of their body and identity. Participant 3 rightly asks the question, "How do you know?" (Interview, Participant 3). The assumptions made when drawing conclusions about people's relatedness to their body force people into a normative prototype without really inquiring as to the truth of these allegations. The incongruency apparent in the authentic embodiments of my participants is evidence enough that sex and gender are distinct axes along which individuals locate themselves to represent the person only they know themselves to be. These axes do not delineate a binary spectrum along which the physical and the mental exist, but represent infinite points of expression at which an individual may identify. The existence of these axes is particularly evident in the unique transitional journeys of each participant and the idea of passing as oneself.

My participants' bodies, their material, certainly meant something to them, but it did not necessarily mean something about their gender identity. I do not mean to say that these are completely isolated experiences, but linking them in a linear or cyclical pattern disregards the experiences of my participants who expressed gender embodiment in extremely different ways. This manifested in the incredibly diverse and self-driven transitional pathways and how throughout these transitions my participants related to their body parts in varying ways. Participant 1 talked at length about his acceptance of his body prior to top surgery. He conveyed a sense of physical acceptance uncharacteristic of the medical trans narrative, which mandates

that psychological stress be evident for medical necessity. His statement of feeling more comfortable topless pre-op than post-op indicates that while his desired body did not incorporate breasts, he still perceived his body as his own. He comments on the attachment he had to his breasts, and how he did not think of them as birth defects, but rather as something he needed to let go of in the process of self actualization: "It was a push-pull between I was going to be happier when they were gone but it was a letting go. They are still a part of me, but I need to let them go" (Interview, Participant 1). His experience was distinct from Participant 4's conceptualization of the parts she was born with as a birth defect. The simultaneous validity of these two embodiments demonstrates the various points of intersection between sex and gender. This is especially pertinent given that Participant 1 and Participant 4 were the only binary identified individuals who participated in my study as members of the trans community. If sex and gender influence each other in predictable ways through the cycle of materiality creating material, one would assume these two binary identified participants to fit into heteronormative medical definitions. This is not the case, revealing that within each individual identity the axes of sex and gender intersect at different points to which the individual only has true authority to ascribe meaning.

The transitional pathways of my nonbinary participants depicted the unique points of intersection along these axes. Participant 6 and Participant 9 were adamant that the nonbinary aspect of their identities did not make their embodiment, or self, ambiguous. They transcended the rigid categories of man and woman without viewing their gender identity as unstable or unintelligible, as Butler labels those living on the margins (Butler 1993:16). Instead they both used masculine presentations to allow for an increased comfort with femininity, deliberately creating incongruency in their sex and gender to embody an authenticity true to them. The

effeminate expression allowed through a physicality often read as male in their interactions with others denotes that material influences materiality in varying ways on an individual basis, rather than through societal norms and sex performativity. The experiences of Participant 6 and Participant 9 further complicate notions of cyclical material and materiality given that Participant 6 was comfortable in his female body and identified as female despite not identifying as a woman or a man, while Participant 9 took steps to make their body align with normative male characteristics through hormone therapy and top surgery. Each of them negotiated these variations in physicality with their nonbinary identity to embody a true self that cannot be confined to either end of the gender binary. Through a mainstream lens, their varying transitional pathways indicate opposing gender identities. However, in respect to individual authority their genderqueer identities represent the various ways sex and gender intersect in the embodiment of a nonbinary, but non-ambiguous, self.

The problem lies in the representation of these intersections to a society that judges individual identity on appearance. Those who do not pass as binary categories of congruent men and women are abnormal and need to be cured in order to ensure societal stability according to the medical lens. Again, this is one perspective that does not give credit to the concept of passing as oneself instead of what is deemed appropriate in society. Participant 7's experience of wearing a wig in front of their mother, who takes this as an indication of how Participant 7 should present their female-bodiedness, conveys the incongruency that paradoxically is congruent with their actual self. Congruency exists in incongruency when attention to individual perspectives replaces the mainstream medical lens and ideas of material gaining meaning through normative materiality. Participant 7 says that they look like a man wearing a wig, and that this is accurate. They wish that when people mistake them for a man they would not apologize upon hearing their

higher voice (Interview, Participant 7). This participant has validated their own incongruencies and now looks to society to do the same by not insinuating pathology in these incongruencies and being embarrassed when they notice them in social interactions.

My participants are already passing as who they are. What must stop is the assumption that mainstream medical notions of productive bodies dictate the meaning of flesh and performativity. Putting the onus on the individual for losing authority over aspects of their identity through societal influence scapegoats the individual. There are many influences on one's identity, first and foremost being oneself. In turning to lived experiences as the authority over individual existence, sex and gender become far more complicated than the model of cyclical interconnectedness proposed by poststructuralists when analyzing the mainstream. These axes take on more meaning as individual sectors of identity and embodiment, giving credit to the ways in which my participants negotiate these two axes and intersect them at unpredictable junctures to embody their authentic selves. Incongruency becomes congruent when it represents an authentic self. Society may only deem normatively congruent men and women "real," but trans identities reveal that "realness" (Butler 1993:129) comes from the congruency between internal and external expression represented through an individual's negotiation of these axes.

Unsexing Gender and Ungendering Sex

In order to fully understand gender embodiment, society needs to unsex gender and ungender sex. In pairing individual forms of resistance with the concept of gender and sex as distinct axes of identity, a complete image of the individual emerges. This perspective captures the authority people have over their own identity and embodiment in internal and external negotiations of self. Bodies do not belong to categories, but to the individual who is both within

and is the body all at once. The individual ownership necessary for authentic embodiment reinforces the congruence of incongruency. Pulling these identifiers apart requires the reservation of judgment and assumption through bringing individual authority into the mainstream. This process involves asking people about their pronouns regardless of a perceived correlation between gender identity and the sex they were assigned at birth. Unsexing gender is shedding the assumption that every person who presents normatively in relation to their sex also identifies with a normative gender identity. Ungendering sex is medically treating people and covering this treatment based on the body they have, not the gender marker on their forms.

My conversations unanimously pointed to the idea that embodiment exists on an individual basis. Only when the individual has the authority to voice their own experience can society truly realize the unique negotiations of sex and gender encompassed in each person. Resistance is already happening in trans friendly healthcare, social interactions, and individual identities. It is time the larger structures of society let go of an exclusively medicalized model of the trans experience. Certainly the exclusion of trans voices in mainstream society is painful and detrimental, as demonstrated in alarmingly negative statistics related to suicide, depression, and unemployment (Grant et al. 2010), but this does not indicate that these individuals have no control over their own identities and embodiment. It does not imply that the narratives included in the mainstream are the correct ones or the only ones. Instead, it distils an individual's gender to their sex assigned at birth or an individual's sex to a medical reversal of nature's "mistake." The acceptance of incongruency in the lives of my participants validates a model where sex and gender intersect without being owned by each other. Binary gender categories do not own body parts, and body parts do not dictate gender identities.

Unsexing gender and ungendering sex has vast implications for the widespread societal oppression of trans individuals, as well as the gender norms every individual is subjected to day to day with varying levels of intensity and violence. Medicine must assume its proper role as a discipline that assists rather than dictates individuals, creating space for mainstream representation of the meaning individuals ascribe to their own bodies. It is important to look at these incongruencies as implications of the existing problem of medical norms drawing congruency and ascribing it value. There is no validity in giving something the wrong meaning simply to perpetuate the appearance of societal control. Instead, these frameworks of medical power reduce people's productivity to reproductivity. It silences those that are productive without fitting the model of heteronormative reproduction and ignores the benefits of valuing internal intelligibility over societal intelligibility.

Individual authority claimed through resistance already exists as my participants actualize their authentic selves to achieve internal intelligibility. The grievances committed against those resisting and the perpetuation of their exclusion from the mainstream do not extinguish these individuals. In fact, it fuels a counter culture of self-definition and rebellious terminology, a culture of determining one's own biology. The alliances that are beginning to form between the trans community and health professionals in Boston symbolize a movement against capitalist control systems like health insurance companies and a rejection of the infallibility of biopower. The destabilization of the mainstream lies in its inability to accept incongruency. The expansion and enrichment of society lies in its ability to unsex gender and ungender sex, to accept the persistence of individual authority.

Appendix: Glossary

Androgyne - Refers to someone whose gender identity is both male and female, or neither male nor female. A person might present as androgynous, and/or as sometimes male and sometimes female, and might choose to use an androgynous name. Pronoun preference typically varies, including alternately using male or female pronouns, using the pronoun that matches the gender presentation at that time, or using newly developed gender-neutral pronouns (e.g., hir, zie).*

Bottom surgery - Surgical intervention on the genitalia.**

Cisgender - People whose gender identity and gender expression align with their assigned sex at birth (i.e., the sex listed on their birth certificates).*

[Gender] Dysphoria - A strong feeling of discomfort or discontent with one's body.**

FTM - Stands for "Female/[Woman]/Feminine to Male/Man/Masculine." A gender identity that covers people who were assigned female at birth but who are transitioning in some way to being male either in body, mind, or soul.**

Gender bender, Bi-gender, Beyond binary, Gender fluid, Gender outlaw, Pan gender, Polygender - Similar to genderqueer and androgyne, these terms refer to gender variations other than the traditional, dichotomous view of male and female. People who self-refer with these terms may identify and present themselves as both or alternatively male and female, as no gender, or as a gender outside the male/female binary.*

Gender dysphoria - Some people prefer this term over "gender identity disorder" because it has a less stigmatizing impact.*

Gender expression - The external manifestation of a person's gender identity, which may or may not conform to the socially-defined behaviors and external characteristics that are commonly referred to as either masculine or feminine. These behaviors and characteristics are expressed through carriage (movement), dress, grooming, hairstyles, jewelry, mannerisms, physical characteristics, social interactions, and speech patterns (voice).*

Genderfluid - Someone whose gender identities change or flow in unique ways.**

Gender identity - A person's innate, deeply-felt psychological identification as a man, woman, or something else, which may or may not correspond to the person's external body or assigned sex at birth (i.e., the sex listed on the birth certificate).*

Gender non-conforming - People whose gender expression is (1) neither masculine nor feminine or (2) different from traditional or stereotypic expectations of how a man or woman should appear or behave.*

Genderqueer - This term is generally used in two ways: (1) as an umbrella term that includes all people whose gender varies from the traditional norm, akin to the use of the word "queer" to

refer to people whose sexual orientation is not heterosexual only; or (2) to describe a subset of individuals who are born anatomically female or male, but feel their gender identity is neither female or male.* Or someone who queers the idea of gender in their own way and who does not conform or subscribe to the gender binary.**

MTF - Stands for "Male/Man/Masculine To Female/[Woman]/Feminine". A gender identity that covers people who were assigned male at birth but who are transitioning in some way to being female either in body, mind, or soul.**

Nonbinary - An umbrella term used to describe gender identities that are in between or outside the typical Male-Man/Female-Woman gender binary.**

Passing - When people are perceived as the gender they are presenting in (e.g., based on their dress and mannerisms match according to social norms). For example: an anatomical male dressed as a female who is perceived by others as female, or a transman who is perceived as a man.*

Post-op - Describes someone who has undergone surgery.**

Pre-op - Describes someone who has yet to undergo surgery.**

Top surgery - Surgical intervention on the chest, typically removing or adding breasts.**

Transfeminine - The umbrella term for anyone who is on the feminine side of the spectrum in their gender identity or expression.**

Transgender - An umbrella term for people whose gender identity and/or gender expression differs from their assigned sex at birth (i.e., the sex listed on their birth certificates). Some groups define the term more broadly (e.g., by including intersex people) while other people define it more narrowly (e.g., by excluding "true transsexuals"). Transgender people may or may not choose to alter their bodies hormonally and/or surgically.*

Transition - The process that people go through as they change their gender expression and/or physical appearance (e.g., through hormones and/or surgery) to align with their gender identity. A transition may occur over a period of time, and may involve coming out to family, friends, co-workers, and others; changing one's name and/or sex designation on legal documents (e.g., drivers' licenses, birth certificates); and/or medical intervention.*

Transman - Generally refers to someone who was identified female at birth but who identifies and portrays his gender as male. People will often use this term after taking some steps to express their gender as male, or after medically transitioning. Some, but not all, transmen make physical changes through hormones or surgery.*

Transmasculine - The umbrella term for anyone who is on the masculine side of the spectrum in their gender identity or expression.**

Transwoman - Generally refers to someone who was identified male at birth but who identifies and portrays her gender as female. People will often use this term after taking some steps to express their gender as female, or after medically transitioning. Some, but not all, transwomen make physical changes through hormones or surgery.*

Trans* - The word “trans” with an asterisk is used to denote that you are talking about transgender as an umbrella term encompassing the whole community.**

*(“Glossary of Gender and Transgender Terms” January 2010)
**(Simonoff 2014)

Bibliography

American Psychiatric Association
2010 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, D.C.: American Psychiatric Association.

Beredjick, Camille. Advocate.com, "DSM-V To Rename Gender Identity Disorder 'Gender Dysphoria'." Last modified July 23, 2013. Accessed January 30, 2014. http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria.

Blue Cross Blue Shield Massachusetts, "Medical Policy: Transgender Services." Accessed November 11, 2013. http://www.bluecrossma.com/common/en_US/medical_policies/189 Transgender Services prn.pdf

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

Butler, Judith
1990 Gender Trouble: Feminism and the Subversion of Identity. New York and London: Routledge.

Butler, Judith
1993 Bodies that Matter: On the Discursive Limits of 'Sex.' London and New York: Routledge.

Butler, Judith. "Your Behavior Creates Your Gender."*Big Think*, February 19, 2011. March 10, 2014. http://bigthink.com/videos/your-behavior-creates-your-gender.

Carmen, Carrera. "Carmen Carrera's Quest to Become a Victoria's Secret Angel." January 6, 2014. March 5, 2014. http://katiecouric.com/videos/carmen-carreras-quest-to-become-a-victorias-secret-angel/.

CNN Money, "Fortune 500." Last modified 2013. Accessed December 3, 2013. http://money.cnn.com/magazines/fortune/fortune500/index.html.

Cohen-Kettenis, Peggy T and Friedemann Pfafflin
2009 The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults. Archives of Sexual Behavior 39(2):499-513. http://www.cpath.ca/wp-content/uploads/2009/08/COHEN-KETTENIS.DSM_.pdf (accessed February 9, 2014).

Coleman, E., and W. Brockting and M. Botzer and P. Cohen-Kettenis and G. DeCuypere and J. Fraser and J. Green and G. Knudson and W.J. Meyer and S. Monstrey and R.K. Adler and G.R. Brown and A.H. Devor and R. Ehrbar and R. Ettner and E. Eyler and R. Garofalo and D.H. Karasic and A.I. Lev and H. Meyer-Bahlburg and B.P. Hall and F. Pfaefflin and K. Rachlin and B. Robinson and L.S. Schechter and V. Tangpricha and M. van Trotsenburg and A. Vitale and S. Winter and S. Whittle and K.R. Wylie and K. Zucker
2011 Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. International Journal of Transgenderism 13:165-232. http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.

Davis, Erin C.
2008 Situating "fluidity" (trans) gender identification and the regulation of gender diversity. GLQ: A Journal Of Lesbian and Gay Studies 15(1):97-130.

Docter, Richard F.
2008 Becoming a Woman: A Biography of Christine Jorgensen. New York: The Haworth Press.

Douglas, Mary
1966 Secular Defilement. *In* Purity and Danger: An Analysis of the Concepts of Pollution and Taboo. Pp 29-40. London and Boston: Routledge and Keegan Paul.

Eunice Kennedy Shriver National Institute of Child Health and Human Development: Pediatric Endocrinology Training Program, "Tanner Staging for Males and Females." Last modified 2008. Accessed December 3, 2013. https://science.nichd.nih.gov/confluence/display/pe/Tanner Staging for Females and Males.

Feinberg, Leslie
1998 Trans Liberation: Beyond Pink and Blue. Boston: Beacon Press.

Female to Male, "Reconstructive Chest Surgery." Last modified 2014. Accessed March 23, 2014. http://www.femaletomale.org/female-to-male-surgery/.

Fenway Health, "Glossary of Gender and Transgender Terms." Last modified January 2010. Accessed December 5, 2013. http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf?docID=7081.

Foucault, Michel
1977 Discipline and Punishment: The Birth of the Prison. New York: Pantheon Books.

Foucault, Michel
1978 The History of Sexuality: Volume 1 An Introduction. New York: Random House, Inc.

Grant, Jaime M., Ph. D., Lisa A. Mottell, J.D., and Justin Tanis, D. Min.
2010 National Transgender Discrimination Survey Report on Health and Health Care. Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force. http://transequality.org/PDFs/NTDSReportonHealth_final.pdf.

Hausman, Bernice L.
1995 Changing Sex: Transsexualism, Technology, and the Idea of Gender. Durham and London: Duke University Press.

Human Rights Campaign Foundation
2013 Corporate Equality Index. CEI. Washington, D.C.: The Human Rights Campaign Foundation's Workplace Project.

Human Rights Campaign Foundation
2013 Healthcare Equality Index 2007-2013. HEI. Washington, D.C.: The Human Rights Campaign Foundation of Health and Aging Program.

Intersex Initiative. (n.d.). *Insurance coverage for cosmetic genital surgeries*. Retrieved from http://www.intersexinitiative.org/law/insurance.html

Krieger, Nancy
2001 A Glossary for Social Epidemiology. Journal of Epidemiology and Community Health 55:693-700. http://jech.bmj.com/content/55/10/693.full.pdf.

Lombardi, Emilia
2001 Enhancing Transgender Health Care. American Journal of Public Health 91(6):869-872. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.91.6.869.

"Mainstream." Oxford Dictionaries.
http://www.oxforddictionaries.com/us/definition/american_english/mainstream?q=mainstream (accessed April 21, 2014).

Martin, Emily
1987 The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.

Meyerowitz, Joanne
2002 How Sex Changed: A History of Transsexuality in the United States. Cambridge and London: Harvard University Press.

Mock, Janet. "Janet Mock on 'Passing' & Redefining Realness." *Janet Mock* (blog), January 30, 2014. http://www.youtube.com/watch?v=kmqi3LaTef4 (accessed February 19, 2014).

Nagoshi, Julie L. and Stephan/ie Brzuzy
2010 Transgender Theory: Embodying Research and Practice. Journal of Women and Social Work 25(4):431-443. http://aff.sagepub.com/content/25/4/431.full.pdf+html.

Namaste, Viviane K.
2000 Invisible Lives: The Erasure of Transsexual and Transgender People: The University of Chicago Press.

Park, Madison. "Transgender athlete sues CrossFit for banning her from competing as female." CNN. March 7, 2014. http://www.cnn.com/2014/03/07/us/transgender-lawsuit-crossfit/ (accessed April 20, 2014).

Riessman, Catherine K.
1983 Women and Medicalization: A New Perspective. Social Policy 14(1):3-18. http://www.ncbi.nlm.nih.gov/pubmed/10264493

Ross, M. House of Representatives, Committee on Energy and Commerce. (2007). *Reconstructive surgery act of 2007* (H.R. 2820). Retrieved from The Library of Congress website: http://thomas.loc.gov/cgi-bin/query/z?c110:H.R.2820:

Rudacille, Deborah
2005 Childhood, Interrupted. *In* The Riddle of Gender: Science, Activism, and Transgender Rights. Pp 192-239. New York: Pantheon Books.

Simonoff, Cyn. Cyn Simonoff: LGBTQ , Educator, Organizer, Communicator, "Trans 101." Last modified 2014. Accessed March 19, 2014. http://www.cynsimonoff.com/trans-101/.

Stryker, Susan
2008 Transgender History. Berkeley, CA: Seal Press.

Tanner, J.M., and R.H. Whitehouse
1976 Clinical Longitudinal Stantards for Height, Weight, Height Velocity, and the Stages of Puberty. Archives of Disease in Childhood 51(3):170-179. Retrieved from http://adc.bmj.com/content/51/3/170.full.pdf+html.

Teich, Nicholas M.
2012 Transgender 101: A Simple Guide to a Complex Issue. New York: Columbia University Press.

World Professional Association for Transgender Health, "WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide." Last modified June 17, 2008. Accessed October 10, 2013. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947.

World Professional Association for Transgender Health, "WPATH History." Accessed December 5, 2013. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1452&pk_association_webpage=3903.

Zucker, Kenneth J., and Robert L. Spitzer
2005 Was the Gender Identity Disorder of Childhood Diagnosis Introduced into DSM-III as a Backdoor Maneuver to Replace Homosexuality? A Historical Note. Journal of Sex & Marital Therapy 31(1):31-42. Retrieved from http://www.tandfonline.com/doi/pdf/10.1080/00926230590475251