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The Provider's Letter: Cisgender Anxieties, Specters of Regret, and
Trans Agency as Liberation

By

Elias A. Lawliet

A dissertation in partial satisfaction of the

Requirements for the degree of

Doctor of Philosophy

In

Jurisprudence and Social Policy

In the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Calvin Morrill, Chair
Professor Catherine R. Albiston
Professor Osagie K. Obasogie

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Abstract

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Elias Alexander Lawliet

Doctor of Philosophy in Jurisprudence and Social Policy

University of California, Berkeley

Professor Calvin Morrill, Chair

Transgender individuals worldwide are bound to the necessity of the provider's letter—a letter from healthcare professional certifying the validity of their identity—for medical care and legal recognition. The use of the provider's letter continues, despite decades of community pushback, a lack of any evidence of efficacy or positive effect of the requirement, and multiple literatures supporting its unethical and damaging impacts on the trans community. This project uses three approaches, in the form of three separate but thematically connected articles, to understand the letter and its current usage in the trans medical and legal world. The first article defines the providers letter and performs an integrated historical review of the letter and the bodies of literature that have engaged with it; bioethics, critical literatures of medicalization/pathologization, and legal scholarship. This review concludes that the letter, rather than being a supportive or helpful practice, is used to control trans bodies and performances of gendered subjectivity. Further, that the justification of the letter focuses on the specter of regret, which has not been supported by evidence to be a legitimate concern. The second article digs into the history of the letter as an object, revealing its origins as a part of the application for a *transvestite certificate* in early 20th century Germany. This article focuses on sexologist Dr. Magnus Hirschfeld as the creator of the modern understanding of the letter, and its use in the application for the *transvestite certificate*, a pragmatic solution to the problem of presumed transvestites *disturbing the peace*. Hirschfeld's pupil, Dr. Harry Benjamin, brought the letter to the United States and served as the architect for early trans medicine in the mid 20th century, so its Germanic origins are deeply relevant to the modern practice. The final article focuses on an alternative approach to transgender medicine, first laying out the issues with the current medical model, then laying out an alternative model, the gender wellness model. This model rests on the idea that all people have an optimum level of gender wellness, and for some, reaching that optimum level may require intervention. While the letter is a complex object that resists simple categorization, understanding what it was created to do and how it functions practically in the legal and medical realm opens a variety of productive avenues for exploration.

Dedication

This work is dedicated to all trans people, past and present and future. We are beautiful, we resist hegemony, we frighten institutions with our power. Perhaps someday, the rest of the world will learn to listen to us, but until then, may we continue to destroy and remake worlds as we step lightly on this earth.

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Dissertation Introduction

The first time I tried to access top surgery, I didn't know how to start. I called my insurance company, knowing I certainly wouldn't be able to access it without their assistance. The agent that I spoke to informed me, in a deeply apologetic tone, that such a surgery was only covered if you were *actually transgender*. I do not know why this hapless agent assumed that I wasn't actually transgender, and I do not know why they didn't inform me that by that phrase, they meant *diagnosed by a mental health professional*. In my mind in that moment, my worst fear was confirmed—I was a fraud, and it was so obvious that a random stranger on the phone could tell.

Years later, when I was able to access surgery, it was only through attending a support group with two licensed psychologists who then wrote a letter certifying my transgender identity and assuring my insurance and surgeon that the surgical intervention was necessary for my wellness. By that point, I had been researching transgender health for years, and was acquainted with the debates around informed consent and provider's letters. I took for granted that we should have to obtain such letters at first, but after years of research and living through the process myself, I began to wonder where the letter came from and why it existed. I was no longer satisfied with the idea that this was just how things worked. It was quite obviously a poor system, replete with flaws. Yet the World Professional Association for Transgender Health (WPATH) continued to uphold it. Perhaps naively, I assumed there was *some* evidence, *some* reason, *some* explanation for why we had to go through so much trouble.

Thus began the journey that led me to each of the articles in this dissertation. When you begin to pull on the threads of the construct I've chosen to name *the provider's letter*, it connects to almost every thread of the tapestry of modern Western transgender medical and legal history, warts and all. The history of the letter begins, roughly speaking, with Magnus Hirschfeld, but Hirschfeld cannot be understood fully without understanding his ties to the eugenics movement, just as modern gender affirmation medicine cannot be separated from Eugene Steinach and the eugenic quest for eternal youth, also known as *rejuvenation* (Amin, 2018; Sengoopta, 1998). The letter itself, once established as a marker of validity, also becomes a marker of superiority, and access to the privileges that it affords becomes predicated on membership in privileged racial and class groups (Sutton, 2019). Perhaps because these facets of the letter were present from the start, they continue to play defining roles in access to letters in the United States, and worldwide.

The provider's letter crossed the Atlantic by way of Dr. Harry Benjamin, who was Hirschfeld's student and friend. Benjamin wrote his own letters in an attempt to help patients avoid jail time, and nearly lost his license for his trouble (Benjamin et al., 1966). Later, he chose to require a psychologists' letter for medical intervention out of the conviction that without it, there would be catastrophic experiences of regret (Benjamin, 1969). There was no documented evidence that this was actually an issue, and yet, the conviction of a few cisgender doctors that this *could* be an issue outweighed the well-documented reality that trans people were dying without gender affirming medical interventions. This commitment to avoiding the specter of regret resulted in the instantiation of the provider's letter as a formal requirement for accessing medical care, and later, as insurance companies began to cover affirming care, the letter was adopted wholesale as a requirement for coverage.

Today, as letters become more available (and as many clinics will offer hormones, at least, on an informed consent basis), insurance companies frequently employ letters as a means to deny life-saving medical care. For example, a trans woman I met at a holiday party in 2019 was being asked to obtain *three* letters for her gender affirming surgery, in addition to a referral from a primary care physician—a requirement that continued to stymie her multi-year efforts to obtain care. Since then, I have heard many anecdotal reports of this phenomenon from other trans people I met and spoke with, despite the fact that no standard of care recommends such an arcane barrier. In fact, the WPATH has updated its guidance to allow informed consent for hormonal care, despite still requiring two letters for genital surgery or any surgery that effects fertility (WPATH, 2012).

The letter profoundly effects legal access as well. In many states, the provider's letter is required, in some form, to access updated identity documents and gender-related name changes. Sometimes, the provider must state that medical intervention has been completed, or that surgery has been completed. In a few states, it is still impossible to change the sex and/or name on one's birth certificate, regardless of how many letters one has. An incomplete or inaccurate set of identity documents can have a profoundly negative impact on the wellbeing of a trans person, and precludes their capacity to participate fully in society (James et al., 2016; Spade, 2015). This continued refusal to allow the self-determination of trans individuals does not meet any known criteria for ethical or humane policy, nor does it rest on any scientific evidence. I have yet to discover any credible argument in favor of these policies, or any evidence that can be used to argue for their continued usage.

Though some published work contends with the bioethical problems with the letter, more has been written about the negative impact that pathologization has had on trans people's health and well-being (Davy et al., 2018; Schwend, 2020). Many trans people must engage with medical providers in order to access gender affirmation care, and even those who do transition medically must still engage with the healthcare system for routine, acute, and preventative healthcare. Many studies have revealed the stigma trans people face in medical settings, much of which is predicated on the idea that transgender identity is, itself, a mental health issue (including Dolan et al., 2020; Drabish & Theeke, 2022; Goldenberg et al., 2020; Hughto et al., 2015; Poteat et al., 2013). This situation is further exacerbated by the much-touted suicide statistics regarding the trans community, which are often misattributed as a feature of *being trans* instead of a feature of bearing the weight of tremendous social stigma and all of its sequelae.

After years of research, observing, and experiencing these challenges firsthand, I found myself wondering—what if instead of a medical model built on fears of regret, ideas about *true* or *actual* or *good* transsexuals, and assumptions of trans identity as pathology or illness, transgender care was based upon ideas of wellness and wholeness? What might replace letters if it were assumed that trans people could be trusted as the arbiters of our identities and lives? What might trans people be afforded if we were offered the fullness of medical agency and dignity that cisgender people enjoy? What would medical systems look like if cisgender anxieties about *regret* were removed from the calculus? And how might cis people benefit from a system that offers this type of self-determination?

The three articles that follow explore these themes in much greater depth, and provide a foundation upon which a robust body of work can be built. The letter—as a construct, a concept,

as both a real and symbolic object—is an incredibly rich portal to so many aspects of the Western transgender world. Yet literature that pertains to it is sparse and incomplete. The following articles are each self-contained, yet as a body, make a case for the letter as a largely unexamined site where the nuances of trans life, medicine, legality, stigma, and self-determination are consistently renegotiated.

The first article is an integrated historical review. It synthesizes the existing literature that addresses the letter, focusing on bioethics, medicalization and pathologization, and the legal realm. While this literature includes multiple disciplines and subject areas, similar logics are used to both engage with and to critique the letter and its place in each literature. Ultimately, this review reveals that there is no arena wherein the letter is used in a way that is supported by evidence and in line with current understandings of ethics. Rather, the letter is used as a way to verify the veracity of transgender individuals' claims to gendered identity in order to grant them access to legal and medical options that are granted to cisgender people without any sort of letter at all. It is contradictory for various high level medical bodies to proclaim that transgender identities are not mental illness nor pathology, but to simultaneously continue to support outdated and harmful gatekeeping practices such as letters. Although much has changed, the foundational logic of the letter continues to control and constrain the lives and life chances of trans people without evidence of any benefit whatsoever.

But how did the letter come to be? The second article explores the roots of this phenomenon, traveling back to Germany, 1910, and tracing the evolution of this construct through the work of Magnus Hirschfeld. Hirschfeld's unique positionality had profound implications for the formation of the letter, and for the place it occupied in German society, particularly during the Weimar era. The first documented letters were in support of *transvestite certificates*—legal documents that allowed the bearer to dress in clothing of what was presumed to belong to the *other sex* in a specific jurisdiction (Hirschfeld, 1991; Sutton, 2019). Later, *transvestite passports* were created to allow travel between districts, and some were even allowed to adopt another form of their name that was in line with their identity. This unique situation was not exactly meant to be supportive to trans people, but was rather a pragmatic legal solution for the public disturbances caused by those who were *perceived* to be cross dressing, regardless of their actual sex.

While a great deal of primary source material was lost throughout the Third Reich and World War II, most especially when the holdings of the *Institut für Sexualwissenschaft* (Institute for the Science of Sexuality; ISS) were burned, some of the print media of the time has shown that the certificates created a transvestite hierarchy (Marhoeffer, 2015; Sutton, 2012). This hierarchy fell predominantly on class lines, with middle class folks and those without a desire for medical transition being seen as the *good transvestites*, and working class and/or medically transitioning folks seen as the lesser *also transvestites* (Marhoeffer, 2015; Sutton, 2012). That one must be white to be recognized at all was practically a given, but colonialism was ever present, often in the form of stories about traveling to exotic locales either to find some unvarnished example of homosexuality or transvestism, or to achieve a magical gender transformation. While Dr. Benjamin did not live in Germany during this time, the logics underpinning the letter travelled across the Atlantic with it, and understanding its role in the country of its creation offers nuance to the role it has played over decades in transgender medicine.

As an endocrinologist, Benjamin's approach to transgender medicine was the approach of a man who was accustomed to using hormonal intervention to correct an illness. Therefore, it comes as no surprise that transgender medicine was conceptualized as treating the symptoms of a mysterious illness. But what if our models were based on another approach? The final article imagines an alternative model, one based in *gender wellness*, that goes beyond questions of medical transition or narrow legal solutions and provides an avenue for appropriate care of all gendered humans. This model creates avenues for care for those who require non-medical intervention such as social support groups, as well as for those who require extensive medical care including surgeries, hormones, and other adjunctive treatments. This model is based in the foundational assumption that everyone has an ideal level of *gender wellness*, and that some may need medical intervention to attain this, while others may not. This model also creates capacity for individuals who do not identify as trans, but who seek procedures traditionally associated with a gender transition. As new codes are added into the International Classification of Diseases (ICD), this model creates the needed conceptual backing for a future where gender affirming treatment is capacious enough to include all who require it, without any undesired interaction with the mental health system.

While each of these articles speaks to different facets of the letter and to what it has come to represent in the modern medical and legal fields of gender affirmation, they represent only a fraction of the work that needs to be done on this topic. Even as I write this introduction, in the year 2022, the letter itself is being used to constrain and control trans people worldwide. We currently face a massive backlash wherein hundreds of bills are being proposed (and alarmingly, adopted more and more frequently) to mandate the torture and surveillance of transgender children, transgender teens, transgender adults, and our supportive loved ones. When the situation feels hopeless and insurmountable, I remember the countless incredible trans activists, academics, doctors, and mental health professionals who have used their energy, influence, and time to fight back against arcane and transphobic policies for the past century. May this modest entry support future work by us, for us.

The Provider's Letter: An Integrated Historical Review

Introduction

In early 1900's Germany, Magnus Hirschfeld wrote a letter to the chief of police in Hamburg describing an individual who had been assigned female at birth, and who wanted permission to wear men's clothing (Hirschfeld, 1991). Fifty years later, his student and friend, Harry Benjamin, was brought before the medical board on a complaint regarding form-letters he had been offering patients he had designated as *true transsexuals* (Benjamin et al., 1966). At the very end of the 1970's, the first standard of care guidelines specified that anyone who wanted to obtain a hormonal or surgical sex-reassignment would need to obtain a letter of recommendation from a licensed psychologist (Berger et al., 1979). At a Christmas party in 2019, a trans woman told me that she was desperate for a medically necessary surgery, but she was struggling to obtain it—her insurance company required two letters from two separate mental health professionals, as well as a third letter from her primary care doctor.

This smattering of vignettes covers more than a century of time, spans multiple continents across the world, and weaves through medical, academic, and legal contexts. Yet despite their differences, each vignette represents one of many facets of a single object—an object that, over time, has evolved through official instantiation and active contestation to become one of the central vectors of legitimacy for trans identities. I call this object *the provider's letter*, defined as the official certification of a transgender person's gender identity by a medical professional for the purpose of accessing some otherwise inaccessible privilege. The privilege to be accessed is typically freely available to anyone who isn't trans.

The provider's letter has been used for over a hundred years for: law enforcement mitigation (Hirschfeld, 1991; Sears, 2015); marriage legitimation (Flynn, 2006; Larry, 2018); Americans with Disabilities Act (ADA) claims (Levi & Klein, 2006); access and barriers to healthcare (Cavanaugh et al., 2016; Davy et al., 2018; Drescher, 2010; Frey et al., 2017); and for amending identity documents (Adair, 2019; Spade, 2015; Spade, 2007). Although the ethics of the provider's letter have been critiqued in the literature (Ashley, 2019; Cavanaugh et al., 2016; Hale, 2007), no historical review of the letter exists. Most sources that discuss the letter point to the fact that it is required by the WPATH Standards of Care (SOC), but letters predate those standards by decades. When its purpose or necessity are discussed at all, the letter is typically claimed as a necessary requirement to avoid transgender regret and provider misconduct. However, no evidence exists that either of these outcomes is particularly common or in need of regulation through an additional process that is applied only to transgender people, and not to cisgender people seeking the same interventions for other reasons.

Regardless of the hand wringing over regret and provider misconduct, the letter functionally acts as a proxy for the cisgender approval of a transgender person's performance of gender. The process by which some trans people are legitimated and deemed worthy of medical or legal affirmation creates the category of the *true transsexual*. This leaves everyone else—those who cannot be relied upon to articulate their experience or needs or to be given access to legal recognition or medical care—to their own devices. The letter therefore is not only used as a method of gatekeeping various medical interventions and legal privileges, but also a method of separating *legitimate* gender performances from those which are seen or presumed to be

illegitimate to cisgender experts. This state of affairs creates profound inequities in a community which is already beset by a variety of legal, social, and medical challenges that result in profoundly negative health outcomes, poverty, violence, and trauma (James et al., 2016). This integrated historical review aims to elucidate the various literature that engages with the letter in order to create a fuller picture of what this object is and how it functions to legitimate and delegitimize transgender identities in medical and legal contexts.

Materials & Methods

The letter began its official role when it was instantiated into formal use in the first SOC, published in 1979. Though it was neither debated nor questioned in the medical literature of that time, it was brought up in a variety of literatures through the following decades, particularly since the late 1990's. This integrated historical research review draws upon a variety of published works, primarily peer reviewed articles, books, and case law. This approach blends the integrated research review (an exploration of how various scholarly traditions and forms of research have approached the provider's letter) with the historical research review (an examination of how the providers letter has emerged in various contexts and disciplines over time; see Fink, 2014).

The evidence for this review comes in the form of peer-reviewed, published literature that engages with the letter. Through the process of this review, three major realms of literature that engage the letter emerged; bioethics, medicalization/diagnosis, and administrative violence/epistemic injustice.

Each of these realms of literature interacts with and conceptualizes the letter. These literatures take different postures toward the letter, sometimes questioning, sometimes legitimating, and sometimes taking it for granted. These literatures are not, broadly speaking, in conversation with one another—the letter is the space where they come together. By analyzing how each of these literatures understands, presents, interacts with, and legitimizes this object, a new, synthetic understanding of the letter emerges.

Review

Bioethics

Articles in the realm of bioethics have broadly condemned the letter as violating all four of the established pillars of ethical medical decision making. Bioethical arguments are generally made based on four principles: respect for autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2001). Each of these is to be considered *prima facie*—each should be respected implicitly unless some equal or stronger obligation exists. Those scholars who approach the provider's letter from the discipline of bioethics measure its impact against these principles in order to make a normative claim about its ethical status.

The principle of non-maleficence requires that the potential harms be considered. In the realm of medical gatekeeping, the harms are generally accepted to include medical and social risks, irreversible changes, eventual regrets, and perhaps most pointedly, loss of reproductive capabilities (Ashley, 2019; Benjamin et al., 1966; Bouman et al., 2014; Bullough et al., 1997; Hale, 2007; Meyer et al., 2002; Rachlin, 2002; Stoller, 1978; Tomson, 2018). While these harms

must be considered with respect to their gravity, bioethics requires a *balancing* of non-maleficence, respect for autonomy, and beneficence in order to determine the duty of care (Denny & Roberts, 1997; Hale, 2007). A helpful way of considering this weighing process is to look at other medical procedures with similar consequences as analogies. For example, Hale (2007) uses vasectomy as an analogous procedure, because (for the purposes of medical decision making), it is considered an irreversible sterilization. In order to access a vasectomy, the patient must fully understand the consequences of the procedure, and the benefits of alternative measures (Hale, 2007). This is left up to the individual physician and patient—it is a private form of decision making, and does not routinely involve mental health professionals (Sharlip et al., 2012). The medical risks, social risks, potential for regret, permanent effects, and loss of reproductive capacity that exist as potential outcomes of this procedure are not adequate reason to involve mental health professionals or to assume informed consent to be an inadequate prerequisite.

The other important violation of the principle of non-maleficence are the demonstrable harms that occur from medical gatekeeping of gender affirming care (Ashley, 2019; Bouman et al., 2014; Cavanaugh, et al., 2016; Davy et al., 2018; Deutsch, 2012; Fraser & Knudson, 2017; Grant et al., 2011; Hale, 2007; Hughto et al., 2015; James et al., 2016; Lev, 2013; Tomson, 2018). For example, being unable to access gender affirmation care can increase trans individuals risk of suicide, but has been treated in practice as less concerning than the relatively unsupported idea that individuals who regret transition may have an increased suicide risk (Bailey et al., 2014; Bauer et al., 2015; Clements-Nolle et al., 2006; Haas et al., 2014; McNeil & Ellis, 2017; Moody et al., 2015). Additionally, the barriers to healthcare experienced by this population have resulted in extreme health disparities, including high rates of HIV (2.64% in the latest survey, compared to 0.6% in the general population) and drug and alcohol abuse (James et al., 2016). The specter of possible future regret does not bear out as the greater harm, especially when the reported instances of regret are typically reported as 2% or less (Bustos et al., 2021; Dhejne et al., 2014; Pfafflin & Junge, 1992).

Another source of gatekeeping rests on the idea of the “lone practitioner,” a single practitioner who does not consult with others and who is functionally outside the structures that supposedly provide protection for patients (Bouman, et al., 2014). While there is some conflicting evidence that lone practitioners have negatively impacted trans individuals in the past, there is no scholarly or peer-reviewed evidence that this is a real problem that effects a significant number of individuals (Bouman, et al., 2014; Entwistle et al., 2010). Weighed against the very real, measurable harms caused by medical gatekeeping (and especially those harms caused by the requirement for multiple letters for genital surgeries), this argument does not rise to meet the ethical standards of non-maleficence.

Non-maleficence is one principle—it must necessarily be weighed against the others. The first principle, respect for autonomy, is self-evidently violated by the requirement for the provider’s letter (Ashley, 2019; Hale, 2007; Tomson, 2018). Patient autonomy, by definition, allows for a patient to make their own choice regarding the care they will receive after engaging in an informed consent process (Beauchamp & Childress, 2001; Cavanaugh et al., 2016; Entwistle et al., 2010; Hale, 2007; Nelson, 1998; Tomson, 2018). The very purpose of this pillar of bioethics is to discourage medical paternalism. This bears an even greater significance for the trans population, as the discrimination and stigma against this population in healthcare settings is

well established (Ashley, 2019; Cavanaugh et al., 2016; Davy et al., 2018; James et al., 2016; Poteat et al., 2013; Tomson, 2018; Winter et al., 2016). As Tomson states, "...if the healthcare provider makes the assessment of whether or not a patient should be allowed access to gender-affirming care—this is a blatant violation of the principle of respect for autonomy" (2018, pg. 26). Hale (2007) points out that neglecting a patient's right to autonomy implies that they lack full moral worth to make their own decisions and direct their own lives. If a patient *can* consent to a procedure such as a vasectomy, but not to gender affirmation care, the policies betray a difference in *kind*, not just degree, relative to medical care that is not gender affirming (Ashley, 2019; Hale, 2007; Tomson, 2018).

Beneficence is inherently wrapped up in non-maleficence and autonomy; the risks of gender affirmation care are fairly low, while the benefits are very high (Ashley, 2019; Bouman et al., 2014; Cavanaugh et al., 2016; Davy et al., 2018; Deutsch, 2012; Fraser & Knudson, 2017; Hale, 2007; James et al., 2016; Lev, 2013; Lipshie-Williams, 2020; Tomson, 2018). Similarly, the principle of justice (being a fair distribution of risks, benefits, and costs) requires examining the standards themselves and how, even if they were applied equally, they bear out differently for various groups. For example, Tomson (2018) points out that race, employment status, income, and physical appearance all affect an individual's capacity to pass measures of "success" for transition, such as the Real Life Test (RLE). This is when the individual lives in their authentic gender for one or more years and must be judged as "successful" in that gender before they are allowed to access healthcare. The results of the RLE are included explicitly in most guidance for provider's letters. Services being more accessible to those who may be more capable of "passing" as cisgender is a blatant violation of the principle of justice (Ashley, 2019; Hale, 2007; Lipshie-Williams, 2020; Tomson, 2018).

Taken together, these articles span over a decade of bioethical knowledge production, yet still come to more or less the same conclusion—the provider's letter, especially the requirement that *two* such letters be procured for the purpose of obtaining surgery that affects one's genitals or reproductive system, violates bioethical norms. Regardless of concerns about the "lone practitioner," the requirement of having a provider's letter violates the core tenants of bioethics, especially respect for autonomy, which is both particularly valued and also particularly vulnerable in the healthcare setting (Entwistle et al., 2010).

Medicalization & Pathologization

The letter has been an important part of both creating and maintaining the medicalization and pathologization of trans people, resulting in increased stigma surrounding this population. The supposed need for the letter is a norm within a system of pathologization, wherein transgender identity is assumed to be part of a mental illness or deficiency. This is situated within the larger scope of medicalization of the transgender body, identity, and experience—a system which sees all *legitimate* transgender bodies as sites where medical intervention is necessary and welcomed. Because every aspect of access to gender affirming medicine is predicated upon obtaining a letter or multiple letters, trans individuals are often required to perform the expected narratives of pathologization and medicalization.

The medicalization and pathologization literature is by far the most developed body of literature that engages with the provider's letter. This literature focuses almost exclusively on the

intersection between the stigmatizing effect of a formal diagnosis and the impact of gatekeeping on the health outcomes and quality of life of trans people. As such, it typically involves the letter only tangentially, with a stronger focus on the totality of the effects of medicalization/pathologization, and debates about whether or how to maintain diagnoses that are used to provide treatment to trans people who medically transition. This literature is a vital part of both the history and the construction of the letter, because it is quite literally part of how the formal construct of the letter evolved.

A Brief History of Pathologization & Medicalization. The idea of transgender identity as a pathology or as a medical issue at all is a twentieth century construction that emerged from a specific milieu of social norms, shifts in the medical field at large, and the work of a few doctors (Califia, 2003; Davy et al., 2018; Gil-Peterson, 2018; Johnson, 2015; Levi & Klein, 2006; Meyerowitz, 2009; Riggs et al., 2019; Stryker, 2017; Sumerau & Mathers, 2019). Although the word “transgender” itself is a more recent construction, those who fall under its umbrella have been present for the entirety of recorded human history (Feinberg, 1996; Valentine, 2007). In the United States, there is a history of what we now name transgender people/identity/behavior both before (Driskill, 2016) and after (Beemyn, 2013) colonization. Trans people have always lived in communities throughout the United States and were often successful in their authentic gender presentation and accepted by their families and communities (Beemyn, 2013; Gil-Peterson, 2018).

In the realm of science and medicine, technologies and innovations to change or modify primary and secondary sex characteristics were created as part of a larger eugenic project, based in the ideas of *plasticity* and *rejuvenation* (Amin, 2018; Gil-Peterson, 2018; Sengoopta, 1998). This was, in part, due to the popularity of the theory of human bisexuality, which held that all humans held the potential of both sexes inside them (Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017). As word of this capability of scientists and doctors to transform one’s sex spread, more and more transgender people began to approach doctors in order to gain access to these seemingly miraculous technologies (Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017). Importantly, in these early days, there was no preconceived notion among these individuals that they were disordered per se—they did not come to doctors stating that they were suffering from a mental disorder, but rather described their situations in an incredible variety of ways (Beemyn, 2013; Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017). Some of those who sought medical intervention described some distress, but many discussed how they felt right or good when they presented themselves authentically (Beemyn, 2013; Gil-Peterson, 2018). Because (cisgender) doctors and researchers held the keys to the technologies that individuals could use to transform their bodies, they became the arbiters of what was published and theorized about trans people, or at least, what was considered to be legitimate within the phenomenon (Beemyn, 2013; Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017).

In the mid twentieth century, a constellation of events occurred: (a) Christine Jorgensen burst into the media and American imagination as the “Ex-GI” who became a “blond bombshell,” alerting trans people worldwide that transition *was* possible; (b) Reid Erickson, a wealthy American transgender man, poured millions of dollars into funding gender clinics around the United States; and (c) Harry Benjamin published his book, *The Transsexual Phenomenon* (Beemyn, 2013; Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017). The *transsexual* as a medical construction/diagnosis was cemented into the discourse during this time

(Beemyn, 2013; Drescher et al., 2012; Gil-Peterson, 2018; Meyerowitz, 2009; Stryker, 2017). Tensions arose around who was allowed to obtain medical transitions, and how such care was to be standardized and regulated (Beemyn, 2013; Drescher et al., 2012; Gil-Peterson, 2018). The fullness of this history is beyond the scope of this paper, however, after the Erickson Foundation funding dried up and the anti-transgender backlash of the 1970's began, most gender identity clinics were shuttered and most doctors refused to perform gender confirmation surgeries or even prescribe hormone therapy (Beemyn, 2013; Meyerowitz, 2009; Stryker, 2017).

During the 1970's, as the Gay Liberation movement gained steam, gay men and women began to campaign to have homosexuality removed from the Diagnostic and Statistics Manual (DSM; Drescher, 2010). This activism resulted in the removal of homosexuality from the DSM, but it took some years for the full, new edition of the DSM (DSM-III) to be published. It was during these years that the APA, acting on research by prominent sexologists, endocrinologists, and psychologists of the time, decided to include "gender identity disorder of childhood" and "transsexualism" in their next volume, eventually amended to reflect Gender Identity Disorder (GID) with different sets of criteria for adults and children (Drescher, 2010, pg. 437). This solidified the pathologization of transgender identity, as evidenced by the World Health Organization's (WHO) decision to add transsexualism and gender identity disorder of childhood in its 1992 ICD-10 (Drescher, 2010). Although this move toward formal pathologization is currently seen as a negative development in transgender medical history, that view was not monolithic at the time. The shuttering of many gender identity clinics left a vacuum in the possibilities for medical transition among trans Americans—instantiating GID as a diagnosis carved a pathway for care, however imperfect of a tool it proved to be (Drescher, 2010). However, inclusion in the DSM also cemented the idea that trans identities were a *mental* illness and that they should be treated by doctoral level mental health professionals (Bouman et al., 2010; Drescher, 2014; Ehrbar, 2010; Lev & Klein, 2006; Macdonald-Labelle, 2012; Meyer-Bahlburg, 2010; Sennott, 2010; Toscano & Maynard, 2014).

Although GID allowed for some trans people to access care, its limitations and stigmatizing nature were quickly apprehended by trans people and, to some extent, by the doctors who treated them (Davy et al., 2018; Lev, 2013; Stone, 1991; Winters, 2008). As the American Psychological Association (APA) labored to write and publish their updated DSM-V, the controversy around medicalization resulted in a variety of papers published throughout several journals representing many different viewpoints. Drescher and colleagues provide several in-depth reviews of the controversy (Drescher, 2010; Drescher et al., 2012; Drescher, 2014; Drescher et al., 2016; Reed et al., 2016), although accounting for the full controversy is outside the scope of this paper. In the DSM-V, the APA did remove all mentions of GID, and replaced it instead with Gender Dysphoria (APA, 2013). This was seen by many as a half-measure, or the best that could be done under limiting circumstances (Davy et al., 2018; Lev, 2013; Schwend, 2020). However, "gender dysphoria" was a term already used in popular, academic, and medical discourses to describe the distress that trans individuals felt about the incongruence of their identity and their physical presentation (Ashley, 2019; Davy & Toze, 2018). By taking a known concept and turning it into a literal diagnosis in the DSM, the APA both retained their ability to stigmatize transgender individuals and created confusion around what exactly gender dysphoria is, and whether or not Gender Dysphoria (the diagnosis) and gender dysphoria (the experience) are the same and should be treated in similar ways (Ashley, 2019; Davy & Toze, 2018).

Finally, in the ICD-11 (released in 2018, set to go into effect in 2022), all trans-related diagnostic codes were removed from the chapter titled, “Mental and Behavioral Disorders” and replaced by the “Gender Incongruence” code, located in a new chapter entitled “Conditions related to sexual health” (WHO, 2019). While this was a positive outcome that resulted from decades of activism and academic research, many depathologization advocates still feel the term *incongruence* is pathologizing to a degree, and prefer that it would be replaced by something like “Health care related to gender transition” (Schwend, 2020).

Impact of Pathologization. It is important to note that transgender depathologization efforts are not only focused on medicine and healthcare, but also on legal recognition (Amnesty International, 2014; Davy et al., 2018; Schwend, 2020). It is often required that trans people engage with the healthcare system in various ways in order to access legal recognition, such as name changes, gender marker changes, and birth certificate amendments (Schwend, 2020; Spade, 2015). This is part of a system of *normative accountability*, wherein trans people are required to make their experiences legible to a *cisgendered* system (Johnson, 2015; Sumerau & Mathers, 2019). This system relies on the concept that transgender people have been *born in the wrong body*, and that correcting this requires medical intervention (Johnson, 2015; Schwend, 2020; Spade, 2015; Sumerau & Mathers, 2019).

Throughout this history and up to the present moment, the letter is an object that does much of the practical work of this system. The processes by which a letter is accessed can be opaque to many individuals, and even when one can schedule with a therapist with the knowledge and training to provide a letter, the session and service may or may not be covered by insurance. The bureaucratic hurdles alone can be so overwhelming as to render the entire process impossible to the most marginalized members of the trans community. In addition to these hurdles, the practical reality of obtaining the letter can result in many harmful interactions and microaggressions, including misgendering and *deadnaming*, or being exposed to a name one no longer associates with (Dolan et al., 2020; Freeman & Stewart, 2018; McLemore, 2015).

Full autonomy and depathologization will not be available until transgender healthcare *and* legal recognition is subject to a system of self-attestation, as is currently in place in Argentina, Denmark, Colombia, Ireland, Malta, Bolivia, France, Norway, Portugal, Costa Rica, Chile, and Uruguay (Schwend, 2020; Spade, 2015). Such a system allows for trans people to articulate their own experiences and needs, and crucially, to be believed as credible reporters of their own experiences and needs. This can only be accomplished through abandoning the use of the letter entirely in medical contexts.

Legal Realm

While it may still be a barrier to necessary outcomes, the letter serves a much different function in the legal context. Broadly, the provider’s letter (or, at times, spoken testimony) is used to (a) legitimate or delegitimize a transgender person’s identity for access to a legal benefit such as marriage, or (b) amend a transgender person’s legal identification documents, including state IDs (driver’s license, identification card), federal ID’s (passports, social security cards), and birth certificates. Each of these contexts share key details—for example, it is often the testimony of the credentialed party (not that of the person themselves) that is taken as the expert testimony. However, the implications of these contexts differ greatly, especially in the case where certain

laws have been changed or rendered obsolete. Rather than providing a transgender person with access to medically necessary care, the provider's letter in a legal context provides a transgender person with their very ability to function in a public context, free from interference by others. For this reason, legal scholars have written about the provider's letter (or at times, testimony) through the theoretical lenses of *administrative violence* and *epistemic injustice*.

Administrative Violence and Epistemic Injustice. While depathologization literature does cross over into the legal realms the role of the letter in transgender legal embodiment extends past pathologization and medicalization. Though this body of literature is less developed than that in the previous section, it is still vital to the overall discussion of the letter and the way it functions in the legal realm. The legal system interacts with the provider's letter at any point where a trans person is required to verify their legal sex. Functionally, this occurs in any scenario where a form of legal identification is used, and enters case law most often in the realm of marriage legitimation and sex-based discrimination cases.

Spade (2015) puts forth his theory of *administrative violence*, which occurs when administrative systems create and perpetuate the conditions of oppression (Spade, 2015). It is via the banal processes that distribute life chances that many trans people are excluded from full participation in their own humanity (Spade, 2015). Population-level interventions rely on categories to sort people into groups, and the definition and application of those categories creates “vectors of vulnerability and security” (Spade, 2015, pg. 74). Spade points to three major areas where trans people are affected by this form of violence: identification documents, sex-segregated facilities, and health care access. Additionally, since surveillance and identification verification processes have increased in their severity since September 11th, 2001, transgender people have been severely affected by inconsistencies across their records (Spade, 2015).

Beauchamp (2019) extends this analysis, pointing out that trans can be used as a lens through which to view current surveillance practices. By failing to conform to hegemonic gender norms, anyone can be subjected to state violence, regardless of trans identity or history (Adair, 2019; Beauchamp, 2019; Murib, 2019; Quinan, 2017; Singh, 2019). Normative gender is predicated on racial and economic norms; to shed one's trans status, one must comply with all of the norms of white, middle class, able-bodied, and heterosexual ideals of gender (Adair, 2019; Beauchamp, 2019; Singh, 2019; Spade, 2015). Medicine, administrative law, and legal precedent operate in tandem with neoliberal discourses of individualism and equal rights to craft the category of transnormativity (Adair, 2019; Beauchamp, 2019; Hale, 2007; Spade, 2015; Vipond, 2015). Those who do not or cannot conform are subject to various forms of discipline and violence, which either bring them into line with the normative subject or annihilate them symbolically or physically (Adair, 2019; Beauchamp, 2019; Singh, 2019; Spade, 2015).

Epistemic injustice, defined by Fricker (2007), occurs when a knower's claims to knowledge are invalidated, and/or when knowers lack the requisite grammar or vocabulary by which to articulate their experiences and render them legible. Across many social realms, there is an unspoken commitment to the cisgender paradigm of sex and gender (Aultman, 2016; Fricker & Jenkins, 2017; Sumerau & Mathers, 2019). This is deeply institutionalized in both the medical and the legal realms—in medicine, the “two gender” model of medicine is the only one that is considered, and in the legal realm, the nature of precedent necessarily prioritizes cisgender constructions (Aultman, 2016; Sumerau & Mathers, 2019). Further, transgender people have

been assumed to be unreliable knowers of their own experiences, identities, and selves across all contexts (Aultman, 2016; Sumerau & Mathers, 2019). This assumption of unreliability is encapsulated through the medicalization and pathologization debate discussed earlier, as well as in the many administrative rules that govern transgender bodies. The injuries of epistemic injustice are multiple; not only have trans people been denied an adequate vocabulary for articulating their identities and legal situation, but what vocabulary they have has been largely determined by the same systems that manufacture and perpetuate their oppression (Adair, 2019; Aultman, 2016; Fricker & Jenkins, 2017; Spade, 2015; Sumerau & Mathers, 2019).

Case Law. Examples of the material impacts of these theoretical concepts are plentiful in legal records, especially in cases involving marriage legitimation and identity documents. These cases shed light on the concepts of epistemic injustice and administrative violence, demonstrating how these frameworks are useful for understanding the particular marginalization that the provider's letter (in some legal contexts, the provider's testimony) causes transgender subjects.

Marriage Legitimation. Although marriage legitimation is no longer sex-based in the wake of *Obergefell v. Hodges* (2015), prior to that decision, it sometimes fell to the courts to decide whether or not a marriage between a transgender person and a cisgender person was a valid, opposite-sex marriage, or an invalid, same-sex marriage (Larry, 2018). These cases have been decided on a myriad of different bases, including legal sex, psychological sex, chromosomal sex, physical sex (surgically altered or not), ability to procreate, and ability to engage in heterosexual, vaginal sex (Larry, 2018). Space does not permit a full accounting of these various understandings of sex and how they impact marriage validity, so this section will focus narrowly on one key case, and the cases that were examined in the opinion of the court.

In the case of *Littleton v. Prange* (1999), marriage validity had to be substantiated in order to allow Christie Littleton, a trans woman from Texas, to bring a wrongful death suit in the death of her husband, Jonathan Mark Littleton. This case was explicitly about the medical model of transsexual [sic] identity and whether or not it could overwhelm what the court considered to be "immutably fixed by the Creator at birth" (*Littleton v. Prange*, 1999, pg. 224). This case is noteworthy in part because of the explicit discussion of how, exactly, medicine can be used to affect change to someone's body and therefore, to that person's legal status. Chief Justice Hardberger goes into great detail laying out Christie's history, both personal and medical, as well as the understanding of trans identities prevalent at the time. In this case there were two doctors who provided written and oral testimony (*Littleton v. Prange*, 1999). One, Dr. Greer, was a plastic surgeon, and the other, Dr. Mohl, was a psychiatrist. Both served as members of a multidisciplinary gender dysphoria team at the University of Texas Health Science Center (*Littleton v. Prange*, 1999). These doctors testified that Christie was something that they termed a "true transsexual," meaning that she was "psychologically and psychiatrically female before and after the sex reassignment surgery" (*Littleton v. Prange*, 1999, pg 225). They also testified to the type of medical interventions she had received, and that she could "function sexually as a female." There is no testimony given on exactly what standards were used to determine this except that they relied on guidelines from Johns Hopkins.

The majority opinion in this case was written by Chief Justice Hardberger, who used several cases to discuss the legal history of marriage validation in cases where one part had

transitioned. First, he discussed *Corbett v. Corbett* (1970), an English marriage validation case. In that case, doctor's testimony was used to create four criteria that could be used for assessing "sexual identity" (*Littleton v. Prange*, 1999, pg 227). These were (1) chromosomal factors; (2) gonadal factors (whether one had ovaries or testes); (3) genital factors (both internal and external sex organs); and (4) psychological factors (*Littleton v. Prange*, 1999). Given such a list, the court in *Corbett* predictably relied quite heavily upon biological essentialism to determine the marriage in question to be invalid (*Corbett v. Corbett*, 1970). The Chief Justice then addressed *Anonymous v. Anonymous* (1971), a New York marriage validation case. In this case, there had been no surgical intervention, and the husband claimed not to know that his wife was a transsexual [sic] (*Littleton v. Prange*, 1999, pg 227). There is no report of doctor's testimony in this case.

In the next case brought forth in the opinion, *M.T. v J.T.* (1976), the husband (J.T.) sought to avoid paying alimony by proving that his wife was a man. In that case, the doctor who had performed M.T.'s surgery testified regarding M.T.'s medical treatment, as well as a general discussion of transitioning and of what gender identity entails (*Littleton v. Prange*, 1999). The doctor in that case described M.T.'s vagina as "the same as a normal [sic] female vagina after a hysterectomy" (*Littleton v. Prange*, 1999, pg 228). In this case, the court sided with M.T., holding that her choice was medically sound and "not mere whim." The appellate court confirmed, finding that because M.T. had "the full capacity to function sexually as [...] female," and could therefore be legally married (*Littleton v. Prange*, 1999, pg 228).

Finally, the court considered *In re Ladrach* (1987), an Ohio case where a trans woman sought to be legally allowed to marry a man. In this case, a doctor bolstered the case by explaining that Ladrach had "normal female genitalia," but when asked, stated that it would be extremely unlikely that Ladrach's chromosomes would be that of a female (*In re Ladrach*, 1987, pg 830). The court denied the marriage license, essentially stating that it was a matter for the legislature and not the courts. After laying out all of these cases, the majority finds that Littleton is a male, despite the fact that "she has made every conceivable effort to make herself female," including amending her Texas birth certificate (*In re Ladrach*, 1987, pg 832). A grim pronouncement that would not be overturned for 20 years. Regardless of the perceived expertise of medical professionals and their testimony, courts nationwide continued to find (more often than not) that changing one's sex for the purposes of marriage simply couldn't be done.

Identity Documents. Social anxiety often precedes increases in surveillance and control around identity and identity documentation (Beauchamp, 2019; Spade, 2015). Such laws proliferated after the events of September 11th, 2001 (Spade, 2007). Spade (2007) published a flowchart that illustrated the spectrum of requirements for changing one's gender marker on their identification. His research revealed that requirements varied from self-attestation (San Francisco, New York City, Boston Homeless Shelters) to reclassification never allowed (Tennessee birth certificate and prison placement; Spade, 2007). Between those extremes were policies accepting a provider's letter stating *appropriate treatment* had been provided, a letter stating unspecified surgery had been conducted, or a letter stating that an extremely specific surgery was done (Spade, 2007).

Although many of the details of the policies have changed since that analysis was completed, self-attestation remains a slender category. Most states fall somewhere in between the extremes, but neatly all still require a provider's letter of some kind. Further, many cisgender

people who fulfill gatekeeping roles, including doctors, lawyers, psychologists, and administrators, carry with them an idea of the correct narrative of transgender identity (Vade, 2005). This creates a situation where those whose experience falls outside of the expected narrative may be denied medically necessary care as well as identification documents.

Given the ubiquity and importance of legal identification in everyday life, having an ID that fails to reflect one's identity, or having identity documents that fail to match, can devastate an individual's ability to function safely in the world. All of these factors have led to a country in which very few transgender people have a full set of correct identity documents. In the United States Transgender Survey, conducted in 2015, only 11% of the respondents had accurate name and gender information on all of their documents (James et al., 2015). Most egregious was the category of those who wanted to change their birth certificate; only 9% had been able to do so (James et al., 2015). Worse, almost half of the sample had no form of identification with the correct name, and 67% of the sample did not have identification with the correct gender marker (James et al., 2015). Thirty-five percent of those who had not tried to change their documents cited cost as the main factor (James et al., 2015). The cost of changing one's documents can be prohibitively high, and the cost of obtaining a provider's letter can add hundreds of dollars, depending on the individual's billing practices and patient's insurance (James et al., 2015). Thus it is not just simply the difficulty of obtaining the provider's letter, or navigating the forms, or getting a court order, or the cost of all of these activities, but all of those factors intersecting with a community that has high levels of unemployment, homelessness, and poverty (James et al., 2015). Requiring a provider's letter and other forms of legitimation to update identity documents directly limits the life chances of transgender people.

Discussion

Because the provider's letter is used across both medical and legal contexts to *legitimate* transgender identities, similar logics are foundational despite the differences in the academic disciplines (medicine, bioethics, history, and law) that this review has engaged with. Perhaps most importantly, the very existence of the letter itself, regardless of context, lays bare the idea that transgender people's identities must be verified by another party in order to be considered valid in medical and legal contexts. Because the majority of doctors and mental health providers are cisgender, an implicit assumption exists that the person who is doing the verifying is not, themselves, a trans-identified person. Until the last few decades, that assumption was nearly always perfectly accurate. It is only very recently that *out* transgender people have been able to practice as doctors and mental health providers, and therefore it does not seem coincidental that insurance companies have started to require three or more letters where previously, one might have been considered adequate.

I am unaware of any medical or legal context where a cisgender person is required to have their gender identity verified by a mental health professional, much less two mental health professionals and a primary care physician. It stands to reason that there exists some fundamental belief that transgender people cannot be trusted to represent themselves accurately for legal or medical purposes in the same way that cisgender people are. Even if a transgender person is seeking a gender confirmation surgery, it is unclear why a mental health provider would be involved every single time. Even if one were to argue that some trans people have severe mental illness that should be well controlled before engaging in surgery or hormones, that only

implicates transgender people with severe mental illnesses, and doesn't begin to address the legal aspects of the letter at all. Indeed, as I have reviewed this literature, I have never yet found a single argument for its inclusion that is not based on conjecture and hypotheticals that all reliably reduce down to a fundamental belief that transgender people are incapable of exercising medical and legal agency. It should not need to be said that this is patently untrue.

When the letter requirement was first instantiated into formal use, Harry Benjamin (1969) said:

Throughout the years of my interest in transsexual patients, two nightmares have plagued me, when it came to surgery. If the operation was denied or made impossible for whatever reason, medical or economic, self-mutilization or suicide could be the consequence. Both, unfortunately, have occurred. The other nightmare was and is the fear that the operation might later be regretted. That, too, has happened. **Actually, there was hardly ever admission to that effect**, but that means little. It would be difficult to admit to such a mistake. In possibly 4 to 5% of the operated male transsexuals (and in one female), I have a lingering suspicion that there is a degree of remorse and they would undo what was done, if it were possible. Therefore, to prevent such dire outcome, psychiatric evaluation as a part of a thorough study of each case is highly desirable, together with a prolonged period of observation, up to a year.

Essentially, then, Benjamin himself is saying that he (at the time of this writing) had never been told by a patient that they had regrets, but he assumed 4-5% of his patients had them. Compare this to the sentence directly before that, where Benjamin says (without providing percentages) that he is aware of a number of individuals who have died by suicide or self-mutilated due to the overwhelming nature of their gender dysphoria.

That this was considered evidence for a policy that have been in formal use for half a century, and which continues to not only be used but actually be expanded upon, is a gross misuse of scientific and medical authority. Further, there is no reason why the lives of countless trans people who have died by suicide due to a lack of medical care are weighted as less important than those who potentially might die by suicide due to regret. Though Benjamin did not have the evidence at that time, subsequent studies have consistently shown the rate of transgender regret to be extremely low. A recent meta-analysis has shown a regret rate of approximately 1% across all gender confirmation surgeries (Bustos et al., 2021). Compare this, for example, to the rate of regret for total knee replacements, which is 6-30% regardless of complications (Mahdi et al., 2020). While there may have been some individuals whose mental health and life were deeply impacted by transgender regret, there are many thousands who are negatively impacted by a lack of medical care and incorrect identification documents—both of which have been shown to negatively impact mental, emotional, and physical health as well as life chances (James et al., 2016)

I am unaware of any studies that examine the cisgender preoccupation with the specter of transgender regret, but it appears that presence of this phenomenon, and not actual regret, has had an outsized effect on policies requiring one, two, three, or more letters. As of this time, the newest version of the WPATH SOC (version 8) has not yet been published. However, even if the letter requirement has been changed in this updated version, such a change will not move quickly

through the medical literature or the United States insurance system. More research is needed to understand the specific contours of stigma and cisgender panic that have led to the widespread use of the provider's letter and the denial of the agency and autonomy of transgender individuals. Without that context, the letter will continue to be erroneously propped up as a reasonable prophylactic for transgender regret.

Transition between Articles 1 & 2

As was mentioned in both the introduction and the first article, the letter is currently used for gatekeeping purposes—acting as a requirement for obtaining gender affirming care and legal recognition through identity documents. But the first known letters had nothing to do with medicine and very little to do with mental health. They were instead part of an application for a very specific legal document known as a *Transvestiten* or a *transvestite certificate*, a document that allowed individuals to cross-dress in public. These documents were used by a broad category of people known at that time and in that place as *transvestites*, a category with no current analog. These certificates were something of a collaboration between Dr. Magnus Hirschfeld and the police of Berlin, a pragmatic solution to a variety of issues around the maintenance of public gender expression. It is unclear if the *transvestite certificates* would have ever been created without the input of Hirschfeld and his cozy relationship with various high-ranking law enforcement officials.

Hirschfeld's intense involvement in both the creation of early letters and the necessity to obtain *transvestite certificates* begs many questions, including *why* the letter was created and what elements of Hirschfeld's personal beliefs and biases were baked into its foundations. But letters were neither created nor disbursed in a vacuum, and they had an impact on the culture that they were birthed into, the people who obtained them, and the people who were unable to obtain them. The following article attempts to pull at these various threads, covering the history of Hirschfeld himself, the letter's inception, and the sociocultural impacts on transvestites in Germany during the early twentieth century.

Constructing the ‘True Transvestite’: The Origins of the Provider’s Letter in Early Twentieth Century Germany

Introduction

In 1908 or 1909, a German person named Katharina T. (Hereafter, K.T.) sought to be allowed to go about in men’s clothing without being arrested for public indecency and to change their name to a masculine form (Hirschfeld, 1991). In order to be granted access to this privilege, K.T. went to Dr. Magnus Hirschfeld, currently widely credited as the progenitor of modern Western trans medicine, and asked for a letter. This letter would be part of the application for a *transvestite certificate*, which functioned as a passport for a specific jurisdiction that allowed a person to dress in accordance with a gender outside their assigned sex without being arrested or charged with a crime (Caplan, 2011; Marhoefer, 2015; Sutton, 2012). Although Hirschfeld published the letter in his 1910 volume, *Die Transvestiten*, he includes his letter as an example of transvestitism occurring in conjunction with homosexuality. He does not provide any details as to why K.T. came to him for this letter, nor does he explain why a letter was the chosen intervention, nor who decided that a letter was a necessary part of an application for a transvestite certificate.

This letter was a prototypical form of a document that has existed in some form or another in the transgender medical and legal realm ever since, having been brought to the United States through Hirschfeld’s student, Harry Benjamin. I refer to this object as *the provider’s letter*, defined as the official certification of a transgender person’s gender identity by a medical professional for the purpose of accessing some otherwise inaccessible privilege (Lawliet, 2022). The privilege to be accessed is typically freely available to anyone who isn’t trans (Lawliet, 2022). While this object has been the source of a great deal of debate in transgender medical, legal, bioethical, and psychological literature, its origins have not been elucidated. Because the first letters were generated by Hirschfeld, and were very specific to the legal/social/medical context in which he operated, understanding the provider’s letter requires a more thorough understanding of Hirschfeld’s standpoint, and the specific time and space that he occupied.

This article examines the origins of the letter through the relationship between Hirschfeld, law enforcement, and the specific community cultivated through his *Institut für Sexualwissenschaft* (Institute for the Science of Sexuality; ISS), as well as the broader impact of the letter on Weimar-era subcultures that have reverberated forward to the modern day. While the letter started as a pragmatic solution for law enforcement and social order, it was taken up by the community in a way that reinforced social divisions based on class, race, and gender presentation. As a result, the community was divided into the *true transvestites*—those who were able to obtain letters and remain legible as white, middle class, and law abiding—and the *also transvestites*—those who were unable to access these privileges because of class status, race, and/or the desire to medically transition and were thus seen as deviant and inherently suspect (Sutton, 2012). These social categories were carried forward as vectors of privilege and marginalization in the United States, where the *true transvestite* evolved into the *good transsexual*, a category that was used to determine who was given access to medical care and legal legitimacy, and who was not (Skidmore, 2011).

The impact of the letter itself is far-ranging, but it bears the unmistakable echoes of the man who created it. Understanding Hirschfeld's context, culture, compatriots, colleagues, and standpoint is vital to grasping the provider's letter as a site where gender was created, surveilled, and regulated. Understanding the sociocultural contexts that the letter and its creator operated within gives important context for the development of an object that has held such a complicated role in the transgender medical, legal, and social realms.

Note on Terminology

Much of how we currently think of and describe both gender and sexuality can be directly traced to the sexologists of the 19th and 20th century. However, language has changed a great deal over time, with some of the words common to Hirschfeld's era critiqued for their imprecise and/or pathologizing nature. Words like *homosexual*, *transvestite*, and *transsexual* are uncommon in modern parlance, and are contested both in community spaces and in the literature. Following Marhoeffer (2015) and Sutton (2012), I use these words throughout this article to remain true to their original context. *Transvestite*, for example, is a word that does not really have a modern analog. It captured a group of people situated in time, space, and history who interacted with the norms of their culture in unique ways (Marhoeffer, 2015). *Homosexual* carried a unique political and social valence for Hirschfeld, in part because it was a criminalized identity and one that he sought to decriminalize through science. *Transsexual* represents both cisgender sexologists' translations of their patients' experiences, as well as the way many understood their medical and embodied experiences in the 20th century and beyond. Each of these terms is used specifically and intentionally and should be read not as appropriate parlance for our modern community, but as verbal markers with their own situated histories.

Magnus Hirschfeld: A Situated History

The first (documented) letter was generated by Hirschfeld, who would go on to be the most prolific writer of his time of such letters to law enforcement, researchers, and other medical professionals (Caplan, 2011). As "The Einstein of Sex," Hirschfeld was a figure of great importance, and is the father of many modern approaches to transgender identity and especially transgender medicine. His influence permeates LGBTQ history and activism, including his conviction that justice for homosexuals and transvestites could, and would, be accomplished through science (Bauer et al., 2017; Wolff, 1986). In many ways, Hirschfeld was well ahead of his time—his theory of sexual intermediaries held that sexuality and gender differences were natural, and that the permutations of these characteristics were endless (Hirschfeld, 1991).

However, Hirschfeld is not an uncomplicated figure. He was a middle-class doctor from a middle-class background, an advocate for those seen as deviant, but also a self-proclaimed eugenicist (Wolff, 1986). He was a Jewish man by birth, but didn't publicly claim that label (Bauer et al., 2017; Wolff, 1986). He had strong, lasting partnerships with men, but never publicly revealed that he was a homosexual (something that could have landed him in prison at the time; Bauer et al., 2017; Wolff, 1986). He cross-dressed and went by "Tante Magnesia" in the bar scene, but always discussed his sexual intermediaries and transvestites from a detached, scientific perspective (Benjamin, 1970; Bauer et al., 2017; Wolff, 1986). And finally, he espoused progressive views regarding racism and feminism, but often failed to include the voices of racially oppressed and/or feminist scholars in his work (Bauer et al., 2017; Wolff, 1986).

Hirschfeld's standpoint was deeply specific, both in time and in geographic location. He built on the work of his sexological forebears, such as Karl Heinrich Ulrichs and Havelock Ellis, and his contemporaries, such as Karl Steinach and Sigmund Freud (Hirschfeld, 1991). His middle-class status, Enlightenment ideals, eugenicist beliefs, and commitment to activism all informed his work—work that continued on after his death through his friend, student, and colleague, Dr. Harry Benjamin, a German Jewish endocrinologist living in the United States. The unique trajectory of his life and broader sociocultural context is imbricated with the trajectory of the letter itself.

Summary of Hirschfeld's Professional Work

It is important to mention that Hirschfeld, unlike many of the American sexologists, was involved with the communities that he studied in a personal way. Unlike Harry Benjamin or Alfred Kinsey, who viewed sexual subcultures from the perspective of scientific voyeurs, Hirschfeld engaged in Berlin's permissive sexual subculture as both a scholar/researcher and as a member of the community. While Hirschfeld demonstrated empathy and appreciation for people from many groups to which he didn't belong, his uniquely deep insights into the world of homosexuals and those he would later term transvestites were at least in part the result of this unique standpoint.

Hirschfeld published his first pamphlet on homosexuality in 1896, *Socrates & Sappho*. In the forward, he wrote about a former patient who had died by suicide (Wolff, 1986). The patient had sent Hirschfeld a letter before he died, explaining that he was a homosexual and asking Hirschfeld to tell his story so that others wouldn't feel as alone as he did (Wolff, 1986). This galvanized Hirschfeld, and he spent the rest of his life working on behalf of individuals like this patient. *Socrates & Sappho* pulled from the work of Kraft-Ebbing, Havelock Ellis, Karl Ulrichs, and Dr. Albert Moll to posit that homosexuality was a natural variation of human behavior (Wolff, 1986). In fact, Hirschfeld created a scale of human desire and sexual drive that anticipated the Kinsey scale some 40 years before Kinsey published his work (Wolff, 1986). This theory, which is explicated thoroughly in *Die Transvestiten*, is Hirschfeld's theory of sexual intermediaries.

Hirschfeld begins this theory by arguing that there are some true and natural differences between what is "purely manly" and "purely womanly" (Hirschfeld, 1991, pg. 215-7). Much of Hirschfeld's descriptions of these characteristics read like a list of stereotypes, and he frequently asserts what is "purely manly" as being in many ways superior to what is "purely womanly." Women who possess passion, fire, or a drive for equality do so because they have some manliness in them (Hirschfeld, 1991). Hirschfeld identifies four groups of sexual characteristics: the sexual organs; the other physical characteristics; the sex drive; and the other emotional characteristics. The theory posits that anyone who does not have 100% traits that comport with their sex assigned at birth would be a sexual intermediary. Hirschfeld also makes sure to point out that no man is completely without something of the feminine, and no woman is completely without something of the masculine. Therefore, we are all more or less on a spectrum of sexual intermediacy (Hirschfeld, 1991).

Socrates & Sappho made quite a splash, with Hirschfeld quickly becoming *the* person to seek out for all those who saw themselves reflected in his work on sexual intermediaries (Wolff,

1986). His dedication to producing works that could be read and appreciated by the general public as well as other doctors and scientists gave his work a broad appeal. While some sexologists and scientists hated his theories, the press that they gave him only helped his theories spread further. With this contentious, but growing base of support, Hirschfeld was able to channel his energy and blossoming notoriety into starting the *Wissenschaftlich-humanitäre komitee*—The Scientific-Humanitarian Committee—in 1897, a group that was entirely dedicated to repealing Paragraph 175 (Wolff, 1986). The SHC is often cited as one of the earliest homosexual rights organizations, and Hirschfeld’s standpoint can still be felt reverberating through modern gay rights organizations, even 120-ish years later.

Die Transvestiten was published in 1912, two years before the first world war. In this volume, Hirschfeld named and described transvestites, offering case studies and analysis, including the letter mentioned in the introduction. Wolff (1986) reports that when *Die Tranvestiten* was published, it was reported on by "practically every newspaper and journal, the serious as well as the sensational" (pg. 107). Based on the information in *Die Transvestiten*, we know that those who wanted to legally or physically change their sex were already seeking aid from Hirschfeld. The publication of this volume only increased the number of individuals who would come to Hirschfeld for gender-related support.

The ISS & the Weimar Era

After WWI, in the midst of the reconfiguration of German political power and property, Magnus Hirschfeld purchased a "palatial mansion" (Wolff, 1986, pg 175) that had previously belonged to the ambassador to France. This building became the first ISS on July 1, 1919 and was established explicitly to be a space for "research, teaching, healing, and refuge" that was available to all those who needed it (Bauer et al., 2017; Marhoefer, 2015). The ISS was the first institute of its kind in the entire world, and very quickly exploded with visitors from every corner of the globe (Bauer et al., 2017; Marhoefer, 2015; Wolff, 1986). Far from being a clinical, sterile building with an institutional feel, the ISS was lush, replete with thick carpets and curtains, sculptures and columns, looking every bit the former opera house that it, in fact, was (Bauer et al., 2017; Wolff, 1986).

The ISS housed many different departments, including eugenic-based marriage and vocational counseling as well as medical care for anyone with sexual issues or abnormalities (Bauer et al., 2017; Wolff, 1986). This group included, but was not limited to, both homosexuals and transvestites. Hirschfeld maintained a massive collection of photographs, letters, and case studies about transvestites, those we would currently refer to as people with intersex conditions, individuals with a wide variety of paraphilia and fetishes, and homosexuals (Bauer et al., 2017; Taylor, 2017; Wolff, 1986). He collected photographs and stories from all over the world, often ascribing Western interpretations of human behavior to these photographs (Bauer et al., 2017; Taylor, 2017). The ISS also held sexual objects including sex toys, lacy feminine underwear worn by "ferociously masculine Prussian officers beneath their uniforms," and whips and chains for sexual use (Wolff, 1986, pg. 176). The collection also included sexually explicit or pornographic drawings and paintings by Hirschfeld’s patients.

The ISS was not simply an archive, nor a private university, nor a medical institute, nor a research institute, nor a gathering place, nor a home, but in fact a mix of all of these in one

opulently-kept building. As revealed by Bauer et al. (2017), the ISS was also a gathering place for the far left, especially for illegal communist visitors. Hirschfeld made space in his institute for political radicals, as he himself identified closely with socialism and was very interested in far-left ideology (Bauer et al., 2017; Wolff, 1986). In addition to communists, he also hosted a variety of famous intellectuals such as Walter Benjamin and Ernst Bloch, though curiously, neither chose to write about their time at the institute. According to Bauer et al. (2017), this indicates some disjuncture between sexual reform and other forms of social or political work.

Documents from the ISS suggest that it was seen as a “live-work community” by some of those who inhabited it, including many transvestites that may have struggled to find work elsewhere (Bauer et al., 2017). Dorchen, one of the first individuals to have a complete vaginoplasty, was employed by the institute as a domestic worker. Of course, Hirschfeld and his partner, Karl Giese, lived at the ISS as well, and they held events and threw parties there. While it may fall far afield of our current norms, Hirschfeld and others who worked in the institute as doctors and specialists would socialize in that space with the same individuals who came to them for services.

Notoriety and international fame, however, were neither adequate to protect the ISS nor to protect Hirschfeld himself. As Hirschfeld became more famous and more respected for his work in sexology, he simultaneously became more of a target for Nazis and anyone else who objected to his views on Paragraph 175, his Jewish heritage, or his acceptance of homosexuality (Wolff, 1986). Hirschfeld began to be harassed at public appearances, with said harassment often becoming violent toward either himself or the audience. At one presentation in Munich, Hirschfeld was warned that there was a planned attack on his life, but he went ahead with the presentation anyway (Wolff, 1986). He had informed the police ahead of time that there would potentially be trouble, and had expected that they would provide him with some measure of protection. They did not, and when Hirschfeld left the lecture hall, he was jumped and beaten unconscious.

Hirschfeld woke up in a hospital to the news that he had been killed in the attack, and worked quickly to set the record straight. Nevertheless, the incident betrayed both the rising anti-Semitic violence in Germany *and* the unwillingness of law enforcement to do anything to address and/or curb said violence (Wolff, 1986). Law enforcement suggested that Hirschfeld not give presentations anymore, and while Hirschfeld did take some time away from doing so, he did not cease entirely (Wolff, 1986). Ten years passed before Hirschfeld left on a world speaking tour to escape the violence that plagued him in Germany—a tour that would last three years and slowly stretch into an exile.

In the span of that decade, the multifaceted ISS had time to flourish in all of its many purposes and forms. Professionals and lay people alike came to the ISS for tours and lectures, offered by Giese and others. Heterosexual couples came for eugenic marriage counseling and family planning, cisgender men came for treatment of erectile dysfunction and other sexual issues, and transvestites came for cutting edge hormonal and surgical treatments, as well as for the letters that would allow them to access transvestite certificates and passports. While much of the information regarding who was treated at the institute, who had letters written for them, and who found their community there has been lost to Nazi fires and/or history, the small miracle of a place that explicitly served to normalize Hirschfeld’s sexual intermediaries and to provide them

with their daily needs feels fragile, ephemeral. Yet I would argue that it was precisely because Hirschfeld (and most of his colleagues at the ISS) were themselves queer that they were able to carve out such a place. No other sexuality institute has ever been made primarily by and for queers.

This is not to say or suggest that Hirschfeld and his colleagues were somehow perfect or perfectly enlightened, or that any of them, by virtue of their sexuality alone, were politically radical utopians. As Marhoeffer (2015) details, the Weimar-era tendency to bundle a variety of sexual behaviors under the umbrella of “immorality” meant that rules meant to regulate, for example, female sex workers could eventually come back and impact male/male couples. All that was considered immoral was fair game. Further, in order to make political gains for some homosexuals, others would be further marginalized under the guise of “immorality” (Marhoeffer, 2015). Hirschfeld was certainly one of those who argued for these more conservative, more constrictive attitudes toward those whom the politics of the time stereotyped as immoral (Marhoeffer, 2015). Ahead of his time in so many ways, Hirschfeld was still a human, and at times, espoused regressive ideas and ideals.

Eugenics & Colonialism in Sexology

Like most of those in his time and position, Hirschfeld believed strongly in eugenics, though his understanding and practice of it was without the current context so strongly influenced by the Holocaust. To Hirschfeld, eugenics was a way to lessen human suffering, allow couples to make mindful reproductive choices, and eradicate preventable health issues (Sengoopta, 1998; Wolff, 1986). Though Hirschfeld’s eugenic commitments may have been motivated differently than the ethos of racial purity that defined Hitler’s regime, the foundational logics of eugenics deeply influenced his approach to sexology. Because eugenics was considered a scientifically legitimate pursuit, Hirschfeld and other sexologists would use it to increase the perceived legitimacy of sexology (Amin, 2018; Sengoopta, 1998). Hirschfeld was joined in this project by other famous sexologists and researchers such as Eugene Steinach, Harry Benjamin’s mentor and the researcher who popularized *rejuvenation* procedures like that which was performed on Lili Elbe, aka *The Danish Girl* (Amin, 2018; Sengoopta, 1998; Taylor, 2017). Many of the procedures that were the prototypes for modern day hormone replacement therapy and gender confirmation surgery were originally conceived of under the eugenic pursuit of *rejuvenation* or anti-aging (Amin, 2018; Taylor, 2017).

As pointed out by Bauer et al. (2017), Hirschfeld did not personally participate in colonialism, but he did benefit from the proliferation of scientific pursuits that came about due to German colonization. Further, in his mission to establish that homosexuality was *natural* and practiced worldwide, Hirschfeld frequently stripped evidence of its cultural context and reduced it to a Western context (Bauer et al., 2017; Herrn & Taylor, 2018). Further, in the effort to build out a taxonomy of *natural* sex and gender behavior, Hirschfeld often relied on eugenic racial logics and approaches (Bauer et al., 2017; Herrn & Taylor, 2018; Marhoefer, 2019; Taylor et al., 2017). The far-reaching impacts of these logics on the social aspects of trans medical care are still present in the modern day, and account for part of the reason why the letter has flourished in the United States, and by extension through the international reach of the WPATH SOC, to the world.

Law Enforcement, Homosexuality & Cross Dressing

One surprising find in this literature is the willing complicity of law enforcement with Hirschfeld, Berlin's homosexual community, and the Scientific-humanitarian Committee (SHC). Wolff (1986) recounts how Hirschfeld was friends with multiple chiefs of the police, including an H. von Treskow, who contributed to the main publication of the SHC, *The Yearbook for Sexual Intermediaries*. Also, L. Von Meerscheidt-Hüllessem, one of the highest-ranking law enforcement officers in Berlin, was one of the first members of the SHC (Wolff, 1986). The involvement of law enforcement with Hirschfeld and their sympathy and/or complicity with the Berlin underground and homosexuals more broadly is important to note, because the origins of the transvestite certificates are somewhat murky, and the method of introduction of the letter as a piece of the application is unknown. In this modern time, especially in the United States context, it can be difficult to understand how or why the police would choose to collaborate with individuals who dressed outside the norm for their sex assigned at birth, or who engaged in illegal sexual behavior. Some distance from the modern U.S. law enforcement system is needed to understand that the *transvestite certificates* were a pragmatic solution to the problem of *disturbing the peace*.

Berlin's law enforcement kept detailed records on their citizenry, and anyone who was known to be a homosexual was marked as such on their official documents (Caplan, 2011; Hirschfeld, 1991; Wolff, 1986). While paragraph 175 criminalized homosexuality for men, women's homosexuality was not criminalized under any law (Caplan, 2011). Still, it seems that both men and women could be labelled as known homosexuals (Caplan, 2011; Hirschfeld, 1991; Wolff, 1986). Cross-dressing, or dressing as a sex other than what one was assigned at birth, was not illegal or in any way forbidden by the criminal code (Hirschfeld, 1991; Marhoefer, 2019; Sutton, 2012). Therefore, when individuals were arrested ostensibly for wearing the clothing of another gender, the real offense was actually *disturbing the peace*. As Hirschfeld described in *Die Transvestiten*, this caused a variety of legal issues. For example, there were individuals who, when dressed as their assigned sex, were *assumed* to be cross-dressing and therefore *disturbed the peace* and were arrested, only to be found to be dressed properly for their assigned sex. In some cases, this even resulted in the punishment of the officers who arrested the person in question (Hirschfeld, 1991).

When such events occurred, the charge of disturbing the peace was never leveled against those who objected to the person they perceived as being inappropriately dressed, despite the fact that it was the reactions of bystanders, and not the person themselves, that comprised a disturbance. In the eyes of the law, the one at fault for a disturbance was the one to whom others were reacting, and not those who reacted. This created an interesting problem for those who couldn't "pass" as their assigned gender. Hirschfeld (1991) discusses one Anna Smith of St. Louis, who was mercilessly harassed on the street when wearing women's clothing due to her thick, black beard. She claimed to have tried everything to remove the hair, and that if she weren't allowed to go about in men's clothing, she would end her life (Hirschfeld, 1991). In such a case, Hirschfeld pointed out, it was easy to argue that the individual must be allowed to wear the clothing that they felt more comfortable in, and that by doing so, less public disturbance was created.

One particularly striking story in *Die Transvestiten* is that of Mrs. K., a woman who was arrested, repeatedly, for cross-dressing. Mrs. K carried papers certifying her identity as a woman, and her marriage to a man. Due to the number of times that she had been arrested, Mrs. K. even carried with her a certificate from a police physician that stated she had been “examined” and was “a certified female” (Hirschfeld, 1991, pg 269). It is left to the reader to surmise what this examination entailed, but regardless of the details, one would assume such a remarkable certificate would be adequate to prove one’s right to wear women’s clothing. It was not, and the story even states that she was mocked for her large, feminine wig and hat (Hirschfeld, 1991).

This story in itself gives a complex and multi-layered view of the issue. It was not Mrs. K’s cross dressing that was at issue, but rather the *perception* of law enforcement and fellow citizens that her clothing, which was appropriate for a woman of her social position, was a disguise. The social perception of her masculinity was the issue, and was so strong that the solution proposed by the police was that Mrs. K actually start wearing men’s clothing, as this would make her “feel much better, and the police, too” (Hirschfeld, 1991, pg. 269). Put very plainly, *law enforcement was asking Mrs. K to cross-dress*, because it would make them (and presumably, the general population) more comfortable. It is unclear if Mrs. K found this solution to be acceptable or desirable.

The next story Hirschfeld includes complicates the narrative further. A “doctor in jurisprudence,” Miss A., reports to a feminist newspaper that she was arrested for cross dressing. She states that when she was stopped, she told the police officer that she was a doctor of jurisprudence and that a false arrest would result in some punishment for him. Still, he arrested her, and by the time they reached the station they had amassed “40 to 50 curious onlookers” (Hirschfeld, 1991, pg. 270). At the police station, it was quickly determined that she was a woman, and she was therefore released and the arresting officer punished. This resulted in so much press coverage that the mayor put out his own version of events, according to the police, which suggested that Miss A. brought herself to the station and that she was an activist trying to change an aspect of the criminal code.

To be clear, in each of these instances, the issue that was judged problematic was the inability of the individuals to perform their gender in a way that was socially acceptable. In the instance of Mrs. K, she actually obtained multiple letters from authoritative sources (the state as well as the police physician) stating that she was a woman, and even more, a heterosexual woman married to a man. However, her masculinity was apparently so pronounced that she “...looked like a man wearing even the prettiest wig or woman’s hat” (Hirschfeld, 1991, pg. 269). Hirschfeld describes a variety of people, some assigned female and others male, who are arrested and charged with gross indecency. However, the court seems to rule differently for those who seemingly can’t help their situation, such as Mrs. K and Anna Smith, as opposed to those who are dressed according to preference, no matter how well they pass.

Of course, most of those who were harassed and arrested for cross-dressing were transvestites (Sutton, 2012). Essentially, these individuals dressed in a way that violated the norms and expectations for their assigned sex. This description is deceptively simple, but in the eyes of law enforcement, it was very simple—either you were allowed, by virtue of your assigned sex, to wear the clothing you were wearing, or you weren’t. The question asked of Miss A., Mrs. K, or K.T. was not about identity at all—it was instead a question of societal

expectation and social perception. In addition to surveilling known homosexuals, law enforcement demonstrated a vested interest in curbing the appearance, but not the reality, of cross-gendered behavior. Yet this created a practical issue—how could they know, without making embarrassing mistakes, who should and should not be arrested for mischief and gross indecency?

Understanding this state of affairs is essential for understanding the story of K.T. referenced in the introduction and the evolution of the letter itself. Because of his activism against paragraph 175 and in favor of homosexuals, Hirschfeld was already a controversial figure by the time K.T. sought their letter in 1908 or 1909. Still, he was a well-respected professional, one of the world's foremost authorities on matters of sex, with quite a few contacts and friends in Berlin's law enforcement. While we can't know how the practice of writing letters began, nor whether including such a document in the application for a transvestite certificate was K.T.'s idea, the police chief's idea, or Hirschfeld's idea, we do know that the first recorded letter was written by Hirschfeld for this purpose in either 1908 or 1909. It is also clear from the contents of the letter that the particulars of its details were influenced both by Hirschfeld's personal standpoint, and by law enforcement's implicit commitment to social control.

Transvestite Certificates

In *Die Transvestiten*, Hirschfeld describes the letter discussed in the introduction of this chapter, written for K.T. As far as I can tell, this is the first recorded provider's letter. Hirschfeld and Abrahams wrote the letter as a part of an application for the previously mentioned transvestite certificate (Hirschfeld, 1991; Sutton, 2012). The police accepted this letter and K.T.'s application in part—they allowed K.T. to dress in men's clothing, but did not accept the name change (Hirschfeld, 1991). Transvestite certificates, and later, transvestite passports, continued to develop and be used for several decades, even to some extent during the Third Reich (Caplan, 2011; Herrn, 2005; Sutton, 2019). In later years, during the Weimar era, provisional name changes were allowed, and individuals were sometimes given permission to use a gender-neutral form of their name, such as “Alex,” “Toni,” or “Gert” (Sutton, 2012).

Transvestite certificates were extremely specific documents. They were hand-written, so clearly, there were not many of them in existence (Caplan, 2011). Further, a transvestite certificate was only good for a specific jurisdiction (Caplan, 2011; Marhoefer, 2015; Sutton, 2012). For any individual who wanted to be free to travel among various jurisdictions while remaining in their chosen dress, it was necessary to procure a “transvestite passport,” a document that would allow them access to multiple jurisdictions (Marhoefer, 2015; Sutton, 2012). Although the policies governing how one was meant to apply for them have been lost to history, some clues may be gleaned from K.T.'s letter, as presented by Hirschfeld in *Die Transvestiten* (1991).

K.T.'s letter

The letter starts by stating that K.T. was applying to be allowed to wear men's clothing, and to use a masculine first name (Hirschfeld, 1991). It states that they had come to Dr. Hirschfeld and Dr. Abraham to “certify the petition with an expert medical opinion” (Hirschfeld, 1991, pg. 151). The doctors write that they “undertook a thorough physical and psychological

examination and spent a long time observing” (pg. 151). The letter of support they offered for K.T., then, followed from the examinations and observations, and would carry a special emphasis on K.T.’s sexuality.

The letter begins by describing that K.T. lost their father at age 6, and mother at age 11, and was therefore raised by an aunt. The next few lines of information comport with what is now considered to be an expected trans narrative, not unlike that which was reported by Harry Benjamin (Benjamin, 1967). However, it is important to recall that when this letter was written (1908 or 1909), there were very few writings that would have described K.T. or given them a blueprint for how to present themselves. Still, it is impossible to know how much of the content of the letter was a straightforward reflection of K.T.’s words, and how much was tailored to support K.T.’s case. The narrative presentation of K.T.’s life focuses on the fact that they never felt like a girl. K.T. described being interested only in masculine games as a child (in playing house, they played the father), and sexual interactions and attractions to girls and women (Hirschfeld, 1991). K.T. also had no interest in feminine hobbies, and took up smoking at a young age. Hirschfeld and Abraham take care to describe that when K.T. wears women’s clothing, they are mistaken for a male transvestite, or a man wearing women’s clothing. This causes a disturbance, whereas in their usual costume of men’s clothing, they “attract no attention whatsoever” (pg. 152). Absent the teasing, and with the advantage of feeling “far more satisfied” (pg. 152), K.T.’s mood improved dramatically (Hirschfeld, 1991).

The experts describe K.T.’s body in extreme detail, both clothed and unclothed, and make observations about their mannerisms and even the skill with which they dress (Hirschfeld, 1991). They make observations about K.T.’s facial and pubic hair, hips, thighs, and breasts, which they interpret as lacking any trace of “hermaphroditism [sic]” (Hirschfeld, 1991, pg. 153). In their “Expert Opinion” section of the letter, Hirschfeld and Abraham write that K.T. gives the impression of the “fixed type” (pg. 153), though they do not define what they mean by this. They go on to strongly support K.T.’s bid to be allowed to go about in men’s clothing, and their request to use a masculine first name. Hirschfeld and Abraham make very strong points about how in order to work, K.T. needs to be able to use a masculine first name, and that doing so would “make [their] existence a great deal easier” (Hirschfeld, 1991, pg. 154). They make sure to support K.T.’s mental health, character, and intelligence, but also point out that the stress of being forced to wear feminine clothing could potentially result in suicidality (Hirschfeld, 1991).

Hirschfeld and Abraham are very clear about the gravity of this petition—they state plainly that the granting of this request is “a question of existence for [K.T.]” (Hirschfeld, 1991, pg. 154). The letter balances the personal impact of this situation for K.T. with the social impact of their request, with careful explanations of how K.T.’s appearance in women’s clothing disturbs the peace and how they cause no trouble at all when in men’s clothing (Hirschfeld, 1991). These points speak to the pragmatic nature of the transvestite certificates as a tool—law enforcement needed evidence that granting this certificate would decrease public disturbance. It was imperative that they understood that this was not simply a matter of helping one person live a better, more fulfilling life, nor was this simply about ensuring one person was not subjected to extremely detrimental levels of stress. Rather, allowing K.T. to wear men’s clothing would effectively make their jobs as law enforcement easier, and would leave them less susceptible to punishment resulting from wrongful arrests.

Social Impacts of the Transvestite Certificate

While K.T.'s is the first letter I have been able to find, it is most likely a representative of the types of letters Hirschfeld was writing for multiple petitioners during this period. In other words, I do not claim that this letter was the point of generation for transvestite culture in this era, but rather that it represents an early point where many pertinent concerns were coalescing around the topics of gender non-conformity, transvestite identity, and social belonging. As such, it contained many of the seeds that would grow slowly over the next decade or so, taking root in both the culture and the bureaucracy, tended by Hirschfeld and his colleagues before and throughout the newly-established Institute for Sexual Science, exploding into bloom through the Weimar era, only to be nearly eradicated by the Nazi's in 1933. *Die Transvestiten* was published in 1910, a few years before the profound disruption of World War I. Therefore, it is not surprising that the main impacts of both the book and the letter published in it were seen after the war.

No scientific research or advancement takes place in a vacuum—culture, time, and place are always relevant to what research gets done, by whom, and how it is interpreted. Yet in the case of Hirschfeld's research, the interconnections between the researchers and what would eventually coalesce into the transvestite community were not just present, but intentionally cultivated (Bakkar et al., 2020). Hirschfeld's status among transvestites gave him unparalleled access, which thereby increased the quality and credibility of his work. This article aims to develop more robust, horizontal history of transvestite culture, in line with Bakkar et al's (2020) commitment to show how “trans individuals often create their own experts and instrumentalize them as mouthpieces for self-articulation—precisely because this path of medicine or science [is] the only path available to them” (pg. 2).

There are several specific seeds here that I will examine, including: (a) the Bourgeoisie idea of respectability that was inevitably attached to the idea of a true transvestite identity; (b) the construction of the transvestite as heterosexual and paradoxically gender conforming; (c) the construction of the transvestite as a white figure; and (d) the specific phenomenon of looping in the relationships between transvestites and the medical/sexological/scientific community. Each of these proved potent—following the letter across the Atlantic and over a few decades and finding their way into mid-century United States trans culture.

The True Transvestite & Bourgeoisie Respectability

The relationship between Bourgeoisie respectability politics and transvestite identity is, in part, a function of the archive itself. Weimar-era Berlin had a thriving, robust, and diverse community of gender non-conforming people that lived and worked outside the realm of the middle-class (Marhoefer, 2015; Sutton, 2012; Sutton, 2019). However, most of the archive that exists revolves around the notes, reflections, and publications of sexologists and doctors, as well as the media created by and sold to middle-class Germans (Sutton, 2019). Although Hirschfeld himself enjoyed spending time at the clubs and bars with the working-class gender non-conformists, he also carried Bourgeoisie sensibilities and spent time engaging with his fellow middle-class citizens. However, it is important to note that the transvestite cultures described in this section were not the *only* such cultures at play in Weimar-era Berlin. Unfortunately, many documents providing evidence for the working-class counterculture were either destroyed by the

Nazis during their ascent to power, or have been lost to history. Therefore, most of what we know about trans culture during this time is based on the middle class.

The category of “transvestite” is in many ways culturally and temporally specific. It was the result of a long-running dissatisfaction with other proposed identity categories such as *inversion* or *contrary sexual feeling* that came from 19th century writings (Sutton, 2019). Although, as mentioned, Hirschfeld’s volume *Die Transvestiten* was published in 1910, the liberalized public sphere of the Weimar era allowed transvestite media to exist and avoid official censorship (Sutton 2019). These factors, combined with the new interest in transvestites expressed by sexologists and psycho-analysts and the activism of homosexuals, allowed for the formation of a transvestite counter-public (Sutton, 2012; Sutton, 2019).

Transvestite media was primarily distributed through homosexual women’s media, in part due to the blurriness of these categories and in part because transvestite media could not support itself as a sub-genre fully divorced from more established homosexual media (Marhoefer, 2015; Sutton, 2012). Based on the magazines that have been studied, both lesbian and transvestite movements were primarily grounded in claims to respectability and citizenship (Marhoefer, 2015). The importance of these magazines and this media cannot be overstated—these forms of media allowed transvestites to find one another, to connect and coordinate, to develop a sense of community that was accessible even to those who were not able to travel to social clubs or bars (Marhoefer, 2015; Sutton, 2012). Although many of these bids for respectability could be seen as homonormative by the modern reader, Marhoefer (2015) points out that the lesbians and transvestites of the Weimar era were challenging dominant heteronormative institutions. Therefore, they were not homonormative *per se*, but neither were they radical in their politics. Marhoefer (2015) describes the tentative arrangement of this era as the “Weimar settlement on sexual politics,” a collection of laws and policies that made life more tolerable for many Germans, including gays and lesbians, at the expense of a minority who were seen as deviant and in need of regulation.

Writing and activism in the transvestite media was based on a somewhat paradoxical idea—because transvestites could be viewed as subversive agents whose existence was destructive to social norms and structures, those who campaigned for acceptance had to walk the line of being visible enough to raise awareness, but invisible enough to avoid causing a scene (Sutton, 2012). As part of this project, many middle-class transvestites also wanted to prove their patriotism and dedication to their country (Sutton, 2012). Obtaining a transvestite certificate (and as a part of that process, a letter) was seen as a vital aspect of respectable transgender identity (Marhoefer, 2015; Sutton, 2012). Some even went so far as to repeat nationalistic slogans and sentiments and to share stories of themselves or their compatriots in the war (Sutton, 2012). Thus, the expectations for transvestite behavior and appearance were laid out in the transvestite media, with those who could and did conform being seen as good, trustworthy, and perhaps most importantly, *genuine* or *true* transvestites, as opposed to immoral degenerates (Sutton, 2012). One way in which transvestites were judged was by their ability to conform to gender standards, regardless of what gender they were embodying.

Another way that these transvestite publications created distance between their target readers and the undesirable others was to separate themselves linguistically. Those who were trustworthy or genuine were welcome to be involved in clubs, gatherings, or memberships, while

dishonest elements were excluded (Sutton, 2012). *Dishonest elements* was a broad label that included sex workers and anyone with criminal involvement, though there were many others deemed unsavory, all of whom were captured under the label *Auchtransvestiten*, or *also-transvestites* (Sutton, 2012). This contrasted with the gender conforming, middle-class, respectable *true transvestite* (Sutton, 2012). Those who wished to change their physical attributes to align with their gender were also looked down upon, as they were seen to be too radical and out of touch with reality (Sutton, 2012).

Unfortunately, very few clues remain as to what, if any, reaction the *also-transvestites* had regarding these perceptions of their inadequacy. Most of the primary source material that remains, that examined by Sutton (2012) and Marhoeffer (2015), comes from the print media, which was produced by, and echoed the viewpoint of, the middle class/bourgeoisie. Reading these pieces and seeing the deeply gendered norms echoed by the writers of the magazine leaves many questions regarding the thoughts and opinions of working class and otherwise marginalized *also-transvestites*, but there is no currently known archive that addresses these questions. Instead, we are left with the edited words of a very specific slice of the community—a slice that was openly dedicated to respectability and a commitment to the existing political and scientific structures that they perceived as a legitimate path toward social and legal acceptance (Marhoeffer, 2015).

The True Transvestite & Whiteness

A large and longstanding body of research examines the connections between structural racism and queer identities, and the scholarship regarding transness and race has been growing (Abelson, 2019; Aizura, 2011; Gill-Peterson, 2018; Green & Bey, 2017; Sears, 2015; Snorton, 2017; Vidal-Ortiz, 2009). Transgender standards of beauty and “passing” have long been critiqued for their reliance on traditional white and/or European beauty norms, especially when an inability to pass has been used to gate-keep an individual’s access to medical transition (Stryker, 2009). It is easy to read breathless, mid-century media descriptions of the United States’ first transgender celebrity, Christine Jorgensen, and hear the racial implications in phrases like “blond bombshell” (Lovelock, 2017; Stryker, 2009). Yet the instantiation of a queer and/or trans identity that stood instead of, or even superseded race, was something that started largely with Hirschfeld and his colleagues, decades before Jorgensen became a celebrity sensation (Marhoeffer, 2019).

Marhoeffer (2019) points out that the deracialization of the queer subject began with Hirschfeld’s work. This was not in any way part of the Nazi ideology around race or gender, but rather reflected the centrist, Bourgeoisie politics which came into prominence in many queer spaces. Although Marhoeffer’s work focuses primarily on the homosexual and homosexual politics, she also provides some evidence that this same implicit whitewashing was baked in to trans identities as well. Essentially, it was through the process of analogy that barriers to intersectional awarenesses of gender, sexuality, race, and other similar topics were erected, because “analogy works by emphasizing one particular correspondence between two otherwise unlike things” (Marhoeffer, 2019, p 98).

Kurt Hiller (collaborator, friend, and professional partner of Hirschfeld) created the analogy of the *sexual minority* as a class of people, just as racial and ethnic minorities were. This

created a reality where sexual minorities were *only* oppressed for their sexuality, and not for any other characteristic. By taking away the possibility of what we now term intersectional oppression or intersectional identity (Crenshaw, 1989), Hiller deracialized sexual minority identity—a move that, in the Western context, implicitly renders anyone in the realm of sexual minority white (Marhoeffer, 2019). Current research suggests that those who are multiply marginalized as both LGBTQ and Black, Indigenous, or people of color are subject to more discrimination, more stress, and more severe negative health outcomes than white LGBTQ populations (Cyrus, 2017). Decades of this erasure have contributed to the whitewashing of the queer & trans community in the popular imagination.

Both Hiller and Hirschfeld spent a great deal of their *oeuvres* pointing to copious global examples of sexual and gender behavior that fell outside the narrow confines of white Western norms, clearly signifying that they knew that people of every ethnic, racial, and cultural background could experience same-sex desire and/or step outside the narrow confines of Western, binary, assigned gender roles. However, Hirschfeld himself created a clear hierarchy in how to think about race and gender. “Beyond question,” Hirschfeld asserted boldly, “the sexual type conquers the racial type” (Marhoefer, 2019, pg. 93). In other words, regardless of any person’s racial identity, their sexual minority status was more important and relevant to their behavior. This conquering was theoretically useful, because it allowed Hirschfeld to make strong arguments that supported his work, arguments that turned on concepts such as *natural* character of homosexual and transvestite behavior throughout nature and through all peoples (Marhoefer, 2019). And yet, as a white, European gay man who self-identified as anti-racist and anti-imperialist, Hirschfeld set quite a series of fraught precedents that one can clearly see echoed through to modern LGBTQIA+ culture, especially among its white members.

While most of Marhoefer’s (2019) piece relates to homosexuality, gay history, and modern queer spaces, she also gestures toward how these same frames were used to whitewash transvestite identity. Most prominently, the Imperialist framework relied on the distinction between the civilized and the savage (Marhoefer, 2015; Tobin, 2015). There had been a push in European anthropology toward characterizing homosexuality as a result of over-civilization, which caused degeneration and separated people from their *natural* state (Tobin, 2015). Members of the Scientific Humanitarian Committee worked hard to prove the opposite, pointing to the various peoples, groups, and countries where the behavior they called homosexual was apparent, accepted, and therefore could be termed *natural*. This created a complicated set of views about the *primitives* and their views and practices—to a certain middle-class transvestite crowd, it also created orientalist fantasies of escape.

The main evidence of this comes in the form of a story found in 1925 German transvestite magazine, *The Transvestite*. The story describes someone who was assigned male at birth, and who travels to India on a work assignment (Marhoefer, 2019). She obtains the feminine dress traditionally worn by locals and bathes in a sacred stream, after which she wraps herself in the feminine clothing and sleeps in her tent. After this she is much more satisfied, and even finds a romantic partner who appreciates her as she is (back in Germany, of course). In Weimar Era Germany, such a story was aimed primarily at the white, middle-class transvestites who would have bought such a magazine—those who could have seen themselves in the events, and fantasized about going to a place less *civilized* (in European terms) and therefore, more *naively accepting* (Marhoefer, 2019; Sutton, 2012).

The racialized aspects of trans identity, real or perceived, matter deeply, because they were part of a set of norms that came together in mid-century America to define who would be considered a *good* or *true transsexual* and who would not (Skidmore, 2011). The idea of the *true transvestite*, created in the German transvestite media, is one of many cultural influences that crystallized into the form of the *good transsexual* in the mid-century United States. The *good transsexual* would conform to gendered expectations, including heterosexuality, passing, and a set of interests and behaviors that were associated with the sex they transitioned into. It was, therefore, the *good transsexual* for whom a letter would be written, and therefore, only a *good transsexual* whose gender would be legitimated by medical and legal authorities (Skidmore, 2011). As one's access medications, surgeries, and other life-saving interventions were predicated on their capacity to perform the role of the *good transsexual*, the whiteness of the proper trans subject became a matter of literal life and death (Skidmore, 2011).

Looping

Throughout the history of transgender medicine, before *transgender* existed as a category, and before medical interventions were pioneered, there was *looping*. Ian Hacking built the framework of *looping* on a foundation laid by Foucault, a theoretical framework to capture the phenomenon by which a group is named, and then the group changes as a result of, or in accordance with, that label (Hacking, 1995). A classic example is the construction of *the homosexual*, which Foucault studied a great deal and which has been written about at great length by others already (Foucault, 2012; Hacking, 1995; Sutton, 2019). Sutton extends this framework to capture what I believe to be a rather unique and enduring feature of the trans community—that they have always participated in their own medical social construction, and in fact, regularly challenged that which was expected of them. Not only is the letter itself a direct product of a looping process, but the changes and updates made to it over the years are as well.

Although the details on the genesis of KT's letter are somewhat murky, I believe it is safe to consider the letter as the product of a looping process between three entities; KT, the police, and Hirschfeld and Abraham. KT wanted a new, less-gendered name and to be able to wear men's clothing without fear or threat from either their fellow citizens or from police. Police wanted to maintain the social order, avoid outbreaks of mob violence, and prohibit individuals from using cross-dressing to avoid their debts or to participate in fraud. And Hirschfeld and Abraham wanted to further societal acceptance of homosexuals and transvestites, and also further their work as experts of sex and gender. While its unclear exactly the order in which things happened, we know that KT was designated a transvestite and given a certificate, that the police were able to create a whole new system for the social control of transvestites, and that Hirschfeld and Abraham solidified themselves as the primary writers of letters, and (quite arguably) furthered the legal acceptance of transvestites.

While KT's letter is a great example of looping, it was not the first instance of this phenomenon between sexologists and those whom they studied (Sutton, 2019). It was an early example of a phenomenon that ran strong through both media and medicine in the Weimar-era (Marhoeffer, 2105; Sutton, 2012; Sutton, 2019). In fact, this phenomenon would cross the ocean and spread through the world, cross-pollinated by Hirschfeld on his world tour, and become firmly established as practice in the U.S. through Hirschfeld's mentee, friend, and ultimately intellectual inheritor, Harry Benjamin. Looping has always been present in transgender medicine

and in the relationships between trans people and those who participate in their social discipline and control, including law enforcement officers, bureaucratic rule-makers, psychologists/psychotherapists, and healthcare providers.

Hirschfeld and his colleagues published books and papers and articles in transvestite periodicals, explaining their work, their opinions, and the scientific advancements they were making. By this time, gender affirming surgeries and medical care were being offered by the ISS, and that was well known. As the medical providers published articles about their work, the transvestite community would engage with them, while individual transvestites would continue receiving care through the ISS. Hirschfeld's book remained the definitive tome on transvestite identity in the medical and scientific sense, but the social meaning of the transvestite community, and when and how they should be assimilated into broader Germany, remained contested. As this looping process continued, ideas and practices were updated and changed according to the conversations occurring both in transvestite media and those occurring at the ISS between patient and provider.

In the ISS, the transvestite media, and likely in many more intimate contexts lost to history (i.e. personal correspondence, night clubs, parties, etc.), transvestites hotly debated every aspect of themselves and their places in society. They did not do this as receptacles of knowledge passed down to them from experts, but rather as meaning-makers themselves, both changed by the labels they were given and changing those labels and their capacity in return. Across oceans and decades, up until the moment I am writing these words and well past the moment you will read them, this looping process continues, the bounds of sex and gender pushed and stretched and redrawn until what once felt all-encompassing begins to feel like the lightest scratch on the seemingly-endless surface of human variation.

Hirschfeld's Death & Legacy

In 1930, Hirschfeld's health was flagging, his life was in danger, and he felt that he could no longer fight against the forces that were pushing Germany toward Nazism and the far right. Further, he wanted to spend time both sharing the information that he had amassed, and observing the sexual mores and norms in other cultures. So he took up the invitation of Harry Benjamin, his friend, student, and colleague, to help arrange a speaking tour in the United States (Bauer et al., 2017; Wolff, 1986). As Bauer et al. (2017) points out, this tour was both a trauma and a relief. Although Hirschfeld seemingly left to continue his research and to spread his teaching across the world, it was also clear that his leaving was, in many ways, an exile (Bauer et al., 2017; Wolff, 1986). In hindsight, it is nearly always discussed in these terms.

By the time Hirschfeld finished his United States tour, he had picked up the nickname "The Einstein of Sex," and had realized that he wasn't welcome to come home to Germany (Bauer et al., 2017). From there he embarked to Hawaii, Japan, Taiwan, China, Indonesia, the Philippines, India, Egypt, and Palestine before returning to exile in France. It was during this trip that Hirschfeld met Li Shiu Tong, also known as Tao Li, a young Chinese man who became both his romantic companion and his apprentice (Bauer et al., 2017). Tao Li's father expressed hope that his son would become the "Dr. Hirschfeld of China" when he held a goodbye party for his son and Hirschfeld, but that would never occur (Bauer et al., 2017). Instead, Tao Li accompanied Hirschfeld on his travels through the remaining countries, and the two men became extremely

close. Close enough that Hirschfeld actively wrote his private will so that Tao Li would get all his personal effects and money, and would return his ashes to his long-term companion, Karl Giese (Bauer et al., 2017).

The two men seemed to have shared a deep connection, which solidified through a combination of love, shared interests, and shared trauma. It was Tao Li who sat in a theatre next to Hirschfeld in France, the two of them watching newsreel footage of Hirschfeld's beloved ISS being ransacked and destroyed by Nazis on May 6th, 1933 (Bauer et al., 2017; Mancini, 2010; Wolff, 1986). While many of the Jewish leaders and members of the ISS had already been chased out, there were still people at the Institute, including Dorchen—previously mentioned as one of the first recipients of gender affirmation surgery at the ISS (Bauer et al., 2017). While it is unclear what happened to her, whether she was taken to a concentration camp or managed to escape, it is clear that the day the ISS was destroyed represents one of the most devastating cultural losses for queer and trans people of the Western world. Approximately 20,000 books, 35,000 photographs, and over 40,000 case studies were destroyed in the carnage, and what wasn't lost that day was scattered to government offices, collectors, and on occasion, squirreled away by workers and patients of the ISS and/or their families.

Hirschfeld had the items he was traveling with, and Giese brought what he could with him as he fled to France, but the loss can't be overstated. Hirschfeld, Giese, and Li Shui Tong settled in Nice, France, where Hirschfeld hoped to reopen his famous institute, but was unable to raise sufficient financial support (Mancini, 2010). The years of exile were unimaginably traumatic, as many of Hirschfeld's colleagues fled Germany and sought refuge in Europe or the United States. Many died by suicide, even after escaping the Third Reich, overwhelmed by grief and trauma (Wolff, 1986). Hirschfeld fought to keep his spirits up, but died by heart failure on the morning of his sixty-seventh birthday. Neither Giese nor Li Shui Tong were present when he died, as both were abroad.

Hirschfeld's estate was divided between the two men, with each being charged to use his estate to continue the work of the ISS. After Hirschfeld's death, the two parted ways, with Giese moving to Brno, where he died by suicide in 1938. His holdings of Hirschfeld's estate were lost to history, and it is unlikely that they will be restored to the archive. Tao Li, however, is a different story. While several scholars have become fascinated with Li Shui Tong, and have made an attempt to understand his life after Hirschfeld's death, he has not left many records behind (Bauer et al., 2017). He did, however, faithfully carry Hirschfeld's holdings with him, including Hirschfeld's plaster death mask, all over the world throughout his entire life. After he passed away in his apartment in Canada, a neighbor of his, Adam Smith, rescued the Hirschfeld items before they were thrown in the trash (Dose, 2012). Smith posted his findings on a message board on the internet in the 90's. It wasn't until the early 2000's that Hirschfeld archivist and researcher Ralf Dose ran across the nearly ten-year-old post on the message board. He managed to find Smith and claim the materials that Li Shui Tong had so carefully saved and carried with him across land and sea (Dose, 2012).

Much of Hirschfeld's archive was put back together this way—through luck, happenstance, and the extremely hard work of a few dedicated individuals (Bauer et al., 2017; Dose, 2012; Wolff, 1986). The intricate weave of these stories and the cultural specificities of both Hirschfeld and Berlin are all inevitably jumbled together in the DNA of the letter. This

story, a founding story, is partial by nature. Much has been lost to history, including knowledge of the conversations that happened around the letters, and how much involvement Harry Benjamin had with them. We know that Benjamin spent time with both Hirschfeld and the chief of police in queer dive bars. We know that Hirschfeld created letters as a pragmatic solution that served both the individuals he called *transvestites*, and the law enforcement in Berlin and Germany. We know that Benjamin was primarily interested in life extension and *rejuvenation* through his mentor Eugene Steinach, but that Hirschfeld cultivated in him a certain compassion for and curiosity regarding this population, though Benjamin often found the individuals he met off-putting and strange. Finally, we know that Hirschfeld coined (but rarely used) the term that Benjamin would popularize in his bestselling book—*The Transsexual Phenomenon*.

Conclusion

In many ways, Hirschfeld's letter and the transvestite certificate in general were a brilliant solution to a multi-faceted issue. In line with his Enlightenment ideals and lifelong commitment to justice through science, Hirschfeld used his capacity as a professional and a doctor to lend legitimacy to the claims of transvestites who wanted to dress according to what we would now describe as gender identity. His letters and the transvestite certificates that they supported functioned more or less to frame him and those doctors who worked with him in the ISS as (presumably cisgender, if not presumably heterosexual) experts with the training and cool detachment to adequately evaluate the transvestites and make determinations regarding their authenticity and character. Therefore, since their inception the letters have functioned primarily as a presumed cisgender stamp of approval on a trans person's performance of their gender.

It was necessary to create such a proxy because the state could not be trusted to make such delicate distinctions. Left to their own devices, police were arresting mannish women and effeminate men simply for walking down the road, disagreeing over what constituted gross indecency and public disturbance, and getting in trouble with their superior officers and with the public. With the assumedly cool, objective eye of the sex expert, law enforcement could disentangle itself from any fraught judgment calls. The transvestite certificate offered law enforcement a way to control the transvestite's movement through jurisdictions and their presentation in public, without necessitating that officers on the streets make split-second decisions about an individual's sex. To be clear, the goal of the transvestite certificates and passports was not a radical one—the point was to protect those who did not make a scene. The goal was, in other words, to enable the movement and existence of *true transvestites* in a prescribed jurisdiction; a *true transvestite* being one who could be recognized and validated by the eye of science, and who didn't make a public spectacle of themselves.

Of course, being a *true transvestite* was essentially an issue of access and social power—a status available to those with sufficient class and racial privilege, the ability to pass, and those who neither needed nor asked for medical intervention to their bodies. The letter and its relationship to transvestite identity created a set of norms that not only reverberated through Weimar-era Germany, but extended across the Atlantic. These norms echoed through the transsexual culture in the United States, finding their way into the practices of Harry Benjamin, the creation of the *good transsexual*, and into the foundational logics of the letter itself. It is not only the modern usages of the letter that must be re-examined for their role in the oppression of transgender people, but the cultural contexts that this document has woven through. More

research is needed both on the role of the letter in German transvestite society and the ways in which this object has been taken up, contested, abandoned, and clung to by various actors throughout the 20th and 21st century. For an object that has wielded such power, that has acted as an often-impenetrable wall between trans people and medically-necessary care, and that has also been summarily cast aside as invalid in legal and medical contexts, the letter itself is deeply understudied. This article merely scratches the surface of the history of this multifaceted object.

Transition Between Articles 2 & 3

The previous articles have focused primarily on the place that the letter occupies in the literature and its origins in the early days of transvestite culture in Germany. These articles are foundational knowledge for the following, which explores an alternative model for trans medicine which I call the Gender Wellness Model. This research was first presented at Philadelphia Transgender Wellness conference in 2019, and has also been presented at the Australian Professional Association for Transgender Health conference in 2019.

After establishing what the letter is and how it has been understood in the literature, and examining where it came from and why it exists, the final article is one of many answers to the question, “What if there were no letters at all?” This is a conceit that should not be considered radical. The idea that trans people should not need to access letters is the natural result of acknowledging that trans people are human beings who deserve equal agency and autonomy with all other beings.

This article posits that all humans could be served better by creating a system that uplifts and honors the experience, identity, and agency of trans people. Gender is felt and expressed in the body in ways that interact deeply with modern medicine. If gender is considered to be one of many forms of wellness, we can acknowledge that each person may need different interventions, whether medical or social, to obtain their optimal level of gender wellness. A medical framework built on this foundation would be more robust than the current model by far, and allow individual autonomy while facilitating insurance coverage. The following article lays the foundation for this model, while more research is needed to flesh out its components.

Foundation for the Gender Wellness Model of Transgender Care

Introduction

Over fifteen years ago, the American Medical Association (AMA) supported the medical necessity of gender affirmation care and decried any insurance plans that would exclude these services (AMA, 2008). Yet even after the years and the passage of the Affordable Care Act, obtaining gender affirming medical services can still be a fraught process, replete with barriers and frustration. For example, the presence of the diagnosis of gender dysphoria (GD) in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) creates a uniquely difficult situation where transgender (trans) people are forced to obtain approval for their medical care from a psychiatrist or psychologist. GD is a psychiatric diagnosis that represents the tension between psychology and general medicine in the management of trans healthcare. GD was introduced in the DSM-V as a half-measure; though trans advocates were calling for depathologization and removal of the gender identity disorder (GID) diagnosis from the DSM entirely, there was concern among many that this would result in a lack of insurance coverage for transgender patients (Drescher, 2010; Lev, 2013). GD is a vestigial diagnosis resulting from the long and complicated history between trans people and the researchers and psychologists who studied them. From the nineteen forties until now, gender affirming medicine in the United States has been based on models of distress, loss, morbidity, and distrust of the trans patient (Califia, 2003; Meyerowitz, 2009; Stryker, 2017).

This didn't have to be the case. One of the earliest researchers, sexologist Magnus Hirschfeld, approached the people he called *transvestites* with an open mind. He spoke with trans people, and more crucially, he listened to them when they spoke. He was a part of the communities where *transvestites* lived and played, and while he studied sex and gender from a medical/scientific lens, the conclusions he came to were rather different from later, American researchers. Instead of their deviance, he discussed the positive benefits they derived from dressing in clothing that affirmed their identities, and he felt that the physician's role in trans care was to facilitate social support and transition (Hirschfeld, 1991). While Hirschfeld was far from perfect, his approach to gender and sexual care was more focused on wellness and health than that of his student and friend, Dr. Harry Benjamin, whose work focused more on the pathological nature of transgender identity. Though some research has looked at the positive aspects of gender transition and trans identity, the focus on GID and its progeny, GD, have skewed the conversation toward the negative results of *not* providing care, rather than the positive effects such care can have. The choice to emphasize distress in trans healthcare has negatively impacted trans people in a variety of ways (Drescher, 2010; Lev, 2013). To increase the wellness of this population, a new solution is in order.

In this paper, I will discuss the history of gender affirmation medicine, the discrepancies between Hirschfeld's work and the subsequent work of other researchers, psychologists, and doctors who worked in the area of transgender medicine. I will situate that history within the broader movements of medicine from a paternalistic model to a patient-centered, informed consent model. I will discuss the controversy around depathologization and the inclusion of GD in the DSM-V, the current literature surrounding trans identities and care, and the components of a wellness model of care. Finally, I will propose my gender wellness model, which incorporates the positive benefits of gender affirmation in a way that can be accessible to all genders and

levels of need. Gender affirming care must be reconceptualized into a model that serves the endless variation of the trans population while providing high quality, culturally sensitive healthcare that results in patients achieving their individual optimum state of gender wellness.

A Brief History of Trans Medicine

In the early twentieth century, sexologists and psychologists who studied sex and gender argued two main ideas about sex and the body—(a) that all humans were “bisexual” (at the time, this meant that they carried aspects of each recognized sex, male and female) and that variation was natural and expected, or (b), that anyone who varied substantially from expected gender norms was a deviant, possibly a criminal (Meyerowitz, 2009). Based on the ideas of the time and the subsequent paths taken by research and medicine, it is easy to imagine potential arms of development for this field; either gender and sexual orientation would be viewed as natural human variation, or a psychopathology to be pitied and treated accordingly. In the United States, the latter gained more traction, and the results of that move have been deeply mixed. To fully understand the current state of transgender medicine, it is important to understand the foundations upon which our current ideas are built. The current system is not the inevitable conclusion of objective scientific research, but rather a deeply flawed tower built on foundations of bias and assumption.

Magnus Hirschfeld & German Sexology

Hirschfeld was a German sexologist who was one of the first researchers to treat trans identity and trans medicine as a serious pursuit. He partnered with other doctors to provide gender affirming care through the *Institut für Sexualwissenschaft* (Institute for the Science of Sexuality; ISS), where he also employed many of his clients, and hosted them for parties (Bauer et al., 2017; Wolff, 1986). Hirschfeld was a singular figure in the history of trans medicine, due to the fact that he was a part of the communities that he served (Bauer et al., 2017). Much of his approach to transgender medicine was based on the idea that gender and sexual variation was a natural phenomenon—this idea animated his political work as well, which was focused on the repeal of Paragraph 175, a German law that criminalized homosexuality. This Hirschfeld was steeped in Enlightenment ideals, and truly believed in justice through science (Bauer et al., 2017; Wolff, 1986). It is, therefore, both ironic and tragic that he was eventually forced to flee Germany due to violence against those who were perceived to be homosexuals and those with Jewish heritage (Bauer et al., 2017; Wolff, 1986).

In the earlier 1900s, Hirschfeld published *Die Transvestiten*, or “The Transvestites,” wherein he explained his theory of sexual intermediaries. This theory made a case for the non-binary nature of physical sex—an argument that is still being made to this day, and which many still fail to fully grasp. Hirschfeld divided sexual characteristics into four groups: (a) primary; including germ cell, oviduct or spermatid duct, and genitals, (b) secondary; including hair, larynx, chest, and pelvis, (c) tertiary; including orientation, approach, disposition, manner of activity, and (d) 4th order; including emotional life, manner of thought, occupation, and clothing. In analyzing these different options, Hirschfeld came up with 43,046,721 combinations, and assumed that this was far too small of a range to capture the actual range of human sexual variation (Hirschfeld, 1991). His views on this matter were so ahead of his time that we have only recently begun to catch up to them.

The idea that sex was so expansive, and that such expansiveness was a natural feature of the human experience, refuted the idea that homosexuality or transvestism should be criminalized or pathologized. The idea that homosexuality should be criminalized, that it was an expression of deviance, was directly connected to the idea that any medical interventions associated with gender expansiveness were a correction to an illness (Powell et al., 2016). By associating anything that fell outside the constrictions of heterosexuality or cisgenderism with disease, illness, and criminality, the conditions were created for a paradigm of medical and legal reality wherein transgender people would be subject to intense stigma, and would be treated as an exception to the ethical frameworks that typically governed how humans were treated in the legal and medical realms. While Hirschfeld clearly believed that this outcome could be avoided by focusing on the *natural* presence of sex and gender differences in human beings, his views were not fully carried forward by his colleague and mentee, Dr. Harry Benjamin.

The case studies that Hirschfeld published in *Die Transvestiten* were also striking in that they differed markedly from later conceptions of trans identity, including those which Benjamin would publish half a century later in *The Transsexual Phenomenon*. Some of the trans women that he spoke to reported strong feminine influences in their childhoods, while others cited no such influence (Hirschfeld, 1991). Some engaged with feminine habits, interests, and clothing as small children, while others had only masculine backgrounds (Hirschfeld, 1991). Still others discussed having a variety of interests that didn't map easily onto gender role stereotypes (Hirschfeld, 1991). Some had slept only with women, some with men, and others reported being sexually attracted to both men and women (Hirschfeld, 1991). Many of them had support from their families, including their wives. These observations are particularly striking given how they contradict the narrow, uniform narrative that later doctors would demand from any patient who wished to receive care (Califia, 2003; Meyerowitz, 2009; Stryker, 2017).

Hirschfeld called these people transvestites, with *trans* meaning opposite or over, and *vestis* meaning clothing (Hirschfeld, 1991). He believed that clothing was “the unconscious language of the spirit,” and to his participants, clothing was more than just an adornment (Hirschfeld, 1991, pg. 203). As Hirschfeld said, “They cannot find enough words to describe the feeling of peace, security and exaltation, happiness and well-being that overcomes them when in the clothing of the other sex.” His participants, as varied as they were, described similarly positive feelings when they were able to embody their authentic gender, with one trans woman stating eloquently “Slips, to me, are a sanctuary.” Another women stated that she began to be in a bad mood if she had to go a few days without wearing women's clothing, but that if she could wear women's clothing a few days in a row, her “joy of living grew and [her] desire for working [became] unusually strong” (Hirschfeld, 1991, pg 126). Hirschfeld was not blind to the fact that the phenomenon he was studying was deeper than clothing. He critiqued his own analysis for describing only the external when, as he said, “the internal is limitless” (Hirschfeld, 1991, pg 233).

While he was well ahead of his time in many ways, Hirschfeld, like most of his contemporaries, identified as a eugenicist (Sengoopta, 1998; Wolff, 1986). At the time, eugenics was seen as a far more respectable and valid pursuit than sexology, thus sexologists used the frameworks of eugenics to bring more validity to their own pursuits (Amin, 2018; Sengoopta, 1998; Taylor et al., 2017). Hirschfeld learned a great deal from famous eugenicist Eugene Steinach, who developed procedures for *rejuvenation* that later became foundational for

transgender medicine (Amin, 2018; Sengoopta, 1998; Taylor et al., 2017). This troubled history is important to note, not only to avoid inappropriately valorizing Hirschfeld, but also because it was carried forward by Hirschfeld's student, Harry Benjamin. Through Benjamin's influence on trans medicine and through the international reach of the World Professional Association for Transgender Health (WPATH), the logics of eugenics have always been present in Western transgender medicine.

Harry Benjamin & U.S. Trans Medicine

In the mid-twentieth century, most doctors and researchers in the United States approached any hint of trans identity from a model of deviancy. In late 19th century, Richard von Kraft-Ebbing declared that gender non-conforming identities were a mental illness brought about by childhood trauma, that trans people were psychopathic, and that the more intensely they identified with the "other gender," the more psychopathic they were (Beemyn, 2011). It is worth noting that Kraft-Ebbing had taken his samples from local law enforcement; in effect, all of the gender non-conforming people he met were quite literally criminals. His conclusions that all trans people were criminals are rather unsurprising given the circumstances (Beemyn, 2011). The next few decades were a profound struggle between those who needed gender affirmation care, and those who could have provided it. The details vary depending on who does the telling (Reay, 2015). Researchers and doctors imagined themselves as intrepid explorers, armed with intellectual curiosity and perfect objectivity, while the trans people who desperately sought care usually found themselves dealing with hostility, mistrust, and unregulated assumptions (Beemyn, 2011; Califia, 2003; Meyerowitz, 2009).

Broadly speaking, the European doctors were more accepting of transgender identities and were more willing to work with trans patients (Frey et al., 2019). Due to the high-profile case of Christine Jorgensen, Danish doctors in particular became inundated with requests for surgery (Meyerowitz, 2009). Because the Danish government forbade the surgeons from helping anyone who wasn't a Danish citizen, the surgeons began to refer patients back to Harry Benjamin (Meyerowitz, 2009). Dr. Benjamin was a German doctor who had travelled with and learned from Hirschfeld, and was more sympathetic to trans people than most of his contemporaries. While Dr. Benjamin would grant access to gender affirmation surgery as a last resort, his criteria were exacting (Califia, 2003; Meyerowitz, 2009).

However, this was far more care than these same patients would typically receive from the university gender clinics. Though "gender identity clinics" sounded, in name, like places where one could go to obtain gender affirming healthcare, in reality they were often labs where researchers could identify what they considered to be therapies for eradicating cross-gender behavior in children (Gill-Peterson, 2018; Meyerowitz, 2009). Many trans people went to such clinics to obtain care, willingly submitted to be research subjects on the vague promise of treatment, and were sorely upset to discover after their participation that the doctors had no interest whatsoever in helping them obtain their goals (Meyerowitz, 2009).

These doctors and researchers came to understand that the only treatment for patients with what John Money referred to as "gender identity errors" was to bring the mind in line with the body, though no one had ever been able to create a method to change what they called *the mind*, or someone's internal experience of their gender (Califia, 2003; Meyerowitz, 2009). Yet

still, they continued to try, again and again, to find a solution that changed the mind rather than the body (Meyerowitz, 2009). Unlike Hirschfeld, these doctors took a paternalistic approach to their patients. They spoke about their patients in disparaging terms and offered them little, if any, agency (Califia, 2003; Meyerowitz, 2009). Even when doctors did give care to trans patients, they required intense, sometimes impossible prerequisites to care, and would deny care for reasons that included their opinion on the patient's ability to pass for their gender post-transition (Meyerowitz, 2009). This approach to medicine caused a variety of problems, the aftershocks of which are still reverberating in modern transgender medicine. As Califia (2003) wrote, "'Help' from doctors is truly a double-edged sword for sexual minorities."

Effects of Paternal Medicine

The gatekeeping that doctors engaged in created a self-defeating cycle—patients who sought gender-affirming care were required to report a very specific life experience in order to obtain care. They had to report having felt their cross-gender identification from a young age, have always had interests and hobbies suitable to the gender role they sought to inhabit, being interested in occupying that role in a heterosexual relationship, and more (Califia, 2003; Meyerowitz, 2009; Stone, 1991). Trans women were required to express a very demure sexuality if anything at all, while trans men were expected to be much more sexually active in line with prevailing gendered stereotypes. Any patient who did not have these experiences had to parrot them, lest they be denied care (Meyerowitz, 2009; Stone, 1991). Of course, as Hirschfeld's work had already shown, trans people had a huge variety of experiences and were not easily distilled to a single model of identity development or life circumstance.

The sex researchers may have suspected they were being deceived, but they seemingly lacked awareness of the fact that this was a direct result of their stringent and unrealistic requirements and paternalistic medicine (Stone, 1991). Instead of moderating their expectations or even engaging in a good-faith scientific analysis, the gender researchers doubled down on the narrative of the duplicitous trans patient (Califia, 2003). This damaging narrative remains to this day. Even Harry Benjamin, so often lauded for his role in the creation of the Standards of Care, spoke poorly of his trans patients. Benjamin claimed that his trans patients were "handicapped by their character and behavior," and referred to them as impatient and ungrateful (Califia, 2003). Benjamin was one of the most charitable; most of the doctors of the time described their patients as psychotic, delusional, liars, incapable of living in society, devious, demanding, manipulative, incapable of love, and more (Reay, 2014).

Richard Green found in 1966 that 4/5ths of the providers he surveyed would label a trans woman "severely neurotic, with 15% diagnosing her as psychotic" (Califia, 2003). The majority of the providers surveyed stated that they would deny gender confirmation surgery regardless of what the patient did to obtain it, even if they patient would die without it (Califia, 2003). Although this area is under-researched, the United States Trans Survey (USTS), the largest quantitative study ever done on the US trans population, found that 33% of its participants had experienced one or more negative instances at a doctor's office, ranging from misgendering to sexual assault (James et al., 2016). The transphobia Green discovered remained, even to this day.

In an effort to standardize the care of trans patients, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) formed and released a set of guidelines in 1979 meant

to provide a path for healthcare providers to follow when treating trans patients (Meyerowitz, 2009). Although surgery could be recommended following these guidelines, the steps to follow were exacting and required the patient to prove themselves in a variety of ways, such as living in their authentic gender identity for a year without hormones (HBIQDA, 1979). Additionally, the next year gender identity disorder (GID) entered the DSM for the first time, formalizing the pathologization of trans identities (Meyerowitz, 2009). In some ways, these changes allowed for more trans people to access care; the presence of a formal criteria created a path to be followed and the opportunity for insurance coverage for gender affirmative care. However, this also functioned to cement many of the barriers to trans care.

Many of the barriers to gender affirming care that were established during the latter part of the 20th century are still prevalent now. The mishandling of trans medicine that occurred during this time has resulted in a system where gender affirming care is difficult to access, unaffordable, and often denied by insurance (Frey et al., 2017). Further, providers still discriminate against their trans patients, fail to learn transgender medicine in medical school, and consider transgender identities to be a pathology (Frey et al., 2017; James et al., 2016). The model created by the gender researchers of the 20th century is neither accurate nor helpful the most vulnerable members of the trans community.

Issues in Modern Trans Medicine

The troubled history of transgender medicine has created the conditions for a troubled present. While progress has been made due to the tireless efforts of transgender scholars, activists, and advocates, transgender healthcare access is still limited, and transgender medicine is under-researched and under-funded (Wanta & Unger, 2017). Most of these issues can be boiled down to the *cisgendering* of transgender medicine, though the issue of pathologization is a consistent problem in the creation of more affirmative models.

Cisgendering Trans Medicine

The concept of *cisgendering reality* is useful in examining the disconnect between the lived trans realities discovered by Hirschfeld and the narrowly-framed stereotypes that the American researchers used to discipline and control their patients. This theory, originally developed by Sumerau, Cragun, and Mathers (2016) describes the ways that cisnormative institutions erase, mark, and punish transgender experiences in ways that reproduce cisnormative ideals of reality. This theory was extended to the interactional level by Mathers (2017), who described a process by which cisgender individuals *cisgender interactions*, or reassert binary, essentialist notions of gender in an effort to navigate challenges to the dominant gender frame while requiring an unequal amount of emotional labor from the transgender people in the interaction.

The process of *cisgendering* is made plain in the history between trans individuals and the doctors and researchers that studied them. This process requires some challenge to a dominant gender frame—in the case of gender affirming medicine, that would be the desire or request to alter one's sexual characteristics (Mathers, 2017). The doctors and researchers reasserted binary notions of gender in a variety of ways, including insisting on the heterosexuality of their patients, giving care only to those they imagined being capable of

achieving a stereotyped gender presentation, requiring them to get all available surgeries regardless of the patient's desires, and requiring them to conform to the strictest interpretations of masculinity or femininity (Califia, 2003; Meyerowitz, 2009; Stryker, 2017). Finally, these researchers required, even demanded, a bottomless well of emotional labor from their patients, which they used to analyze and build theories, but rarely to actually provide the patient with the care they sought.

The problems created by this *cisgendering* process extend past the GID diagnosis (Johnson & Wassersug, 2010; Mathers, 2017). In constructing a cisgender reality wherein binary, stable genders are normal and anything else is deviant, these researchers lost sight of what Hirschfeld had discovered—that transitioning resulted in a *profound peace* (Hirschfeld, 1991). In the framework constructed by the gender researchers of the 20th century, gender dysphoria was a symptom of a profound mental illness, possibly a psychosis (Califia, 2003; Meyerowitz, 2009). Access to care for trans people was predicated upon correctly performing gender dysphoria, and the measure of adequate treatment was a lessening of gender dysphoria (Califia, 2003; Johnson & Wassersug, 2010; Meyerowitz, 2009). In other words, the entire framework for approaching transgender people who asked for medical intervention was based in how negative, how painful, how awful their lives would otherwise be. This approach hasn't much changed. That peace, happiness, and fulfillment that Hirschfeld described has been *cisgendered* out of the paradigm. What remains is a medical framework centered around the idea of curing an ailment, or treating an illness—neither of which are very accurate frames for trans medical journeys.

Controversy: Depathologization vs. Inclusion in the DSM-V

Much like the history of gender affirming healthcare, the controversy surrounding GID and GD as psychological diagnoses is long, detailed, and can only be briefly covered in this paper. Diagnoses that frame trans identities as mental health issues can be found in both the DSM and the International Statistical Classification of Diseases and Related Health Problems (ICD). The ICD first incorporated gender transition processes as a mental health diagnosis in 1975, five years sooner than the DSM (Davy et al., 2018). In more recent years, a movement grew to demand the depathologization of transgender identity, to be replaced with a framework based on human rights and natural human variation (Davy et al., 2018). This movement leans on the human rights framework provided through the Yogyakarta Principles, which were developed by an international working group of experts in 2006, and present to the UN Human Rights Council in 2007 (Davy et al., 2018). These principles reflect international human rights laws and aspirations rights that have been associated with transgender healthcare and include human dignity, self-determination, bodily autonomy, and protection from medical abuse (Davy et al., 2018; O'Flaherty, 2015). These rights are not upheld by models that pathologize transgender identity for the purposes of medical intervention—a claim that was explored in detail by a proliferation of medical literature associated with the revisions of the WPATH SOC, the DSM, and the ICD (Ashley, 2021; Castro-Peraza et al., 2019; Davy et al., 2018; Drescher, 2010; Lev, 2013; Lo & Horton, 2016; Rebeca & Tania, 2021; Suess Schwend, 2020; Suess Schwend et al., 2014; Winter et al, 2016). Transgender activists and some medical and psychological professionals asserted that the pathologization of gender expansive identities could not be understood to be in line with these principles, nor with the principles of bioethics.

As this movement grew in size and support, the American Psychological Association (APA) which publishes the DSM and the World Health Organization (WHO) which publishes the ICD created internal working groups to create a diagnostic criteria that was supposed to be more equitable and reflective of trans people's lived realities (Davy et al., 2018).

Briefly put, the arguments against a psychiatric diagnosis were as follows:

- Labelling natural expressions of gender as mental illnesses further damaged and marginalized the already-vulnerable trans population (Drescher, 2010)
- Labelling children's gender variance as a mental illness contributed to reparative therapies (Drescher, 2010).
- Psychiatric diagnoses were based on arbitrary/subjective norms defined by the psychiatric practitioner, meaning that they could be biased and unscientific (Davy et al., 2018).

The only broadly adopted argument in favor of psychiatric diagnosis was that without such a diagnosis, insurance companies may refuse to cover transgender related healthcare (Davy et al., 2018; Drescher, 2010). When the DSM-V was published, a version of the psychiatric diagnosis remained: Gender Dysphoria (GD). In the view of the APA, this diagnosis was a happy compromise—it maintained a diagnosis so that insurance could be charged, but focused on the distress and negative feelings instead of any specific disordered psychology (Lev, 2013). However, as Lev states, “The story of GID, and the new diagnosis GD, is a narrative of an oppressed people and their liberation struggle, amid the psychobabble of gender conformity, mental illness, and the medicalization of human diversity” (Lev, 2013, pg. 290).

GD was a compromise, but unfortunately it was also a half-measure; it has continued to be used to create an image of mentally ill trans people, and it will continue to be called upon by anyone who wishes to paint trans populations as disordered (Lev, 2013). Caught strangely between these issues is the World Professional Association for Transgender Health (WPATH), which was previously known as HBGDA. As the leading international multidisciplinary organization promoting evidence-based trans healthcare, the WPATH Standards of Care (SOC) are still the standards consulted by most doctors internationally. However, these standards also ascribe to a pathologization model, suggesting a mental health professional (MHP) letter for the initiation of hormonal treatment and requiring two MHP letters for accessing surgery. There is already a precedent for an ICD diagnosis that is not pathologized: pregnancy (Lev, 2013). Such a diagnosis reveals that the rules of the ICD are not so rigid as to disallow for those circumstances in life wherein a doctor's intervention may be needed, even when an illness or pathology is not present.

Diagnoses are not the only option for care. Many of the depathologization movements emerging around the world are focused on the use of a human-rights model (Davy et al., 2018). According to Principle 18 of the Yogyakarta Principles, “Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured, or suppressed.” Following this human rights framework, the Argentinian Gender Identity Law was enacted in 2012. This law not only recognizes a gender change without any medical care requirements, but also establishes the right to state-funded trans healthcare relying on an informed-consent model (ICM; Davy et al., 2018). Suess Schwend (2020) describes the relationship between depathologization, human rights, and

bioethics as a “reciprocal influence” wherein each area shares the priorities of bodily integrity and autonomy as well as the right to participation in health policies (pp. 13). These approaches are relevant not only to trans healthcare, but to the entire project of creating a human-rights based healthcare system (Suess Schwend, 2020).

Informed Consent

ICMs have evolved over the decades as a response to the SOC, and the idea of such a model of treatment has been around for quite some time. Before it existed as ICM, a similar idea was known as the Health Law Standards, which were adopted by consensus in 1993 by the Second International Conference on Transgender Law and Employment Policy (Nelson, 1998). These standards were put forth due to dissatisfaction with the Harry Benjamin Standards. These standards called for hormones on demand provided that no medical contraindications existed, and provided that the individual under treatment complied with regular blood tests (Nelson, 1998). In the subsequent 24 years, ICMs have evolved through its use in clinics in an effort to support patient autonomy (Ashley et al., 2021; Cavanaugh et al., 2016; Schulz, 2018). Though ICMs do not necessarily supply hormones on demand, it uses a discussion between the patient and the provider as the basis for prescription (Ashley et al., 2021; Cavanaugh et al., 2016; Schulz, 2018). Essentially, the provider informs the patient of the risks and benefits of various treatment options, and the patient is allowed to use their personal knowledge to decide which options, if any, are appropriate for them (Ashley et al., 2021; Cavanaugh et al., 2016; Schulz, 2018). The model addresses the possible need for mental health care by allowing the patient and their provider to decide if that avenue is necessary (Ashley et al., 2021; Cavanaugh et al., 2016; Schulz, 2018).

Healthcare providers have conversations with their patients about mental health quite regularly—there’s no reason why they would not be capable of assessing the mental health of transgender patients. IC recognizes that there are some situations where a patient’s mental status may preclude informed consent, but also recognizes that such instances are rare and that a provider can identify them and deal with them properly (Ashley et al., 2021; Cavanaugh et al., 2016; Schulz, 2018). Even a patient who would generally benefit from the involvement of a mental health professional, such as a patient with anxiety, depression, or a personality disorder, may not benefit from therapy if it is present as a condition to accessing hormone therapy (Ashley et al., 2021). If a patient is allowed to access their hormone therapy regardless of a commitment to seeing a psychotherapist, then the patient’s autonomy is kept intact and a productive relationship with a therapist becomes far more likely.

One clinic that has publicly discussed its transition into offering IC care is Fenway Health, an LGBT community clinic located in Boston, Massachusetts. Fenway is both the largest care provider and the largest employer of trans people in Massachusetts, and has been serving trans populations since they opened as a grassroots clinic in 1971 (Reisner et al., 2015). In 2007, Fenway health eschewed the SOC model and instead implemented a modified IC model, where patients filled out a hormones readiness assessment instead of seeing MHPs or passing a “real life test” where the patient lives in their self-identified gender without any medical intervention (Reisner et al., 2015). Fenway has evolved to meet continuously updated standards of patient care under a philosophy of “accessible, patient-centered care that views gender affirmation as a routine part of primary care service delivery, not a psychological or psychiatric condition in need

of treatment” (Reisner et al., 2015, pg. 587). Additionally, Fenway has developed their program in conversation with transgender community members and leaders, and as a result, has held over 80 trainings for local and national mental health and medical providers to become competent providers for their trans patients (Reisner et al., 2015).

Several studies have shown that transgender people delay even routine care due to fears about being mistreated by providers (Grant et al., 2011; James et al., 2016). Delaying routine care due to the possibility of being mistreated by healthcare providers could potentially result in a variety of negative health outcomes resulting from undiagnosed or uncontrolled health issues. Therefore, it is ethically incumbent upon healthcare providers under the principles of beneficence and non-maleficence to ensure that they are reducing barriers to care rather than upholding them. Informed consent has the potential to be a powerful clinical framework; by centering transgender perspectives and prizing agency, it adheres more closely to principles of medical ethics and avoids some of the pitfalls of the pathologization models. However, informed consent is a framework that applies only to transgender people who need hormones and/or surgery, and still operates on the idea of gender dysphoria. In order to create a model that fully captures the rich diversity of transgender experience(s), a new approach will be needed.

Trans Voices/Trans Reality

In an effort to move toward correcting these decades of *cisgendering* and misunderstanding, it is necessary to center the voices of transgender people themselves. For example, in the USTS (conducted in 2015), there were 24 gender identity categories listed on the survey in addition to an “other” category with a write in option. There were over 500 unique gender identities written into that space (James et al., 2016). The pluralism of gender identities that fall under the umbrella of “transgender” was examined extensively by David Valentine in his 2007 book, *Imagining Transgender: An Ethnography of a Category*.” The word “transgender” is a relatively new one, but has found success as a way of referring to all of the many identities that transcend cisnormative assumptions of gender and often, the behaviors that exist outside of the gendered norm (Califia, 2003; Currah, 2006; Lev, 2014; Valentine, 2007). The variety of identities and behaviors subsumed under the word “transgender” are a challenge that has remained unaddressed by existing medical models. With this galaxy of identities, expressions, and needs, a framework is needed that can capture and attend to the individual needs of each person without losing its coherence.

It is fully possible that a transgender person who seeks medical care may require a variety of medications and surgeries, both related and unrelated to their trans identity (Lev, 2014). Conceivably, a patient could present desiring hormones, breast augmentation, genital surgery, facial feminization surgery, a tracheal shave, and hair removal for their face and chest. Another patient may require only low-dose hormones. Another patient may not need any gender care, but may benefit from social support through a support group or a therapist (Lev 2014; Koehler et al., 2018). This proliferation of identities makes it difficult to use statistical methods to analyze information about this population, since such methods revolve around large sample sizes and relatively stable categories (Lev, 2014). As the SOC have evolved, more and more of this variation has been realized; Harry Benjamin himself couldn’t imagine someone who wanted to change the sex without surgically altering their genitals (Meyerowitz, 2009). The current SOC acknowledge that there exists a range of medical interventions for trans people, and that each

individual may avail themselves of these technologies differently (James et al., 2016). Still, few guidelines discuss care for those trans people who do not wish to take hormones or have surgery. Engaging more closely with this population during the creation of guidelines would result in a set of guidelines that could be tailored more closely to the lived experiences of trans individuals.

It is often through interactions with this population that the most useful frames are uncovered. For example, Namaste (2000) discussed the ways that cisgender research questions often function as ways to satisfy cisgender curiosities. This is exemplified in a quote from activist Jeanne B., “A lot of people ask me, ‘What do you do to pass as a woman?’[...] But nobody asks me, ‘How did you manage to live and pass as a man for so many years?’” (Namaste, 2000, pg 32). This reframing exposes the assumptions of the original question—assumptions that are quite explicitly cisgender and fail to reflect the ways that transgender people experience the world, their bodies, and their identities. The question creates normative implications around gender role, identity, and performance that are undone by Jeanne B.’s reply (Namaste, 2000). *The Remedy*, a book of essays released in 2016, overcomes this by centering transgender voices explicitly (Sharman, 2016). This volume includes essays by queer and trans people who are both patients and providers, and illuminates their experiences in healthcare settings as well as the understandings and misunderstandings of those who they work with. For example, in the essay “Unlearning,” a trans medical student describes what it’s like to be trans while learning the two-gender model of medicine. She uses the metaphor of a liver filtering out toxins to discuss how she deals with the daily strain (Sharman, 2016).

In another essay, “Confessions of a Gender Specialist,” a trans-identified doctor discusses the experience of acting as a gatekeeper while being deeply critical of the WPATH SOC and role of psychologists as gatekeepers (Sharman, 2016). Their experience of working within the confines of the SOC while using their own positive of power and privilege to subvert those guidelines is emblematic of the ways that trans people have found to obtain medical care despite the hostilities of the medical system (Sharman, 2016). Similar to those patients who read medical accounts and learned to parrot the only trans narrative that doctors would expect, this willingness and ability to subvert medical authority has become almost as characteristic of trans healthcare as the incompetence of the doctors who attempt to keep care from their patients. However, as the author of the essay points out, the need to fight to avoid being labelled “sick” can keep trans people from seeking help when it is needed (Sharman, 2016). This is yet another example of the ways in which the current model causes far more harm than good.

Wellness Models of Care and Theories of Health

The model of medicine practiced by the 20th century gender researchers fits well under the rubric of *paternalistic medicine*. Such a model characterized the patient/provider relationship as a deeply unequal power dynamic wherein the provider held the medical knowledge and thus, the power to diagnose, prescribe, and otherwise treat the patient (Gold, 2010). In this model of care, the patient was helpless and vulnerable, looked to the doctor for answers, and was expected to blindly comply with whatever the provider asked (Gold, 2010). Under this model, it would not have been uncommon for a doctor to make a treatment decision for the patient without much of any conversation about the patient’s preferences or values (Gold, 2010). Since the shock of the Nuremburg trials, this model was mostly abandoned, although some thought has been given to a

weak paternalism model that still allows for patient's autonomy and decision making (Gold, 2010; Rodrigues-Osorio & Dominguez-Cherit, 2008).

As a reaction to the paternalism model, the autonomous model prizes the patient's autonomy above all, including the doctor's opinions about the patient's care (Rodrigues-Osorio & Dominguez-Cherit, 2008). This model, which is also referred to as the *informed consent* model or the *patient-centered* model, has become more and more prevalent over the past few decades, and has resulted in a variety of changes in how medicine is done (Gold, 2010). In fact, it seems as though one of the last vestiges of paternalism can be found in transgender medicine, where patients are still often required to obtain the permission of one doctor to get care from another. It is unclear if this dynamic still operates in any other form of medicine.

According to the autonomous model, patients should be able to make intentional decisions that are made with substantial understanding and freedom from coercive influences (Entwistle et al., 2010). Unfortunately, many healthcare professionals still view trans patients through a lens of psychological and developmental deficit. (Avera et al., 2015). Despite the more recent focus of the medical establishment on cultural sensitivity and diversity, transgender patients are still approached as victims of gender dysphoria. It is unethical and discriminatory to afford trans patients less autonomy than cis patients.

Ethical Principles

Providers are bound to certain guiding ethical principles, including beneficence (working to benefit patients) and non-maleficence (doing no harm to patients; Pantilat, 2008). These principles can become complex; for example, if a doctor needs to harm a patient temporarily to help them in the long term, doing no harm may need to be modified to doing the least possible harm. However, in the realm of transgender medicine, these lofty principles seem to have been largely ignored or, put generously, loosely interpreted.

The AMA also lists the *process* of informed consent as a guiding ethical principle. According to the AMA, this process includes (a) an assessment of the patient's ability to comprehend the pertinent information, including risks and benefits, and to make an independent and voluntary decision about their care, (b) presenting clear and accurate information about the diagnosis, the nature and purpose of the proposed interventions, and the burdens, risks, and benefits of all options, including foregoing treatment, and (c) documenting the informed consent (AMA, 2018). This process is meant to allow patients to bring their own autonomy into the diagnostic conversation, to make informed choices that are in line with their own values, and to exercise agency in their healthcare decisions.

These ethical principles are meant to work together to preserve patient autonomy and to manage the inherent power imbalances that exist between a doctor and their patient. Entwistle et al. (2010) offered a series of suggestions that providers can use with patients in an effort to support their autonomy in clinical decision making processes. Their recommendations include supporting patient's autonomy over any narrow potential health gains, listening to patients, explaining thoroughly about how their proposed treatment accounts for personal circumstances, concerns, and preferences, enabling patients to ask questions and correcting patient misconceptions, and finally, ensuring that patients feel that they can choose to go against the

provider's recommendation if desired (Entwistle et al, 2010). Above all, the patient's body is their own, and the doctor should not encroach upon that body without explicit and informed permission.

Models of Health

Conceptions of health and wellness have extended across a variety of disciplines, including counseling, medicine, sociology, psychology, and others. Although health used to be associated simply with survival, increasing lifespans and improving medical technology have resulted in a shift toward a series of new definitions. Most recently, health has come to mean well-being and quality of life, with the WHO definition reading, "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Shuster et al., 2004). Many medical and medical-adjacent fields have now begun to incorporate some model of wellness into their guidelines in recognition of this. The Wellness Model proposed by Myers and Sweeney defined wellness for the counseling work as "a positive state of being" (Avera et al., 2015). In this model, gender identity was defined as "satisfaction with one's gender; feeling supported in one's gender; transcendence of gender identity." This is one example of a positive/wellness model of gender.

In nursing, the health and wellness models are built upon a patient's willingness to engage in health promotion behaviors, as well as their self-efficacy. In these health promotion models, nurses look carefully at multiple levels that operate simultaneously to effect health (Liveng et al., 2018). The model put forth by Liveng et al. (2018) allows for the issue of the *wicked problem*, or a problem that effects a certain population across multiple levels. For a trans population, such a problem is broadly defined as stigma or transphobia. At the macro level, this stigma results in hostile law and policies such as the current push for banning transgender women from sports, banning transgender people from bathrooms, and performing genital inspections on schoolchildren. At the meso level, it results in reduced access to jobs and housing, resulting in economic and health inequalities. At the micro level, it results in interpersonal violence. Laying out the contours of the issues allows for the conceptualization of interventions that would affect all three levels of the issue (Liveng et al., 2018).

Health promotion-based models should allow for a given individual to be empowered, and for their own self-efficacy to play a large part in any health-based interventions (Liveng et al., 2018). This works well with medical models based on patient-centered care, which has been associated with better quality of care as well as better health outcomes (van den Berg et al., 2017). Patient centered care includes eight dimensions: respect for the patient's values, preferences, and needs; coordination and integration of care; information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; accommodation of social and emotional support; continuity of care; and accessibility of care (van den Berg et al., 2017). This form of care has been used in non-pathologized medical settings, including the care of pregnant patients, and could be adapted for use with trans populations. This model differs significantly from the medical model of transgender care, and provides a framework from which a more comprehensive and patient-focused model can be built.

The wellness model is largely used in the context of counseling, the health promotion model in the context of nursing, and patient-centered care is used in the realm of medicine.

Bringing these three models together creates theoretical backing for a comprehensive model of transgender healthcare that is non-pathologized, based on ideas of health and wellness, and designed to work closely with the values, desires, and needs of the patient instead of a paternal, cisgender misconception of what trans care should look like (Avera et al., 2015). With consideration to the breadth of trans identity and healthcare needs, these theoretical foundations are ideal for an interdisciplinary framework that serves the needs of this population.

The Gender Wellness Model

To review, the issues with the current model of transgender healthcare are as follows:

- The use of a psychiatric diagnostic protocol to treat a non-psychiatric condition.
- The requirement of a mental health professional's involvement in patient decision-making.
- The pathologization/inclusion in the DSM controversy.
- The negative/disease/deficiency model for determining the medical necessity of care.
- The *cisgendering* of the model, or the lack of attention to the reality of trans lives and experiences.
- The attention to only the medical needs of those trans individuals who require medical intervention for gender affirmation.
- The failure to integrate informed consent/the residual paternalization of medicine.
- The failure to recognize the unethical nature of not providing gender affirmation care to those who require it.
- The creation of a negative/gatekeeping relationship between mental and general healthcare providers and their patients.
- Creates a narrow conception of what gender affirmation care entails.

These challenges can create formidable barriers to care, which can be seen in the most recent statistics regarding transgender healthcare. In the 2015 USTS, one in three respondents reported having a negative experience with a healthcare provider in the past year, and 23% reported delaying medical care due to fear of being mistreated. Further, although 78% wanted hormone therapy, only 49% had been able to obtain it (James et al., 2016). Numbers were even worse for surgery, with only 25% of the sample having been able to obtain it (James et al., 2016). These are just some of the results of the current healthcare model.

To address the above issues and remove barriers to medical care for the trans community, I propose the Gender Wellness Model (GWM). This model is predicated upon the idea that everyone has an ideal gender wellness state, but different individuals may require different interventions to obtain their optimum state of gender wellness. Some cisgender people, for example, may not require any gender-affirmation interventions; their gender wellness may already be in its optimal state without any such interventions. A person who was questioning or exploring their gender identity may need to speak to a gender-specialist, or may wish to try hormones to assess their effect. A trans and/or non-binary person may need hormones and one or more surgeries. The goal of using this framework to address gender wellness would be to increase one's subjective peace, satisfaction, and congruency with their gender.

The GWM would encompass a broad range of gender affirmation care, as well as the other types of care that a trans population needs. Instead of addressing only hormones or surgery, this model of care would account for those forms as care as well as counseling or social work (either for the individuals or for their families as they go through the transition process), general health care with a specific emphasis toward the side effects of hormone treatments, sexual health and STD testing, reproductive health and reproductive preservation, complementary and alternative medicine, and broader support structures such as support groups, employment programs, community events, and affordable housing. This would allow for providers to give competent, culturally sensitive care to any who required gender affirmation without being locked in to a specific model of gender treatment.

The appropriate type and level of care could be discussed between the patient and their provider, and could be decided upon between them. This process wouldn't necessarily prevent the involvement of an MHP, but their involvement would be based on the need for such services as determined by the provider and the patient. The primary care provider (PCP) could prescribe hormones, order any necessary blood tests, and refer the patient to any other necessary services. Ideally, this provider would be part of a larger hospital, clinic, or health system that could provide a range of services to both patients who needed gender affirmation care and patients who do not.

An example of the type of services that would be useful in such a setting can be found in the services provided by Fenway Health, the previously mentioned community clinic in Boston. As part of their trans healthcare program, which operates on the IC model, they provide (a) primary care for adults and adolescents, including internal medicine and family medicine, (b) family planning, including alternative insemination, contraception counseling and administration, (c) transgender care, including reproductive rights and medication counseling, hormone administration, and post operative and prosthetic care, (d) HIV and STD care, including HIV/AIDS care and case management, HIV/STD counseling services, STD treatment and partner notification services, (e) internal medicine subspecialty care, including pulmonology and infectious disease care, (f) other medical specialties, including gynecology, podiatry, and nutrition services, (g) complementary and alternative medicine specialties, including acupuncture, massage therapy, and osteopathic manipulative therapy, (h) integrated behavioral health and non-clinical case managements, (i) diagnostic imaging, such as x-rays, mammography, and bone mineral density screening, (j) clinical and retail pharmacy, (k) dentistry, and (l) optometry (Reisner et al., 2015).

With such a range of services, Fenway Health is able to provide holistic, comprehensive care to their trans patients that is based in the individual's needs. Such a scenario would be ideal for the GWM, but absent a community clinic such as Fenway, this model could still be used in the realm of private practice. A provider could work with a patient to determine their needs for achieving their individual optimum gender wellness, and could prescribe and refer accordingly. Most of the gender affirmation services needed by the trans population are services that are provided regularly and without fanfare to cisgender populations. Hormone therapy is used for a variety of health conditions in people of various genders, including menopause, breast cancer, polycystic ovarian syndrome, hypogonadism, and more. Breast augmentations are done as medically necessary reconstructive surgery for breast cancer survivors, and mastectomies are performed for breast cancer as well. These services are offered for a variety of reasons, only

some of which are considered to be illness or disease. Even when pathology is present, it is not correlated with psychological illness or deficiency.

Features of the Gender Wellness Model

There are many features to this model that would be advantageous in the pursuit of competent gender affirmation care. First, instead of existing in tension with IC models, IC can be seamlessly integrated. Under this model, IC could be used for surgical interventions as well as hormones, and the patient and their provider could both operate according to their personal agency and values. Essentially, this model would provide the same advantages of the medical model and the IC model, but without the negative aspects of pathologization. The GWM allows for a positive conception of transgender identity, but it also allows for a positive conception of transgender care. Providers can partner with their patients to work toward a specific outcome—optimized gender wellness—and instead of taking a paternalistic role (the traditional model) or a relatively hands-off model (IC), can be active partners in achieving positive patient outcomes. This creates an environment of honesty between trans people and their providers—there is no pressure to present a specific narrative under the GWM. Further, this model honors a patient’s experiences and self-knowledge. A patient who is sure that they want hormones or surgery can access it, while a patient who is unsure can either be referred to a gender specialist or even a support group for others in similar situations. There is no need to interrogate or question the patient; instead, the patient can be made to feel secure in expressing themselves honestly, whether that expression is doubt or surety.

The GWM is expansive enough to allow for all of the variation within the trans population. Patients can take the steps that they feel comfortable with, and avoid those that they either don’t desire or aren’t ready to engage in. Under the current SOC, it is recommended that a patient be on hormones for one year before surgery can be done. However, there are some trans people who desire surgery, but not hormones. Under the GWM, the individual could work with their provider to choose an appropriate course of action. The patient could express their autonomy while the provider could give guidance, answer questions, and explain the various options to the patient, or refer them to a surgeon for a consultation.

Importantly, the GWM can include body image issues that are not related to the primary sex characteristics. This could refer to body hair, facial feminization surgeries, and other interventions designed to address characteristics that are not located on the chest or pelvis. Currently, these types of interventions are often still considered to be cosmetic or elective, despite the fact that they can be just as important to the health, safety, and wellness of a patient as chest or genital surgery.

The GWM is not meant to be a static model. One aspect of this model that would be important to maintain would be a reflexive dialogue that included the input of transgender people as well as the providers working with the model. In the event that something needed to be changed, recommendations could be made with preference given to the experiences of trans people. This would be done in an effort to avoid the mistakes made in the previously-used medical models. Ultimately, the model could be adjusted if necessary.

Conclusion

Transgender medicine has a dynamic history in the US and worldwide. Though Hirschfeld was willing to listen to his patients and imagine a place for trans identities in the spectrum of human variation, his work was destroyed. Other doctors and researchers had a different approach, using a model of deviancy, disease, and distress to formulate GID as a diagnosis. Though the most recent version of the DSM changed GID to GD in an effort to address the pathologization without creating a situation where individuals would lose their insurance coverage, this move was inadequate. The problem was deeper than the language used for a diagnosis—mainly, the paradigms for approaching transgender medicine were corrupted from the start because they were created by *cisgendering* the trans experience. This *cisgendering* process erased the joy, peace, and fulfillment that trans people felt once they obtained their ideal state of gender wellness, and instead created an entire diagnostic and treatment regimen that focused only on the negative, or dysphoria. In an effort to move away from pathologization, some healthcare providers and clinics have started using IC. However, the adoption of this model has been uneven, in part because it is in opposition to the current medical model.

Much of this could have been avoided by considering more closely the lived realities that trans people face, and by working with that population to create a medical model more suited to their actual needs. By centering trans voices, the needs of this population become clearer and the positive benefits of transition come to the fore. Though it is understudied, available literature supports that transition results both in better mental health outcomes and a better quality of life. Due to the benefits of transition and the negative results of denying or delaying transition, denying gender affirmative care to those who need it is ethically indefensible. Therefore, a model is needed that can address the ethical implications of denying care. Since the middle of the 20th century, healthcare has moved toward a patient-centered, health-promoting paradigm of care, as counseling has moved toward a wellness model of care. Introducing these concepts into the model of trans medicine helps create a basis for an interdisciplinary model better suited to the needs of the trans population.

To address these issues, I propose the GWM—a model that seeks to help individuals reach their optimum state of gender wellness through a holistic approach to gender affirming care. This model encompasses all gender identities, including those who need medical intervention to actualize their authentic identity and those who do not. It is consistent with the human rights framework set out by the Yogyakarta Principles as well as the principles of bioethics. It honors human dignity, self-determination, bodily autonomy, and protection from medical abuse, and creates the conditions of wellness and opportunity for trans people. This model also addresses the psychosocial needs of trans populations, such as mental healthcare and social support, and medical needs that fall outside the realm of traditional medicine, such as complementary and alternative medicine.

More research is needed to implement and validate this model. However, for want of something superior to the SOC model, IC has already been implemented in a variety of clinics with good results. There is no reason to think that the GWM—thoughtfully implemented with open channels of community feedback—would be less successful. The GWM should be implemented with the highest degree of community collaboration at the organizational, structural, and clinical level. By this, I do not mean with a tokenistic inclusion of trans people,

but with meaningful input, feedback, and power given to community members at various intersections of race, gender, sexuality, and ability who are paid for their labor and involvement. By involving the trans population to engage in a reflexive process of feedback, this model can be tweaked and improved to be generalizable to any clinic, hospital, and healthcare system.

For decades, transgender Americans have been mistreated by their fellow citizens, but also by the doctors, researchers, and psychologists who ostensibly took on the responsibility of assisting them. Transgender healthcare did not have to evolve the way that it has; there could have been a model of care based on natural human variation and the promotion of health and wellness. Though it is impossible to change the past, it is gravely important that researchers and doctors refuse to repeat the mistakes of their forbears. The GWM creates an opportunity for healthcare that provides an opportunity for wellness to people of all genders. There is no reason that, one hundred years after Hirschfeld's ISS, we cannot provide competent transgender healthcare.

Dissertation Conclusion

Just as Hirschfeld was situated in a specific time, place, and cultural moment, this project will be submitted in rather challenging cultural context. It is the summer of 2022, approximately a decade after I took my first forays into transgender healthcare research, and the world feels deeply precarious. Trans people have reached a point of visibility that would have been stunning to me ten years ago, and even moreso to Hirschfeld, Benjamin, and the others whose historical work formed the basis of my evidence for these papers. Hundreds of bills have been introduced into various legislatures seeking to further control, marginalize, and annihilate trans people, especially trans children. *Roe v. Wade* has just been overturned, creating a maelstrom of questions around the legal right to privacy and the related right to bodily autonomy. The cultural zeitgeist feels seismic, with daily quakes, tremors, and sometimes full shakedowns. The letter *is* relevant to the genealogy of this political moment, *is* one of the original overtures toward the legal constraint and control of trans bodies, and yet seems far more banal than a bill that mandates genital inspections for young children and teens.

How do we approach this history, or understand it, when it has such broad and devastating impacts on the present? Perhaps the question haunts many dissertations, but it is impossible to ignore when so many aspects of this research seem so deeply fraught. In many ways, the letter is a key that unlocks so much about the constructs meant to control trans lives. It opens up both the formal constraints of the medical and legal realms, and the mysterious, largely unexplored motivations of the cisgender people who choose to organize their lives around the control, constraint, and marginalization of trans people. And of course, perhaps most importantly, the letter reveals the brilliance, resilience, and ingenuity that trans people display again and again as we outwit those who seek this type of control.

The letter began in this way. A clever tool and turnabout, an illusion that placated the cisgender need to control our lives, our expression, our identities, our possibilities. I cannot guess to what extent Hirschfeld felt that he was in on the joke, but he did help create a system by which he, and others who believed that trans identity was a normal and natural human variation, could turn a key that unlocked a new right—the right to wear gender affirming clothing in public. As a modern reader of these now-historical documents, as I see Hirschfeld's theory of sexual intermediaries, I cannot help but read it as a refutation of the idea that cisness is *inherent* or *natural* in any sense. It may not fully comport with modern ideas of gender and sex, but even now to state that sex is not a binary or biologically fixed state can be seen as radical. Yet Hirschfeld used the language of Enlightenment ideals and the sciences of the day to say that everyone, everywhere, was a sexual intermediary. An in-between. A not-quite-this-or-that. This idea terrified the Third Reich just as it terrifies the cisgender heterosexual United States, so they sent their Aryan children to burn it all down. The gasping desperation of our own political machine has set its sights on the annihilation of gender liberation, and the shape of that campaign is beginning to be apparent.

I find great comfort in the knowledge that they will not succeed. We have always been here, and no one has ever been able to change that. We are clever and replete with the magic of the transitional, the space between and outside of it all, the strength of our bonds to one another. It still hurts to exist in this time and space, to be antagonized in this way, to be shaken to the

core, to feel the pressure to defend your very right to breathe the air of this world. It's just that it is not really anything new. We always survive, and in that way, we are always victorious.

As far as conclusions go, it is a challenge to write one for a topic that is ongoing in every way. The letter continues to be bandied about as a solution for cisgender anxiety about transgender regrets, though it doesn't do a very good job at these (or any other) purported functions. It is, at best, a formality for insurance coverage, and at worst, a wall used to keep trans people from accessing survival. But as an object of study, it is incredibly rich—bigger on the inside, one might say, holding portals to considerations of sex, gender, bodily autonomy, medical and legal authority, large-scale social control, histories of medicine, and of course, most of what is considered to be included in trans studies. The three articles included here are only the barest gesture at this richness, though I hope that they will inspire others to investigate the contours of the letter and all that it influences.

I have established in the first article that the letter is an interesting object of inquiry, worthy of investigation, and that it carries a strong influence in the legal and medical realms of trans life. The letter was (and is still) seen as the legitimation of the transgender person's identity (or performance of identity) by a presumably cisgender provider. The stated purpose of instantiating the letter into formal use in the standards of care was to avoid regret, and specifically, to avoid suicide resulting from post-surgical regret. Though it was well-documented that trans people who were denied care were at great risk of suicide and self-harm, that was not considered as important as Benjamin's unconfirmed suspicion that some small percentage of those who came to him had regrets. Additionally, the letter has continued to be included in every iteration of the standards of care, regardless of the fact that it has been strongly critiqued in multiple literatures and still has not been shown to serve any positive purpose in trans medicine.

To better understand why something so controversial and presumably useless would continue to be reiterated through the legal and medical realms, the second article explored the history of the letter—how it came to be and why, and its impact on the transvestite community in Germany during the Weimar period. This research revealed that the letter began its life as a pragmatic legal solution to the problem of transvestites and others who couldn't or didn't conform to gendered expectations “disturbing the peace.” Law enforcement needed some solution for the vexation of repeatedly arresting people who were not breaking any law, transvestites needed a way to dress in clothing that affirmed their identity without being harassed, and Hirschfeld was there to provide. There were a variety of consequences of this intervention, only some of which were sought or desired. Because the transvestite certificates were seen as a legitimation of one's law-abiding, patriotic nature in addition to their transvestite identity, it was used as part of the requirements for one to be considered a *true transvestite*, as opposed to the marginalized *also-transvestite*. True transvestites fell in line with dominant class, racial, and gender hierarchies, which were then carried across the Atlantic and eventually crystallized into the *good transsexual* via Dr. Harry Benjamin.

The final article in this project is an effort to expand the possibilities of transgender healthcare using arguments grounded in human rights, bioethics, and informed consent. My Gender Wellness Model not only provides a system that can be more responsive to the actual needs of trans people, but also expands past trans-specific medicine to create better medical practices for all bodies. While transgender medicine has come a long way since the mid-century,

our current models are built on an incomplete and inaccurate understanding of trans identity as a pathology. As all major medical bodies have released statements saying that transgender identity is not a pathology, it does not work well for anyone—trans or cis, provider or patient—to continue using the tools created for the pathologizing form of trans healthcare. In creating a new approach, I have sought to make a framework capacious enough for all bodies, for identity fluidity and exploration, for a more accurate understanding of gender identity, expression, and health.

These three articles gesture toward a deeper truth—that transgender people are a rich and beautiful part of the human tapestry, and that cisgender doctors, researchers, politicians, policy makers, psychologists, etc, have sold the whole world short by choosing to see us as a problem to be solved. We are not a problem, and while we carry profound solutions in our brains, blood, and marrow, they are not solutions to our existence, but rather to the human problem of being in a body in a time and place where every nuance of existence is questioned, policed, and controlled. The letter is ultimately an absurdity—an attempt to constrain and define what will continue to be baffling and threatening to those who cling to cisgender, heterosexual hegemony. I will continue, in concert with my community, to work toward the day when those who would constrain us fall away, toward the day when our magic is finally cleared to fill the void left by their fear.

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