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REGULATING HEALTHY GENDER: SURGICAL BODY MODIFICATION
AMONG TRANSGENDER AND CISGENDER CONSUMERS

by

ELROI J. WINDSOR

Under the Direction of Mindy Stomblor

ABSTRACT

Few bodies consistently portray natural or unaltered forms. Instead, humans inhabit bodies imbued with sociocultural meanings about what is attractive, appropriate, functional, and presentable. As such, embodiment is always gendered. The social, extra-corporeal body is a central locus for expressing gender. Surgical body modifications represent inherently gendered technologies of the body. But psychomedical institutions subject people who seek gender-crossing surgeries to increased surveillance, managing and regulating cross-gender embodiment as disorderly. Using mixed research methods, this research systematically compared transgender and cisgender (non-transgender) people's experiences before, during, and after surgical body modification. I conducted a content analysis of 445 threads on a message board for an online

cisgender surgery community, an analysis of 15 international protocols for transgender-specific surgeries, and 40 in-depth interviews with cisgender and transgender people who had surgery. The content analysis of the online community revealed similar themes among cisgender and transgender surgery users. However, detailed protocols existed only for transgender consumers of surgery. Interview findings showed that transgender and cisgender people reported similar presurgical feelings toward their bodies, similar cosmetic and psychological motivations for surgery, and similar benefits of surgery. For both cisgender and transgender people, surgery enhanced the inner self through improving the outer gendered body. Despite these similar embodied experiences, having a cisgender gender status determined respondents' abilities to pursue surgery autonomously and with institutional support. Ultimately, this research highlights inequalities that result from gender status and manifest in psychomedical institutions by identifying the psychosocial impacts of provider/consumer or doctor/patient interactions, relating gendered embodiment to regulatory systems of authority, and illuminating policy implications for clinical practice and legal classifications of sex and gender.

INDEX WORDS: Transgender, Cisgender, Surgical body modification, Cosmetic surgery, Sex reassignment surgery, Gender identity disorder, Body dysmorphic disorder, Gatekeeping, Gender binary

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by

ELROI J. WINDSOR

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2011

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by

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Georgia State University

May 2011

DEDICATION

This dissertation is dedicated to everyone who shared their stories with me. I hope this research aids in framing surgical body modification as an autonomous choice, a social justice issue, and an argument for increased access to quality and comprehensive healthcare.

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The completion of this dissertation benefited from the assistance of many different people. Although I take responsibility for the final product, I owe thanks to the kind individuals who helped me arrive here. To begin, I thank the people who participated in this project. Without your willingness to share your experiences with me, the project would not be possible. I am grateful for your honesty, openness, and time. You are the heart of this study.

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I am ever grateful for the excellent training I received while pursuing the doctoral degree at Georgia State. The opportunity to work with such a stellar group of sociologists has shaped my scholarship, teaching, and professionalism in immeasurable ways. I truly appreciate being

welcomed into and mentored by this talented intellectual community. I extend special thanks to committee member Erin Ruel for her important insights, especially regarding appeals to a mainstream audience. I thank committee member Wendy Simonds for her help and enthusiasm, and especially for pushing my feminist analysis in the conclusion. As my chair, advisor, mentor, and friend, Mindy Stompler provided invaluable suggestions and support in this project and all others that preceded it. I do not believe I can thank her enough for the ways she has inspired me to become a better writer and a more sophisticated thinker. Her keen critiques have undoubtedly made me a better scholar.

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INTRODUCTION

Your body is unnatural. I know you have altered your body in some way, or perhaps in many ways. You probably scrubbed plaque from your teeth today. You may have combed, brushed, or patted down the hair on your head. You are probably disguising the scent of your body through deodorant, lotion, cologne, or chewing gum. At the very least, you have covered your body in clothing, and you likely selected clothing that suits people of your gender. These choices are all body modifications.

Some body modifications have become so normative that they seem natural. They are taken for granted as appropriate behavior for people living in Western, postmodern societies. Other body modifications, however, appear deviant, painful, or totally unnatural. Although people who brush their teeth, wash their hair, and wear shoes are rarely – if ever – chastised for changing their “God-given” or “natural” bodies, people who change their bodies through piercings, tattooing, and plastic surgery encounter judgment for their choices.

In these ways, the body is a cultural form laden with meaning. It is a site of production on which individuals choose to convey personal preferences. It is a locus of self-control and social control: individuals try to control their own bodies, while other individuals and institutions induce bodies to conform to social norms and subject them to intense scrutiny. A sociology of the body, then, considers the self in society as an embodied self. “Embodiment – the physical and mental experience of existence – is the condition of possibility for our relating to other people and to the world” (Cregan 2006:3).

This dissertation analyzes the meanings and experiences of body modifications. Specifically, I have chosen to analyze both individual and institutional dimensions of surgical body modification. At the beginning of this project, I sought to explore how people experienced

– or embodied – surgically altered corporeal states. I also wanted to understand how and why some surgical body modifications required additional surveillance wherein an individual’s ability to give informed consent was insufficient for an operation to occur.

To introduce you to the project, I would like to offer five case scenarios. I interviewed each of these people for this dissertation research.

Jasper is in his early 30s and works in a professional public job. He had surgery on his torso because he “wanted to look better in a button-up” shirt. Although he never hated his body, he felt uncomfortable with it. He believed that surgery could make him more attractive, or “hotter,” as he said. At the time of his surgery, his mental state was stable. After surgery, he was “pretty satisfied” with the results, and explained how the surgery made him feel like he could more freely express himself. Overall, I read Jasper as exceptionally intelligent, easygoing, and reflexive. During our interview at his home, it became clear to me that his life was going well. He has a loving and supportive family and they live in a nice house.

Evelyn is one of the older people whom I interviewed. She grew up in a rural area. She retired after working for four decades in a blue-collar profession, but was looking for more work. After her four children had grown, she had several surgeries to improve her looks. She told me she had a breast augmentation so that she would be “more voluptuous” for her high school reunion. She said she was not dissatisfied with her breasts before surgery; she just wanted them to be bigger. She said her breast surgery strengthened her femininity, but she was already a “girly girl” before the surgery. She told me that all of her plastic surgeons “basically all fell in love” with her and want her to return to visit them. When she does, “they stop what they’re doing.” She believes they think she is a “really unique and charming person.” It is easy for me to understand this sentiment. I found Evelyn to be extraordinarily kind and warm. I enjoyed being around her and would love to run into her again in the future.

Ruth is a middle-aged professional. She is single, has no children, and lives alone with her dog and cat. She is a vivacious person with a sharp sense of humor. Ruth wanted a breast reduction because her breasts brought her unwanted attention. She hated her breasts; they made her feel “schlumpy.” Just two weeks before surgery, she woke in the middle of the night, panicked. She worried that her large breasts might be “the only thing that anybody was ever interested in” and that if she reduced her breasts to a size C she may “never date again.” At the time of her surgery, she was taking anti-depressants for low-grade dysthymic depression. After surgery, she felt elated. She described her breasts as “perfect” and “amazing.” In addition, she was able to get her health insurance company to pay for her surgery because she suffered from chronic migraines.

Luke is a middle-aged professional. He has no children and is currently dating someone. During our interview, he struck me as a thoughtful, likable, and confident person. Luke

worked out at the gym six days a week because he did not want to be “fat.” Although he described his mental health at the time of liposuction surgery as “good,” Luke felt traumatized from years of teasing he endured from his five brothers about his body. He chose to have liposuction without anesthesia so that, as the fat left his body, he could consciously release the emotional negativity associated with his body. The surgery helped his self-image because he no longer sees “a fat person” when he looks in the mirror. After surgery, he felt more comfortable in his body and in revealing his body to others.

Sophie is one of the younger people whom I interviewed. Before she got married and had a child, she had liposuction twice. She told me that the reason she had one of these surgeries was because she believed that her legs were “hideous.” She experienced her body as traumatic and felt “haunted” by it since she was a young child. During adolescence, she was hospitalized for anorexia, and was recovering from a recent bout with her eating disorder at the time of her leg surgery. Although surgery did not give her “the fix” she was hoping for, she was glad she did it. She plans to have more surgery on other parts of her body in the future. During our interview, I perceived Sophie to be intelligent and creative. She is conventionally attractive, but did not seem to perceive herself as such.

These vignettes offer a glimpse into individual experiences of surgical body modification. They illustrate a range of different reasons people had surgery. They show that surgery produced different outcomes for these individuals. Given these variances, how should access to surgery be regulated, if at all? Was surgery appropriate for all these people? Were some people’s desires for surgery more difficult to accept than others? Should all of these people have been allowed to get surgery? Do some warrant health insurance coverage more than others? Should any of them have been evaluated and approved for surgery by a mental health professional?

Psychomedical institutions have developed standards of care for surgery, but these guidelines only apply to one specific group of people. By virtue of being a member of that group, those individuals are typically unable to independently consent to surgery. They are usually required to get evaluated by a professional therapist who then may or may not submit an authorization letter for surgery. In the above vignettes, Jasper and Evelyn are members of this special group. According to the dominant standards of care, only Jasper and Evelyn should be asked to obtain external authorization for surgery. Ruth, Luke, and Sophie, however, do not need

a therapist to validate their desires for surgery. Why? Because Ruth, Luke, and Sophie are not transgender people. Their gender identities and expressions are normative. Herein lies a social problem. This disparate regulation of surgery is the crux of this dissertation.

* * * * *

Since the early 1990s, I have been involved in feminist and queer politics. I first became acquainted with transgender politics in the late 90s. During this time, I encountered radical transgender theory. I read Kate Bornstein and Riki Anne Wilchins, two eloquent and fierce trans women who inspired me to learn more about the policing of gender and to find ways to challenge it. These authors argued that the binary gender system was inherently oppressive. It constrained diverse expressions of humanity through the self and the body. Their arguments continue to frame persistent, vast inequalities that trans people endure to this day. According to a 2011 research report, “Injustice at Every Turn,” trans people face disproportionate rates of discrimination in the workplace, education, housing, healthcare, and public accommodations. They have high rates of family rejection, poverty, violence, and suicide. And when they try to seek help from the justice system, trans people often suffer abuse and harassment from law enforcement officers (Grant et al. 2011). Although we lacked solid research on these social problems in the 1990s, I witnessed some of these injustices in my own communities. I felt compelled to work for trans rights.

In 2000, I started working as a health educator at an HIV/AIDS nonprofit social services organization. My job duties included designing programs for the Brooklyn lesbian, gay, bisexual, queer and questioning community. I organized a support group for transgender people. In this

context, I learned about the politics that informed transgender healthcare. I heard horror stories about people being denied treatment in emergency rooms due to their transgender status. I met a homeless trans woman. She was kind, Black, and just over 60 years old. She changed into men's clothing nightly so she could access shelter, risking her physical and psychological safety every night as she slept in close quarters with men. Her income was low; she bought hormones on the street. I doubt she was able to inject hormones safely each and every time. She stopped attending group, and I wondered if she had been arrested, or worse. In the support group, I met another trans person so impoverished that she could not afford to seek medical attention for the grapefruit-sized growth on her neck. She was a young, white person who grew up as female but felt confused about her gender. She feared mistreatment from doctors, and felt paralyzed to research other options. She was not out as trans to her family. Another member of the group, a Black trans man from the Caribbean, was also not out as trans. He feared rejection from his family members who had expressed disdain for immoral American perverts, including transsexuals. Even though he was attending college and gainfully employed, his decision to start hormone therapy made him an outcast in his home community. These painful stories – and the resilience of the people who shared them – propelled my interest in graduate school. I wanted to research transgender healthcare inequalities after seeing firsthand the real-life consequences of gender policing.

For my master's degree, I studied the healthcare experiences of trans men. I learned about the problems they encountered with doctors and therapists. Some of the research participants reported stories like those I heard in the nonprofit sector. But most of their frustrations related to the ways healthcare institutions guarded access to medical transition. They complained that providers acted as gatekeepers. They lamented the ability to make autonomous decisions about

altering their bodies. I found that the pathologization of cross-gender behaviors and identities, through the labeling of “gender identity disorder,” informed psychomedical gatekeeping. Ultimately, societal interests in maintaining binary gender brought scrutiny to embodiments that challenged the gender order. Without strict adherence to binary gender, gender-crossing behaviors would be unremarkable and mundane. The binary gender system requires surveillance of medical modifications that have the power to change embodiment from one gendered category to another.

My research, in turn, fueled my passion for trans politics. To me, it seems rational that individuals should be able to provide informed consent for body modification procedures. Restrictive gatekeeping seems unjust. After all, non-transgender, or “cisgender,” women do not need a therapist to evaluate them before they begin post-menopause hormone therapy, nor do they need to pass as large-breasted women for any period of time before they can get breast augmentation surgery. And so I unequivocally supported my trans friends who wanted surgery. I congratulated their surgery accomplishments. I checked in on them with telephone calls and emails. After his chest surgery, I brought one friend a smoothie, tidied up his kitchen, and let his dogs outside. I felt proud of them for taking steps to live in the bodies they felt were right.

I did not feel this sense of pride for cisgender people who had cosmetic surgery. I thought they were somewhat vain. I could understand people who cited medical problems for their surgery. I accepted that they wanted to alleviate themselves of some kind of physical pain. But my feminist consciousness was strong. I cringed when I heard about people I knew getting breast implants, nose jobs, or face lifts. I did not view these surgeries as liberating or necessary in the same ways as trans people’s surgeries. I felt like cisgender people were buying into and perpetuating oppressive beauty standards.

Then I met someone who tested my politics. After several years of casual acquaintance, I started becoming close friends with a particular cisgender woman. We planned to meet, but I did not hear from her for weeks. Then she emailed me and revealed that she had just had liposuction surgery and was recovering from it in her mother's home. She wanted liposuction because she believed it would make her feel better in her body. She wrote that she did not know how I would respond, but she wanted to be honest with me since we were becoming better friends. I was surprised. I was familiar with her somewhat troubled mental health history, much of which was related to body image issues. This knowledge caused me to question whether surgery was a good decision. In my response, I chose my words carefully. I offered her cautious support and words of encouragement that were nowhere near the support I had given to trans people I knew less well. She appreciated my response; I thanked her for being open.

Through the years after this turning point, my cisgender friend and I have had many conversations about surgical body modification. She wants to get more surgery in the future. I told her I disapprove and think she should work on accepting her body and perhaps go to counseling to cope with her body image issues. She pointed out that I sounded like a hypocrite because I would never suggest that solution to a trans person. I explained I thought her surgery desires were different. Trans people need surgery to live in their desired genders, while she passed well as a cisgender woman. Her surgery desires stem from an unhealthy place. She argued, alternatively, that her desires for surgery were similar to those of trans people because she felt like she was in an alien body, and wanted to change it so she could feel more comfortable. Still, I could not totally accept this argument. I agreed that everyone has *the right* to have surgery, but I felt that perhaps not everyone should pursue surgery. Again and again, my friend and I debated these issues.

These conversations lingered in the background as I set out to design my dissertation research. As I mentioned already, I find it unfair that transgender people have to seek approval from a therapist before they get surgery when cisgender people do not. I am not the first person to draw this comparison. Others have theorized the unfairness of different regulations of similar services obtained by cisgender and transgender consumers. But I wondered how this theoretical critique would stand up to an empirical investigation. Consequently, I designed a study to systematically compare the experiences of transgender and cisgender consumers of surgical body modification surgery. This dissertation is the result of that research. In it, I analyze an online surgery community, surgery protocols, and interviews with 20 transgender and 20 cisgender people who had surgery.

As a feminist researcher, I desire to be transparent and reflexive in my approach. I have no personal stake in this study. I do not want to surgically modify my body, and the only surgery I ever had was to remove my embedded wisdom teeth. I do acknowledge, however, that if my body looked drastically different, I might pursue surgery. As politics are personal and the personal is political, these biases mark my research framework. To reduce bias, I designed almost identical interviews for cisgender and transgender people. This meant asking respondents some unusual and sometimes awkward questions (e.g., asking a cisgender man, “How would you describe your gender, or your gender identity?” or asking a transgender woman, “How has surgery enhanced your appearance?”). Although I hoped to do right by trans people in this research, those conversations with my surgery-seeking cisgender friend nagged at me. How was I going to reconcile what she called an ideological paradox?

Before I began this study, I expected to find that transgender and cisgender consumers of surgical body modifications would not have equal access to services. I thought that trans people

would encounter restrictive gatekeeping and that cisgender people would be able to get surgery by simply providing the funds and signing the forms. Due to the most widely used healthcare protocols, I expected that transgender people who wanted surgery would first need to obtain approval from a psychotherapist. I also thought that negotiating authorization letters in therapy could vary for people based on different circumstances like class, occupational prestige, and gender conformity. Indeed, some of the data in this study supported these early suppositions. But the research results surprised and intrigued me often. Although I thought cisgender and transgender people might be somewhat similar in terms of their motivations for and satisfaction with surgery, I had no idea how similar their presurgical and postsurgical embodied experiences would be.

The dissertation includes eight chapters. The first chapter provides a review of relevant literature and theoretical frameworks that guided the study. Chapter 2 details the methodology of the study. Chapter 3, “Learning Community Norms,” includes findings from two content analyses. In this chapter, I discuss norms conveyed through two media: an online surgery community and 15 published protocols for regulating surgeries among transgender people. In Chapter 4, “Enhancing the Self through Gendering the Body: Feelings toward the Body that Motivated Surgery,” I relay findings from 40 interviews with consumers of surgical body modification regarding their feelings about their bodies before surgery and their motivations for surgery. I demonstrate similar gendered cosmetic and psychological experiences that motivate surgery among transgender and cisgender respondents. I then detail how rewarding cosmetic and psychological outcomes of surgery intersected to produce enhanced gendered bodies for respondents in Chapter 5, “The Enhanced, Embodied, Gendered Self: Reciprocal Cosmetic and Psychological Effects of Surgery.” In Chapter 6, “Pursuing Surgical Enhancements: Cisgender

Thoroughness and Transgender Gatekeeping,” I relay the similarities and differences reported by cisgender and transgender respondents in their interactions with surgeons and show that cisgender people tended to view surgeons as thorough professionals and transgender people tended to view surgeons as powerful gatekeepers. In Chapter 7, “Becoming Certifiably Sick: How Transgender People Got Surgery and How Cisgender People Got Surgery Covered by Insurance,” I demonstrate how respondents’ therapy experiences and abilities to secure insurance coverage for surgeries reveal how healthcare institutions support physical healing over psychological healing. Finally, I conclude by discussing the theoretical and policy implications of my findings. I propose a new ideology to end gender oppression through envisioning a model of healthy gendered embodiment. This three-tiered model proposes reducing the stigma of gender nonconformity through depathologization, offering legal protection through self-determination for gender nonconforming people, and securing coverage for services that achieve ideal gendered embodiment.

In the end, this research contributes to sociological studies of gender, health, and the body. The research reveals individual and structural components of health disparities where one gender group is systematically privileged over another. It contributes to medical sociology by illuminating power imbalances and psychosocial factors in provider/patient interactions. The research expands on sociologies of the body by illuminating how surgical body modification similarly affects two gender groups who are thought to use surgery as means to achieve different ends. Although narratives about transsexual surgery often rely on tragic cultural tropes about being “trapped in wrong bodies,” this study revealed that trans motivations for surgery were sometimes more about cosmetic improvements. And while cisgender people reported similar cosmetic motivations, they were also equally likely to report feeling tormented by their

presurgical bodies. Finally, this study has implications for public sociology regarding policies informed by the WPATH Standards and the dynamics of clinical practice. Ultimately, this research highlights inequalities that result from gender status and manifest in psychomedical institutions, relating gendered embodiment to regulatory systems of authority, and illuminating policy implications for clinical practice and legal classifications of sex and gender.

CHAPTER 1 – LITERATURE REVIEW AND THEORETICAL FRAMEWORK

The postmodern body is unnatural. In Western societies marked by constant technological innovations, the body cannot escape extra-corporeal management. It is rare when embodiment does not regularly include mundane alterations such as dressing, shaving, and deodorizing. As gender always informs self-expression and social interactions, the body also reflects gendered characteristics. The ways people manage their bodies relate to the gender expressions they choose to convey. Gendered embodiment is as much an expression of self as an affirmation of identity through the eyes of others. Some means for achieving gendered embodiment have elicited more attention than others. Surgical body modification is one form of alteration that has garnered scrutiny.

As the body is a central site for doing gender, surgical body modifications are typically gendered. When people envision changing their bodies, their imagined ideal bodies are gendered bodies. The self-concept is a gendered self. Doing gender is unavoidable in expressing the self (West and Zimmerman 1987). Typically, the transformations that people seek through surgical procedures fit within normative gender expectations that reflect cultural ideals of femininity and masculinity. Critics can view surgical body modification, then, as another mundane way to conform to gender norms. But they do not. Instead, critics theorize surgical body modification as dangerous for many reasons. In addition, psychomedical regulations (or a lack thereof) of surgical body modification reflect sociocultural ideas about appropriately gendered bodies. The ability to autonomously change the body through surgery relies on cultural norms about appropriate gender identities and expressions. The disparate regulation of transgender and cisgender, or non-transgender, surgical body modification is the crux of the current study.

Scholars have asserted that transgender and cisgender groups seek surgery to realize their desired gendered bodies, but that their desires are differently and unfairly regulated. Theorists have critiqued the generous access to surgeries available to cisgender people compared to the restrictions transgender people face (Bornstein 1994; Feinberg 1996; Serano 2007; Spade 2006; Stryker 1997; Waszkiewicz 2006; Wilchins 1997). Although transgender people may get the same surgeries as cisgender consumers, only transgender consumers encounter restrictive regulations in their pursuits of modified gendered embodiment. This critique has been extended to suggest that sex reassignment surgeries might become less stigmatized and less regulated if they were viewed as “cosmetic” surgeries (Halberstam 1996, cited in Sullivan 2006). What has been empirically uncertain, however, is whether transgender people’s surgery experiences are actually comparable to those of cisgender people. If so, comparable empirical evidence might render disparate regulation unnecessary and discriminatory. Prior to the current study, research had not systematically compared cisgender and transgender consumers of surgery. It has been unclear how transgender and cisgender people compare in terms of their motivations for and satisfaction with surgical body modifications, as well as their interactions with healthcare professionals involved in procuring these services. The next section describes literature relevant to the practice of surgical body modifications, the pursuit of surgery by its consumers, and the theoretical frameworks used to interpret the phenomena under study.

Surgical Body Modifications: History, Prevalence, and Demographics

Plastic surgery is a relatively new phenomenon which has evolved throughout the past 100 years. The first plastic surgeries occurred in the late 19th century, when a few surgeons began to reconstruct more “attractive” noses, deemed so by surgeons and their patients. By the

close of the century, the first publications on rhinoplasty appeared in American texts and offered techniques to improve the surgery (Dolsky 1999). During World War I, plastic surgery emerged as an official medical profession. At this time, surgeons used technological advancements to repair facial injuries that soldiers sustained in battle. Formerly “disfigured” patients reported relief through reconstructive surgery, and their satisfaction propelled the discipline (Sarwer et al. 1998). These interventions launched the plastic surgery specialization in the United States.

Through the 1930s, plastic surgeons garnered increased attention and established professional organizations dedicated to their services. At this time, some surgeons emphasized their work as reconstructive healers of congenital “defects” and traumas, and shunned procedures with mere aesthetic aims. But during the first half of the 1900s, other surgeons introduced a variety of new cosmetic procedures, including eyelid reconstruction, chemical peels, hair restoration, and breast augmentation. Conflict between plastic surgeons who believed their practices aimed to heal and repair versus those who used the same techniques to improve otherwise healthy bodies marked the emergence of the field (Dolsky 1999).

This division continued through the 1960s when the reconstructive camp shifted to recognize the increased interests in practicing surgery of a more cosmetic nature. By the close of the 60s, some reconstructive and cosmetic surgeons acted upon their shared interests and disseminated knowledge between the fields. But discord between surgeons working with aesthetics and those dealing with functionality continued through the 70s. Then in the 1980s, official certifying boards dedicated to plastic surgery evolved. This increased professionalization, coupled with widespread public interest in the procedures, diminished professional distinctions between functional or aesthetic motivations for surgery. Surgeons who specialized in cosmetic procedures became more accepted as credible and legitimate professionals by their professional

peers and the general public. The end of this professional division enabled plastic surgeons to share information and broaden their technical skills (Dolsky 1999).

Although surgical body modifications include medical procedures that fall under the broad umbrella term “plastic surgery,” existing terminology reflects past distinctions based on the purpose of the surgery. The general term “plastic surgery” refers to procedures that mold or shape the body’s physical characteristics. These procedures highlight the body’s plasticity or malleability and include two types: reconstructive and cosmetic or aesthetic surgeries (PR-USA.net 2008). Procedures described as “reconstructive” surgery aim to repair congenital anomalies or traumatic injuries, whereas “cosmetic” surgery aims to improve presumably imperfect features or to evoke a more youthful or attractive look. Differentiating between reconstructive and cosmetic surgery, however, is not always definitive. Cosmetic surgery involves enhancing a body that is already considered “normal.” Reconstructive surgery generally involves improving the function of the body, but it may also transform an “abnormal” physical structure into something more aesthetically pleasing. For example, surgeries like rhinoplasty, breast reduction, and eyelid surgery may aim to repair the function of the body, but the surgery may also have cosmetic benefits. As Monstrey, De Cuypere, and Ettner (2007) argue:

[I]n the field of plastic surgery, there is no clear distinction between what is purely reconstructive and what is purely cosmetic. The medical indication for any plastic surgery procedure often depends on many factors, including economic, cultural, regional, religious, and even personal variables: e.g., reimbursement of surgical treatment for prominent ears, breast reduction, abdominoplasty, etc., and varies from country to country, decade to decade, insurance company to insurance company, and even amongst decision makers within the same company. Most often, plastic surgery is an admixture of reconstructive and cosmetic components. (P. 93)

Classifications of reconstructive or cosmetic rely on defining what counts as a “normal” body, which is a subjective judgment. The classification of surgical body modification is important

because health insurance typically covers surgeries with a reconstructive aim (American Society of Plastic Surgeons 2010; Carefair.com 2009).

In the United States, surgical body modifications have become more commonplace and accepted. According to the American Society for Aesthetic Plastic Surgery (ASAPS), almost 10 million cosmetic modification procedures occurred in the United States in 2009, costing nearly \$10.5 billion (ASAPS 2010a). These figures include surgical and nonsurgical procedures and represent a 147% increase since the organization first collected statistics in 1997 (ASAPS 2010b). Of the 10 million cosmetic procedures performed in the United States in 2009, over 1.4 million were surgical procedures, representing a 50% increase since 1997 (ASAPS 2010a). The most common surgical body modification is breast augmentation, followed by liposuction, eyelid surgery, rhinoplasty, and abdominoplasty. For women, the most common surgeries are breast augmentation, liposuction, eyelid surgery, abdominoplasty, and breast reduction. For men, the most popular surgery is liposuction, followed by rhinoplasty, eyelid surgery, breast reduction, and hair transplantation (ASAPS 2010b). No reliable data exist on rates of repeat surgeries, but Blum (2005) found that both patients and surgeons believed they were common. Based on national averages for physician and surgeon fees in 2009, the top three most expensive surgeries were lower body lifts (\$7,809), facelifts (\$6,881), and breast reductions (\$5,637). The least costly surgeries were lip augmentations (\$2,017), chin augmentations (\$2,269), and vaginal rejuvenations (\$2,689) (ASAPS 2010a).

Surgical body modification is popular across a wide range of people who can afford it. People get surgery across the life course, but those between 35 and 50 years old represent nearly half of all consumers. Racial and ethnic minorities obtained 22% of all procedures in 2009, most of whom were Hispanics (9%), followed by African Americans (6%), Asian Americans (4%),

and other minority racial groups (3%) (ASAPS 2010b). Thus, compared to the general population in the United States, non-Hispanic white people are overrepresented among surgery consumers. Surgery consumption also varies regionally. People living in warmer climates request surgery more often, and southern women seek larger breast augmentations (Blum 2005). The most obvious demographic factor in plastic surgery is the dramatic gender divide. Women are more interested than men in obtaining surgery (Frederick, Lever, and Peplau 2007), and they consume most cosmetic services more often. In 2009, women consumed 90% of all cosmetic procedures, which was a 3% decrease from the previous year. Although men consumed just over 9% of cosmetic procedures, this number increased 8% from the previous year (ASAPS 2010a). Data collection agencies do not routinely ask about patients' sexualities, but news media outlets claim that gay men make up the majority of men who get surgical body modification (Blanchard and Hope 2010; Schechter N.d.). Other research suggests that compared to heterosexual men, gay men report higher levels of dissatisfaction with their bodies (Morrison, Morrison, and Sager 2004; Peplau et al. 2009).

In addition to the growing popularity of surgical body modification, attitudes toward these procedures are becoming more accepting. A small majority of Americans support surgical body modification. In 2009, 59% of women and 51% of men approved of surgery. Compared to five years ago, these figures indicate that 22% of women and 17% of men now have more supportive attitudes toward surgery. Still, only 37% of women and 19% of men would consider having surgery themselves (ASAPS 2010a). Another study in 2007 showed that 23% of men reported interest in surgery, and 17% reported possible interest (Frederick et al. 2007). Overall, women are more contemplative and supportive of surgery. Although people who get surgery may be stigmatized as vain, shallow, or insecure, 73% of women and 66% of men reported that they

would not be embarrassed if people besides close friends and family knew they had surgery (ASAPS 2010a). In addition, televised docudramas about plastic surgery feature aesthetic surgeries more often than reconstructive surgeries, which popularize surgery for cosmetic purposes (Covino 2004). The commercialization of medicine, improved safety, and increasing media representations that depict cosmetic procedures as exciting, safe, smart, and healthy choices, facilitate this decreased stigma (Brooks 2004; Pruzinsky et al. 2006).

National statistics on plastic surgery do not specify how many men and women who consume surgery are transgender. Thus, reliable statistics of surgery among transgender consumers are more difficult to obtain, as are basic demographic characteristics of the transgender population in general. Estimates of the transsexual population vary widely. The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) reported that one in 30,000 people who were assigned male at birth and one in 100,000 people who were assigned female at birth will have sex reassignment surgery (SRS) in the United States (APA 1994). Other research suggests that these figures are grossly underestimated. Meta-analyses of previously reported prevalence data revealed that transsexuality – a term typically reserved for transgender people who pursue medical and surgical transitions – may occur in approximately one in 1000-2000 people, but another calculation suggested that at least one in 500 people is transsexual (Conway 2007; Olyslager and Conway 2007). These transsexual prevalence figures usually rely on some kind of surgery acquisition. Thus, transgender people likely represent a noticeable proportion of all cosmetic surgery procedures.

Regulating Surgical Body Modifications

Surgical body modifications involve professional guidelines that apply to all consumers of these services. Before conferring surgery, providers may screen prospective patients for certain physical or health factors (Gimlin 2000). Surgeons may ask patients to quit smoking, or they may refuse surgery if patients have a body mass index that is too high or low (Bikhchandani, Varma, and Henderson 2007). Other lifestyle factors that compromise patient safety may delay surgery. Surgeons may advise prospective patients to maintain a healthy diet, exercise regularly, stay well-rested, avoid stress, and decrease alcohol consumption and sun exposure (ASAPS 2008). These recommendations are not necessarily specific to surgical body modification; they reflect general health guidelines for patients undergoing invasive operations. They apply to both cisgender and transgender consumers.

Typically, surgical body modification requires surgeons to remove, reduce, reconstruct, or enlarge physiologically healthy tissues. Surgical alterations of “healthy” bodies provoke controversy. Some people want increased regulations to assess prospective patients’ psychosocial health before surgery. As professional and authoritative bodies, healthcare institutions can create additional regulations for obtaining surgical procedures. They can assess how a patient’s mental health potentially informs motivation for surgery and likelihood of postsurgical satisfaction. Historically, consumers of surgical body modification have faced different regulations based on their gender statuses as transgender or cisgender.

Although it is standard practice for surgeons to ask prospective patients about their motivations for and expectations of surgery, it is not standard to mandate psychological evaluations prior to surgery for cisgender patients. Despite some concerns about the mental wellbeing of surgery consumers, few psychomedical professionals have officially recommended

that prospective cisgender patients have their mental health evaluated before accessing surgery (Hodgkinson 2005). But research on the relationship between body dysmorphic disorder and surgery interventions challenges existing loose protocols. The following section reviews the motivations for surgery among cisgender consumers.

Cisgender motivations for surgery. When considering the regulation of surgical body modification, it is important to assess motivations for surgery. But motivations for surgery represent an under-researched area (Sarwer 2006). Cisgender people may get surgery to enhance their physical appearances and improve their body image (Sarwer et al. 1998). Men and women who get surgery appear more interested in health and fitness than those who do not. They may get surgery as part of other self-care, viewing surgery as similar to diet and exercise regimens (Pertschuk et al. 1998).

Existing literature on motivations for surgery focuses overwhelmingly on cisgender women consumers, which reflects the gender imbalance of surgery consumers. Women spend a lot of time carefully considering the risks and costs of surgical procedures. They report that they do not feel coerced into getting surgery (Gimlin 2000). Rather, they get surgery to look “normal,” expand their social opportunities, and because they want to treat themselves to something they feel they deserve (Gagné and McGaughey 2002). They report that they get surgery to remedy flaws that occurred due to factors out of their control, not because they lacked the effort to change them through other means. They get surgery to present appearances that embody their self-images, which are gendered projects that reflect differences across age, class, race and ethnicity (Gimlin 2000). Body image issues and the normalization of surgery are strong predictors for surgery among women (von Soest et al. 2006).

Research on cisgender men who consume surgical body modification is more limited. Existing research suggests that numerous similarities exist between cisgender men and women consumers of surgical body modification in terms of motivations, expectations, and satisfaction (Dowling, Honigman, and Jackson 2010; Pertschuk et al. 1998). Like women, men who get surgery are similarly dissatisfied with a problem body part. But men who get surgery tend to be less invested in physical appearance. Instead, men who get surgery are more interested in physical fitness (Pertschuk et al. 1998). Some research has shown that men who get surgery are similarly concerned about their physical appearances compared to men who do not get surgery. But men who report lower self-confidence are more likely to consider surgery (Ricciardelli and Clow 2009).

Research on cisgender people's motivations for surgery reveals similarities to the "inner self" narratives often expressed by transgender consumers. Cisgender women may seek surgery to obtain the embodied identities of their younger selves, whom they see as losing through the aging process. They may view their unaltered bodies as reflecting false selfhoods or character traits that conceal their true identities. In addition, some women may get surgery to resemble celebrities. An extreme example is polysurgical consumer Cindy Jackson, who had multiple surgeries to appropriate the look of the doll Barbie. At least six women have followed Jackson by attempting to clone her image. These women asserted that they felt they looked like Jackson and wanted to reconcile their internal feelings with their external appearances (Blum 2005). Surgical body modification for cisgender women, then, can be conceived as "not an act of deception, but an effort to align body with self" (Gimlin 2000:89). The similarities of these narratives of aligning the body with an internal sense of self begs further exploration, as

cisgender and transgender populations have not been systematically compared prior to the current study.

Transgender motivations for surgery. Unlike research on cisgender consumers' motivations, much research has been done to understand transgender people's desires for medical and surgical transition. Most professionals who work with transgender populations recognize that the primary motivation for medical transition is a desire to align the physical body with one's internal sense of gender (King 1993). Transgender people typically pursue surgical body modification to align their bodies with their self-images. Like cisgender surgeries, surgeries among transgender people "make the external, visible body conform to the patient's idea of him/herself – an image of the psychological self externalized on the body's tissue" (Hausman 1995:50).

The ability to "pass" as a woman is often desired among transgender women. Transgender women sometimes want genital surgery due to extreme dissatisfaction with having male genitalia (Schrock, Reid, and Boyd 2005). Transgender men often state that they want surgery to correct or repair their bodies. They anticipate that surgeries will ease their abilities to access social spaces where bodies are more visible (Rubin 2003). Although it is possible that transgender motivations for specific surgeries – such as liposuction and facelifts – are similar to those of cisgender people, no research has studied these comparisons before the current study.

Mental health issues among cisgender consumers. The psychological characteristics of cisgender people who seek and get surgical body modification are important to consider in examining access to surgery. Professionals who want to assess the mental health of prospective surgery patients may argue for increased regulation using research to justify their arguments. Although some clinical research has found psychopathology in prospective patients, studies

using standardized measures have found less psychopathology (Sarwer et al. 1998). Overall, existing research on the mental health of cisgender surgery consumers varies.

Much of the research on the mental health of cisgender surgery consumers relates to body image issues. On a basic level, the pursuit of surgery is informed by an individual's concerns about physical appearance, or body image. Body image is an important factor in one's overall mental wellbeing and self-esteem. But body image is a complicated characteristic informed by multiple factors. Body image can be affected by perceptual inaccuracies, such as viewing a body part as a seriously distorted feature that is not recognized by others as an objective reality. Life experiences, such as high school locker room teasing, may also affect body image. Sociocultural influences like media representations and the popularization of surgery also affect the relationship between body image and surgery. If a person is dissatisfied with some part of his or her body, and this dissatisfaction causes distress and poor self-image, then surgery may be desirable. Body image also varies in degree and level of importance (Sarwer et al. 1998). It is possible to have a poor body image that is a low priority in one's overall happiness. It may not affect self-confidence enough to pursue surgery. Although body image relates to surgical body modification, the strength of this relationship is not easily interpreted. In one study on body image, people who reported interest in surgery did not have poorer body images compared to those who were uninterested (Frederick et al. 2007). Thus, these two populations may be somewhat similar in terms of general body image. But professionals concerned with psychopathology of surgery patients underscore the importance of considering a prospective patient's mental health issues, including body image. These advocates cite ethical concerns in treating possible mental health issues with surgical interventions.

Concern about the mental health of cisgender consumers of surgical body modification is not new. In the 1940s, clinical literature started reporting psychiatric evaluations of people seeking surgery. Surgeons were interested in identifying patients whose psychological concerns would not be improved through surgery and who might even have adverse emotional reactions after surgery. Doctors often thought their patients had psychological impairments, especially when these patients sought multiple procedures or were men. But doctors typically did not withhold surgery, as patients typically regarded the results of these procedures positively (Sarwer et al. 1998).

To date, psychiatric evaluations of surgery patients have revealed trends in psychological disturbance among certain surgery consumers. Some surgeons and mental health providers contend that men who consume surgical body modification have psychological problems (Goin and Goin 1981; Nakamura, Mulliken, and Belfer 2000), including diagnoses of psychosis, neurosis, and personality disorder (Jacobson et al. 1960). One study found that almost 48% of 415 surgery consumers in Japan had an diagnosable mental disorder listed in the *International Classification of Diseases* (ICD) (Ishigooka et al. 1998). Cross-cultural evidence suggests that Japanese men seeking surgery have also been diagnosed with psychological problems, including poor social adjustment, depression, anxiety, neurosis, body dysmorphic disorder, personality disorder, delusional thought disorder, schizophrenia, and psychosis. American and Japanese men who seek surgery appear to have more psychological problems than women consumers (Nakamura et al. 2000). Thus, some professionals believe men are in greater need of psychological services (Pertschuk et al. 1998). These differences, however, may stem from greater social acceptance of women's beauty pursuits. Men who seek beauty may experience social stigma for doing so (Nakamura et al. 2000).

Much research on the mental health of cisgender surgery consumers focuses on the psychological diagnosis of body dysmorphic disorder (BDD). Psychomedical literature has discussed dysmorphophobia for about 100 years (Hodgkinson 2005). In 1987, body dysmorphic disorder first appeared as a diagnostic nomenclature in the DSM-III-R (Sarwer et al. 1998). Currently, BDD represents the only diagnosis that addresses concerns related to body image. Clinicians describe BDD as “a preoccupation with a defect in appearance that is either imagined or slight, and leads to significant distress or impairment in social, occupational, or other areas of functioning” (Pertschuk et al. 1998:20), but its cause is unknown. Clinical discussions of BDD often compare it to the anxiety disorder of obsessive-compulsivity. Clinicians argue that people with BDD fixate on aspects of their physical appearance, which may negatively impact their interpersonal lives. They contend that people with BDD may try to conceal their appearance with excessive makeup or oversized clothing (Hodgkinson 2005). Psychomedical professionals consider BDD a serious disorder that is often accompanied by other mental health issues, such as depression and suicidal behavior (Hodgkinson 2005; Rief et al. 2006).

Although psychomedical professionals generally agree on the existence of BDD, accurate information on its prevalence is still unclear. Some studies have suggested that BDD has a 2% prevalence rate and is increasing (Hodgkinson 2005). A national and representative sample in Germany found a slightly lower BDD prevalence rate of 1.7% (Rief et al. 2006). Many clinicians also believe that BDD affects men and women about equally, but some research has found higher BDD rates among women than men (Aouizerate et al. 2003). Compared to men, women have reported more body dissatisfaction in general and more dissatisfaction concerning the “problem” body parts (Rief et al. 2006).

Despite uncertain prevalence rates, the evolution of body dysmorphic disorder as a psychological diagnosis has raised concerns and challenges for surgeons who seek to satisfy their customers with exclusively physical alterations (Pertschuk et al. 1998). People with BDD may make up between 6-15% of all surgery consumers (Ishigooka et al. 1998; Phillips et al. 2000). These people may seek surgery to remedy a perceived bodily defect to which they direct extreme critique and disgust. But according to clinicians, people with BDD are typically not satisfied with surgery (Hodgkinson 2005). A 30-person study of men and women diagnosed with BDD found that medical interventions were usually ineffective in treating the disorder, and that surgery exacerbated symptoms (Phillips et al. 1993). Another study of men who had surgery found that while few men met the criteria for BDD, many expressed body image concerns that were similar to men who sought therapy for help in dealing with their body image. These results question the helpfulness of surgery for men who do not quite meet BDD criteria but still have serious body image issues (Pertschuk et al. 1998). In contrast, a study with people who sought surgery on body parts with no or minimal problem, where roughly half of these people met the criteria for a BDD diagnosis, found that most of the people with and without a BDD diagnosis had surgery, and most reported high postsurgical satisfaction. Several people in the non-BDD group later met the criteria for BDD during follow-up interviews, and one person in the BDD group did not fit the criteria later (Tignol et al. 2007). Although the findings illustrate the ways BDD diagnoses can shift among people with no discernible or major problem on their bodies, the authors of this study believed their results justified increased vigilance from surgeons.

Due to this research, some psychological clinicians advise surgeons to be aware of BDD and treat suspected patients with caution. They instruct surgeons to watch for patients who seem to exaggerate minimal variations and wear “doll-like” makeup (Hodgkinson 2005:504). They

inform surgeons to note when patients have had previous surgeries that they feel are unsatisfactory, or believe that surgery will greatly improve their interpersonal relationships. They caution surgeons that people with BDD may believe surgery has not met their great expectations, and they may return to the surgeon dissatisfied and upset. These clinicians warn that people with BDD may request more surgery, a refund of services, or may become hostile and threaten the surgeon. Thus, some providers recommend that surgeons who suspect BDD should avoid surgery and instead refer patients to mental health professionals (Hodgkinson 2005). Other researchers have called for integrating the services of surgeons and therapists in procuring surgeries (e.g., Nakamura et al. 2000). With half of surgical body modification patients taking psychotropic drugs and over a quarter using antidepressants, some argue that psychological testing may be desirable during surgery consultations (Hodgkinson 2005). To reduce distress, some surgeons have prescribed beta-blockers to patients to reduce postsurgical dissatisfaction (Gruber et al. 2009), since negative outcomes can trigger psychiatric problems (Castle, Honigman, and Phillips 2002).

Despite mental health components of surgery, many surgeons do not collaborate with psychotherapists. Surgeons express concern that therapists lack experience handling prospective surgery clients in terms of evaluating body image disorders (Nakamura et al. 2000). Most health professionals do not recommend psychiatric evaluations for all cisgender surgery consumers. Instead, they recommend that surgeons have adequate training to identify patients who will experience postsurgical dissatisfactions that outweigh the psychological benefits of surgery (Goldwyn 2006; Meningaud et al. 2003; Pruzinsky et al. 2006). Some argue that existing mental disorder should not preclude people from getting surgery at all. They suggest that surgeons

assess prospective consumers' mental health status and history on a case by case basis (Castle et al. 2002).

Surgeons' resistance to systematic psychiatric evaluations frames current protocols. At present, psychomedical institutions have no regulations that require cisgender people to get approval from mental health professionals before surgery. Some surgeons may find presurgical mental health evaluations ideal, but most likely view this effort as impractical (Goldwyn 2006). Instead, individual surgeons rely on their own professional judgments about the appropriateness of surgery. In a news story about teens and surgical body modification, one surgeon described how she determined whether teens were mature enough to consent to surgery. She said she asked young prospective patients: "What's involved with wanting that change? What's their expectation from the procedure? How do they want that body part to look?" (Park 2010). This surgeon said that she may decline treatment for young patients whom she felt were unprepared for surgery. Instead, she would recommend a mental health evaluation for body dysmorphic disorder (Park 2010). A text on psychological issues in cosmetic surgery identifies six problematic patient types that may give surgeons pause. These patient types include people such as "the VIP patient" who is well-known in the community and may feel entitled to service, "the perfectionist patient" who has unrealistic or unsatisfiable expectations, and "the patient thought to be in need of psychiatric care" (Goldwyn 2006:14-17). But the absence of specific, standard mental health protocols for cisgender surgery consumers illustrates how doctors assess these prospective patients as individuals. The absence of specific protocols also demonstrates that psychomedical institutions generally recognize cisgender people as autonomous consumers who are able to provide informed consent before surgically modifying their bodies.

The debate over regulating cisgender surgeries, however, typically neglects to include the perspectives of surgery consumers. Little research has considered how cisgender consumers of surgery might react to increased regulation. Providers do not know how they might appreciate psychological evaluations prior to surgery. Although many consumers who are diagnosed with BDD welcome such treatment, others resist psychotherapy (Phillips 2000). Indeed, the process of classifying human conditions as mental disorders is a subjective social process often fraught with political tension. Defining the parameters of mental “disorder” is a socially constructed reality that differs across cultures and throughout history. Even demonstrating reliability of diagnosing remains challenging for psychotherapists who use the same diagnostic criteria set forth in the DSM (Spiegel 2005). Overall, the lack of information regarding cisgender consumers’ thoughts on increased regulation contrasts with the vast amount of advice for consumers about surgery. The American Society for Aesthetic Plastic Surgery offers guidelines for choosing a quality surgeon (ASAPS 2009). Consumers can also find extensive information and advice through websites like www.yourplasticsurgeryguide.com (Consumer Guide to Plastic Surgery 2010). Thus, much information exists to prepare cisgender surgery consumers so that they are informed about best practices.

Overall, cisgender people who want surgical body modification typically do not encounter systematic barriers to surgery. Clinical debates about their psychological states before and after surgery have not yet led to increased regulation or mandated psychiatric evaluations. Although some cisgender consumers of surgery experience distress before and after surgery, these disturbances have not been common or alarming enough to warrant significantly revised surgery practices.

Mental health issues among transgender consumers. In contrast to cisgender surgery patients, transgender people encounter specific regulations in accessing surgical body modification. Due to the ways their desires for differently gendered bodies remain pathologized in psychomedical institutions, transgender people who seek surgery to express their gender identities must obtain approval from mental health professionals. This regulation stems from a long tradition of pathologization that transgender people have endured since they were allowed the opportunity to pursue medical transition (King 1993).

Access to cross-gender medical transition has always been informed by pathological classifications of transsexuality. While scholars have documented great gender diversity throughout history and across cultures (Feinberg 1996), transsexual bodily pursuits remain stigmatized in Western societies. Psychomedical clinicians have spent the past several decades constructing the diagnostic boundaries of transsexuality and treatment protocols for medical transition, consequently securing their roles as authoritative gatekeepers (King 1993; Shapiro 1991; Stone 1991). As clinicians refined psychiatric diagnostic criteria to justify surgical procedures through the 1960s and 70s, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) issued the first edition of *The Standards of Care for Gender Identity Disorders* in 1979 (Meyer et al. 2001), hereafter referred to as the WPATH Standards.¹ These standards evolved to become the official professional guidelines used by providers treating transsexuals. The 22-page booklet outlines ways for providers to assess clients' eligibility and readiness for hormones and surgeries, and recommends psychotherapy prior to medical and surgical interventions.

¹ Although the most recent standards of care are issued under the HBIGDA name, this organization changed its name in 2006 to the World Professional Association for Transgender Health (WPATH).

The WPATH Standards acknowledge that cross-cultural gender expressions may produce varying social, behavioral, and spiritual interpretations, but the standards rely on pathologizing gender nonconformity. The WPATH Standards are based on the existence of gender identity disorder (GID), an officially recognized diagnosis in the DSM (Meyer et al. 2001). The GID diagnosis is used to indicate transsexuality and signify eligibility for medical transition (Lev 2004). The WPATH Standards outline detailed treatment trajectories for people who want to modify their bodies with hormones or surgeries in cross-gender ways. They state that prior to starting hormones or having surgery, transgender people should first meet with a therapist. Herein, therapists should evaluate clients and authorize medical transition by labeling transsexuals with GID. Therapists should then write a formal letter that includes this diagnosis and states the client's eligibility for medical transition. The WPATH Standards recommend that surgeons ensure they receive these letters before counseling prospective patients about the physical and social risks and benefits of the procedures (Meyer et al. 2001).

Without the underlying GID diagnosis, the WPATH recommendations would lack foundation. Many advocates for transgender self-determination resist the classification of gender nonconformity as mental illness. They argue for removing GID from the DSM (Lobel 1996; National Coalition for LGBT Health 2004; Weiss 2004; Wilchins 1996; Wilchins 1997). Trans activist Riki Wilchins (1997) uses the analogy of "Rhino-Identity Disorder" to discuss the gatekeeping of surgeries among trans people in comparison to the lack of restrictions for people who want to change the shape of their noses through rhinoplasty. In addition, some trans people view psychotherapists as gatekeepers who decide their eligibility for medical transition (Bockting et al. 2004). Consequently, interactions between transgender people and their doctors

have been strained (Meyerowitz 2002). Thus, the classification of cross-gender identities and expressions as pathological remains a contentious issue.

Despite the widespread use of the WPATH Standards, the process of regulating medical transition is under-researched. Aside from anecdotal evidence, limited statistical data (e.g., Denny and Roberts 1997), and clinicians surveying their own clients (e.g., Bockting et al. 2004; Rachlin 2001), researchers do not know much about gatekeeping within psychomedical institutions and how gender and sexual stereotypes may influence gatekeeping practices. Although WPATH publishes ethical guidelines that caution against prescribing treatment based on gender stereotypes (WPATH 2005), GID classifications still employ stereotypical notions of gendered behavior, stemming from a medical model based on binary gender essentialism (Wilson 1998). Trans people do not present uniform gender and sexual expressions (Bolin 1988; Raj 2002), but psychomedical professionals may expect them to undergo stereotyped gender coaching with therapists (Shapiro 1991) or conceal atypical gender expressions (Monro 2000). Historically, transsexual women have reported that men therapists impose harsher views of femininity on them than women (Bolin 1988). Physicians may pressure trans women to defend their choices to determine whether they are really transsexual (Billings and Urban 1982), or base trans women's readiness for surgery on judgments about their physical attractiveness (Kessler and McKenna 1978). Other research suggests that transsexual men strategically present more heterosexual, masculine expressions to secure services (Windsor 2011). This research suggests that the gender presentations of trans people may affect their abilities to access medical transition. In addition, Lawrence (2003) found that in a study of 232 trans women, 22% reported being able to get SRS without meeting at least one eligibility criterion of the WPATH Standards, which illustrates their inconsistent use in practice. Furthermore, adherence to the WPATH

Standards did not relate to satisfaction with surgery (Lawrence 2003). This research challenges the practical application of the WPATH Standards.

Surgery satisfaction among cisgender consumers. In response to calls for increased regulation of cisgender surgery, surgeons often cite research on the positive mental health effects of surgery (Sarwer et al. 1998). Emphasizing the psychological benefits of surgery has a long history in justifying the practice (Hausman 1995). Although the desire for surgical body modification has been identified as a psychological drive, research on cisgender satisfaction focuses more on the technical results of surgery than on psychosocial function (Meningaud et al. 2003). Consumers of surgery perceive interventions to be successful when they leave their bodies looking “natural,” effortless, and unaltered (Hurd Clarke and Griffin 2007). Few researchers have conducted methodologically robust studies on psychosocial components of surgery using control groups (Castle et al. 2002). But existing research shows that surgery aids consumers’ mental health and quality of life (Rankin et al. 1998), where many presurgical psychosocial problems were successfully alleviated through surgery (Klassen et al. 1996). For example, women who had abdominoplasty reported improved body image. Although their general psychosocial functioning did not change, these women experienced postsurgical satisfaction with appearance and confidence in exposing their bodies during sex (Bolton et al. 2003). Other women reported that, after surgery, they could wear revealing clothing and felt more outgoing (Gimlin 2000). In general, satisfaction relates to feeling that surgery improved appearance and body image. Satisfied patients report that they would get surgery again and would recommend surgery to others (Sarwer et al. 2005).

Dissatisfaction with surgery among cisgender consumers relates to psychosocial issues. Despite sharing preoperative psychosocial status with women, men reported more postoperative

dissatisfaction (Dowling et al. 2010). Negative surgery outcomes may be associated with getting procedures that are more “type-changing” (e.g., rhinoplasty, breast augmentation) than “restorative” (e.g., facelift, liposuction) (Veale 2006). In addition, dissatisfaction can occur when people envision surgery as having the potential to change their lives in major ways (Hodgkinson 2005).

Surgery satisfaction among transgender consumers. Excessive gatekeeping of surgery for trans people may impede their psychosocial wellbeing. Research indicates that transsexuals are more satisfied with their bodies after they have gotten surgeries. Compared to a group of postoperative transsexuals, a group of preoperative transsexuals reported feeling less secure, less confident, and more unattractive (Kraemer et al. 2008). One meta-analysis measuring transsexuals’ satisfaction following surgical reconstructions, based on more than 80 case studies conducted over 30 years in multiple countries, found that postsurgical satisfaction was high. Following surgery, most transsexuals reported less suffering, increased satisfaction, and positive experiences with sexual partnering, mental stability, and socio-economic functioning. Trans men reported slightly more general satisfaction than trans women (Pfäfflin and Junge 1998). These findings suggest that transgender people generally benefit from surgical interventions.

In contrast to research measuring the technical and physical success of surgeries among both transgender and cisgender consumers, research on psychosocial issues related to surgery tends to focus on procedures obtained by transgender consumers. Specifically, clinicians seem most concerned with transgender respondents who regret having surgery. In a study of 232 trans women who had SRS between 1994 and 2000 with one U.S. surgeon, most were extremely satisfied with the results. Among them, 96% reported feeling happy overall with the surgery, and 97% reported an improved quality of life. No trans women in the study reported persistent regret

over having SRS. Those who reported occasional regret represented 6% of the sample. These respondents attributed regretful feelings to unsatisfactory functional and physical outcomes of the surgery or to social problems such as familial rejection (Lawrence 2003). Another study of 218 trans people who had SRS in Sweden between 1972 and 1992 found that the 3.8% patients who expressed regret tended to lack familial support (Landen et al. 1998). Studies on trans people's surgery regret tend to focus on results of SRS. These trans people do not represent members of the trans community who get an array of gender-affirming surgeries or who transition without surgical aids. One study that included transgender people who had different types of gender-affirming surgeries found that most reported surgery satisfaction, positive social functioning, and a satisfying sex life (Smith et al. 2005). A meta-analysis of 2,000 people who had surgery found that gender-affirming treatments were effective and produced desirable results. Patients experienced decreased suffering and increased satisfaction, including in terms of sexual partnering and psychosocial functioning. Regret and suicide after gender reassignment were rare. Less than 1% of trans men and 1-1.5% of trans women experienced persistent regret (Pfäfflin and Junge 1998). Since 1991, subsequent studies have found even lower rates of regret (Bowman and Goldberg 2006).

Research regarding disparate regulation of cisgender and transgender surgeries reflects ideologies about gender and the conditions in which gender boundaries can be crossed. The next section outlines the theoretical frameworks that guided the current study.

Theoretical Frameworks on Surgical Body Modification

“Cosmetic, or aesthetic, surgery represents a universal human desire to maintain or restore normal appearance or to enhance it toward an aesthetic ideal” (Dolsky 1999:886). This

statement, offered by a plastic surgeon, speaks volumes about the motivations and goals in accessing surgical body modification. He assumes that the pursuit of normative beauty motivates every living person. He also assumes that surgery is a natural means to normative beauty, and that what is “normal” is an attractive appearance. Surgeons certainly aim to normalize the procedures they sell to consumers. The surgery industry promotes ideas that everyone is in need of beautification, and that surgery may aid individuals’ natural desire to look better while also aiding society in producing admirable bodies (Covino 2004). Other scholars, however, offer different theoretical perspectives to explain and understand the pursuit of surgically altered ideals.

Unlike non-medical body modifications like shaving or wearing makeup, critics view surgery as markedly different. They view surgeries as risky and extreme alterations that oppressively invade the body to satisfy superficial beauty ideals. General critiques of medical body modification relate to issues of safety and health. Surgical procedures can be dangerous and painful. Consumers risk serious complications, ranging from bruising and numbness to fibrous encapsulation and even death. For these reasons, surgical body modification is harder to defend than other forms of less invasive body work (Gimlin 2000). Feminist critics of surgery echo these concerns and offer theoretical frameworks to understand the desire to surgically modify the body.

Feminist theories on surgical body modification. Body projects that rely on surgical alterations have been the source of much theoretical debate. Feminists have theorized diverse meanings of surgical body modification for women. Their perspectives fall into two primary camps: one that suggests false consciousness and another that emphasizes agency. Feminists who view surgery practices as manifestations of false consciousness argue that women obtain surgery

to alter their bodies within restrictive patriarchal standards of femininity, conforming to ageist conceptions of beauty (Morgan 1991). Body projects of women, then, are not equal to those of men, as feminine disciplinary practices are part of gender subordination (Bartky 1997). This feminist framework argues that “cosmetic surgery also produces a fundamental story of sameness versus difference, a story of encroaching aesthetic conformity” (Brooks 2004:225). Surgery is then informed by familiar power relations (Brush 1998). Alternately, feminists may view surgery practices as emphasizing agency and free will. This framework suggests that women pursue modifications to gain power in their relationships with men. Women are not simply fooled by oppression, but actively choose and defend their decisions to change their bodies. Within this framework, surgery might even be considered courageous, as women take risks to enhance their quality of life (Davis 1991).

A third feminist perspective synthesizes elements of the previous two, and draws on Foucauldian understandings of power relations where surgical body modification is a choice influenced by external social pressures (Gagné and McGaughey 2002). This perspective recognizes that women may get surgery within an oppressive context, but that they also may exert agency within it. These feminists would argue that women may choose to get surgery, but the surgery reflects hegemonic beauty standards. As such, these women cannot truly align their altered bodies with their self-images because they can never perfectly achieve that idealized version of themselves as younger, more attractive women (Gimlin 2000). In addition, the body is not only a text of culture, but also a “direct locus of social control” in need of management and self-modification (Bordo 1997:91). Overall, feminist critiques of surgical body modification typically focus on “cosmetic” interventions, not “reconstructive” surgeries. Such frameworks imply that some forms of embodiment are appropriate for intervention while others are undeserving of surgical alterations (Talley 2008).

Feminist theory has also contributed to understanding surgery among transsexuals as distinct from the “cosmetic” surgery pursued by cisgender women. In the late 1970s, feminist theorists problematized transsexuality and critiqued surgeons for medically changing gender and sexuality to further oppress women (Bolin 1988; Ekins 1997). For example, Raymond (1979) argued that by pursuing medical transition, transsexuals objectified the female form and thereby raped women’s bodies. These feminist arguments sparked controversy and discussion, but lacked sufficient empirical basis for understanding the medicalization of transsexuality. Marxist sociologists Billings and Urban (1982) expanded on feminist critiques of transsexuality, arguing that transsexuals represented a socially constructed reality enabled and created only by psychomedical institutions. They criticized medicine for praising surgically constructed genitals as luxurious commodities for “sexual deviants” and “victims of aberrant gender-role conditioning” (Billings and Urban 1982:107). They questioned transsexuals’ reports of surgical satisfaction, arguing that the permanence of genital surgery demanded that patients invent new ways to deal with their irreversible decisions. While Billings and Urban (1982) argue that the medical discourse of transsexuality supports conventional gender systems, they fault transsexuals for accepting bodily mutilation over resisting gender stereotypes.

Transsexuals countered these perspectives by discussing their decisions to pursue differently gendered bodies as autonomous choices. They challenged the privileging of cisgender experiences in analyses and theories of gender. As one prominent transsexual man explained:

When we focus on the proposition that dichotomous gender is the bellwether of social privilege, and when we view transsexual people as social constructions of social constructions in an attempt to understand how gender conventions are learned or manipulated, we actually deny the incredible potential of gender variance and its natural diversity, and we categorically deny both transindividuals and non-transindividuals agency in experiencing or freely expressing their own genders. (Green 2005:294-5)

Other feminist and justice-oriented trans people have asserted agency in pursuing medical transition (e.g., Bornstein 1994; Feinberg 1996; Serano 2007; Spade 2006; Stryker 1997; Waszkiewicz 2006; Wilchins 1997). They argue that it is unfair to demand that transgender subjectivity deconstruct binary gender any more than cisgender subjectivity. They argue that doing so affords cisgender people the privilege to assume stable gender statuses without critical attention (Spade 2006). But both trans and cis surgical body modifications destabilize social status “because the subjects cross what is normally considered an impenetrable class boundary: from unattractive to beautiful, from fat to thin, and in the case of transsexuals, from male to female, or from female to male” (Serano 2007:57). In addition, the pathologization of gender diversity frequently focuses on male-to-female/feminine transgressions, while female-assigned people enjoy more liberty in expressing masculinity (Serano 2007). Although trans people question distinctions between transgender and cisgender gendered embodiment, they also validate the pain reported by many trans people. For example, Wilchins (1997) asks:

[L]ook at what kind of cultural practice required me to produce an identity to justify [feeling pain]. Why did my discomfort require justification, and why was the only compelling justification that I had a particular gendered identity? Was my pain or desire insufficient in and of itself so that without the proper paperwork and pedigree I failed to convince? Doesn't the need for a gender identity point instead to our deep and abiding hostility to gender variance? In a civilized society, wanting what you want and getting help should not require you to accept a psychiatric diagnosis, produce a dog-and-pony show of your distress, and provide an identity to justify its realness. That is a debasing and dehumanizing procedure. (P. 192)

This assertion illuminates how systematic resistance to gender diversity requires trans people to construct specific narratives that uphold categorical exclusions to gender and bodily autonomy.

These justice-oriented theoretical perspectives interpret different meanings of surgical body modifications among transsexuals and cissexuals. Taken as a whole, however, they provide important insights for understanding meanings of changing bodies within medical contexts. As

such, the current research considers these theories as they relate to broader theoretical insights offered through poststructuralism.

Poststructural theories on surgical body modification. Poststructural theory recognizes that identities and experiences of groups that are afforded power and privilege typically remain unmarked. It highlights the structural forces that maintain dominance of some groups over others. However, it contends that all identities are unstable and directs a deconstructionist lens to numerous social realities and subjectivities. Concerning transgender experiences, poststructuralism asserts that without strict societal adherence to dichotomous expression of gender, the atypical gendered paths that transgender people crave would not need authentication to progress. Societies with immutable gender rules view gender variance as dysfunctional (Weiss 2004) and in need of professional management. Validating transsexuals through pathology “protects our cultural notions of the relations of genitalia and gender role and ensures that . . . gender will not be profaned by a permanent class of genital imposters” (Bolin 1988:54). In addition, biology and psychoanalysis have historically detailed abnormal and deviant behaviors to clarify what is normal (Braidotti 1997). Thus, transgender transitions are restricted more than cisgender transitions. Poststructuralism helps us to consider the management of transgender pursuits as informed by rigid notions of gender. But it also allows us to consider the minimal regulation of cisgender pursuits as informed by the same sociocultural processes.

In addition, critics of surgery charge surgical body modification with commercializing bodies through developments that present infinite opportunities for recreation (Gimlin 2000). From this perspective, the body has become another commodity in need of maintenance and expected to mutate to perfection. Bodies are sites of struggle and sites of resistance. They are constantly in motion, always already involved in the production of identity. They are classed,

raced, aged, and of course, gendered (Gimlin 2000). Thus, inquiry into surgical body modification offers an important opportunity for poststructural theoretical insights. The central point of poststructuralism is that “discourse constructs meaning” (Hines 2006:50), a tenet crucial to understanding surgical body modifications.

In particular, Foucauldian interpretations of regulations of the body, medical discourse, and productive power represent highly useful tools. Foucault (1965) theorized the medical management of the docile body. He explained how the body became subjected to increased technology and scientific inquiry. In this way, surgical body modification might be read as a profitable project of the modern era wherein humans are invested in refining their bodies through technological enhancements. In addition, Foucault’s ideas are useful in comparing cisgender and transgender consumers of surgery under the authority of psychomedical institutions. This concept is also helpful in studying how these populations help construct discourse on surgery. Finally, Foucault’s (1978) notion of “bio-power,” or power at the cellular level, offers an opportunity to conceive of surgical body modifications as enabling consumers to produce new ideas about bodies. Surgeries are what Foucault (1988) described as “technologies of the self” which “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain sense of happiness, purity, wisdom, perfection, or immortality” (p. 18). Individuals, then, can experience surgeries as transformative just as they produce ideas about ideal bodies. Using body technologies thus illustrates power as productive (Foucault 1977). Consumers and healthcare authorities both discursively discipline the body.

As technologies of the self, surgical body modifications belong in the vast repertoire of body work performed by most people almost without thought. Although some critics might consider surgery an extreme means to looking better, others may view it as a solution that takes less time, effort, and emotional labor than decades of dieting, contorting, concealing, and camouflaging. Consider the immeasurable ways people modify their bodies to conform to Western norms. People apply make-up, hair extensions, nail polish, and colognes. We tan, work out, and dye our hair. People add to the body, but we also try to hide what is already present. Women conceal their shapes with support hose and push-up bras. Men cover bald spots with hats and drape shirts over extended bellies. People shave, trim, and pluck. We disguise our scents with deodorant, breath mints, and lotions. “Individuals change the form and function of their body in efforts to achieve socially valued body shapes, facial features, and standards of beauty” (Shapiro 2010:52). Overall, people spend a lot of time and energy trying to look different than their “natural” or unaltered bodily form. Surgical body modifications, then, are not necessarily extreme or ultimate endeavors. They can be viewed as efficient and expedient. Within postmodern American culture, they have become normalized (Brooks 2004).

Examining surgical body modifications as comparable to other forms of body modifications requires deconstructing body work as non-hierarchical. Granted, surgeries are invasive. Surgery involves cutting into the flesh (Hausman 1995), risking infection, nerve damage, and death (Yoho, Romaine, and O’Neil 2005). But nonsurgical body modifications also have harmful consequences. Tanning beds are associated with skin cancer (Woo and Eide 2010). Regular wear of high-heeled shoes can lead to degenerative joint disorders and other adverse musculoskeletal effects (Yung-Hui and Wei-Hsien 2005). Given the vast array of body modifications used on a daily basis, it is difficult to rank the psychosocial and physical risks of

different procedures. For example, how does one assess the severity of four hours of liposuction versus 30 years of rigorous exercise and restrictive dieting? These modifications aim for the same effect, but which is more extreme? Which is more dangerous? Establishing an uncontroversial hierarchy of body technologies, then, is ineffective.

Although aesthetic modification industries typically do not distinguish between surgical and nonsurgical body treatments (Covino 2004), a major difference between surgical body modification and other forms of alterations is that surgery involves professional assistance. Typically, able-bodied and class-privileged individuals can readily access make-up, shaving supplies, and exercise equipment. Although skilled professionals offer services in each of these areas, most body modifications are self-directed practices. People who want to surgically alter their bodies must enlist the assistance of a surgeon, as self-surgery is rarely a viable option. The decision to undergo surgical body modification, then, requires consumers to engage with healthcare institutions. Thus, individuals who want to change their bodies must communicate their preferences to healthcare professionals, who must evaluate their requests within authoritative guidelines for treatment. This relationship enables dialectical – reciprocal or mutually responsive effects or actions – constructions of ideal bodies and directs consumers to relay narratives that conform to authoritative models created by psychomedical institutions. With differing regulations for transgender and cisgender pursuits for body alterations, the boundaries of healthy gender become clearer and more defined, even as they are exposed as permeable and in flux. These poststructural concepts lent analytical frameworks to interpreting the current study's findings. The next chapter outlines the methodologies that I used to collect and analyze data.

CHAPTER 2 – METHODOLOGY

In my research, I aimed to understand the experiences of people who used surgical body modification to improve their appearances. I wanted to compare the experiences of cisgender and transgender consumers of surgeries. To meet these objectives, I used qualitative research methods. Qualitative inquiries with constructivist paradigms suited exploratory research. Qualitative methods promoted open-ended and interactive responses that enabled the research to evolve and adapt according to emergent data (Guba and Lincoln 1998). I used content analyses and interviewing methods in this study. The Institutional Review Board at Georgia State University approved the research (protocol H09065).

Through content analysis research, I focused on two different sources related to surgical body modification. First, I studied an online community of cisgender surgery consumers by reading posts on an internet message board. I expected this research to provide a preliminary understanding of a population with whom I was not too familiar. The main research question this method answered was: what are the concerns of cisgender consumers and prospective consumers of surgical body modification? As a preliminary inquiry, content analysis of themes in the online surgery community was appropriate. Next, I analyzed the different healthcare protocols for transgender surgeries to understand the different regulations encountered by this community. I wanted to determine how protocols for transgender people's surgeries varied. These protocols are fixed documents, so content analysis was the best method to answer the questions: How is surgical body modification regulated by healthcare authorities? What standards of care exist for surgical body modifications? Do these regulations and standards of care differ according to the type of person accessing surgery (i.e., transgender or non-transgender)?

After the content analyses, I moved to the next phase of data collection: interviewing. As a method that uses interpretative techniques, interviewing consumers of surgeries allowed me to generate concepts and identify relationships (Weiss 1994). Open-ended, in-depth, and face-to-face interviews reflected a feminist methodology that highlighted participants' narratives as data (Reinharz 1992). After unsuccessful local sampling, I conducted a few interviews with cisgender men over the telephone. As the core data in this study, this method answered the questions: what are the processes of surgical body modification? How do people use surgical body modification to enhance and confer their desired embodiment? How do consumers negotiate their desires with surgeons? What regulations do they encounter in these interactions, and how do they feel about them? How do psychological disorder classifications affect these communities? What strategies do consumers employ to facilitate access to services, and how are these influenced by normative gender expressions? How are surgical body modifications treated by insurance companies for consumers and for providers? How does coverage differ for transgender and cisgender consumers? By conducting interviews, I was able to learn details about respondents' experiences with surgical body modification.

This study relied on three, interrelated sources of data. The message board posts by cisgender surgery users, healthcare protocols, and interviews represented different aspects of surgical body modification. The message boards introduced me to an unfamiliar population, oriented me to their common concerns, and facilitated initial directions regarding possible connections between transgender and cisgender surgery communities. The surgery protocols helped me understand how healthcare authorities manage access to surgery for transgender people. The protocols also allowed me to interpret reasons for variations in standards of care on a global level. The interviews with surgery consumers were the richest source of data. They

provided information about motivations for and satisfaction with surgical body modifications. Data from interviews allowed me to systematically compare cisgender and transgender consumers of surgical body modifications. These comparisons enabled me to contextualize consumers' surgery experiences with disparate regulations among transgender and cisgender communities. In the following section, I discuss the details of each method of data collection.

An Online Cisgender Surgery Community – Data Collection

The first source for content analysis was the internet message boards on a website for surgery consumers. Before interviewing cisgender consumers of surgical body modification, I wanted to understand more about their interests in these procedures. I wanted to learn about their motivations for and experiences with getting surgeries. Internet message boards dedicated to discussing surgery seemed likely to provide information about an unfamiliar community. I wanted to interview future respondents about issues important to them, and imagined these discussion boards could orient me to their concerns. I also intended to ask about respondents' relationships to similar online communities to see if they used them. Although the sampled website did not exclude transgender users, the posts appeared to be from people who were not transgender. It is possible, however, that transgender users posted on these boards without identifying their transgender status. Because the primary motivation for analyzing these message boards was to learn more about an unfamiliar group, I did not include a comparative dataset of an online community of transgender surgery users. Since connecting to the transgender community in 1995, I have become familiar with issues that inform their surgery decisions. Ultimately, these boards provided me with basic information about cisgender surgery experiences and helped me revise my interview schedule.

Internet searches for “cosmetic surgery discussion boards” directed me toward multiple potential research sites. After reviewing three major possibilities, I selected one website for analysis: MakeMeHeal.com. This website most clearly met my sample criteria in that it featured recent activity, included diverse topics, and posted a user policy that did not explicitly or implicitly ban use for the primary purpose of conducting research. MakeMeHeal.com included primarily consumer-driven message boards but also had sections for posing questions to surgeons. At times, surgeons participated in the boards designed primarily for consumers. This website allowed me to analyze an internet community with varying levels of professionalism and colloquialism.

Once I identified MakeMeHeal.com as ideal for analysis, I contacted its administrator to seek permission to research. The operator team of the website agreed to grant me research access to the message boards. They requested that I list the website without a pseudonym, especially if quoting users. They also requested copies of any published or unpublished materials. To preserve users’ anonymity, I do not quote from these message boards.

An Online Cisgender Surgery Community – Sample Description

I analyzed the message boards in the website MakeMeHeal.com (MMH). MMH is a website dedicated to people interested in maximizing youthful beauty and minimizing the effects of aging. The website boasts that it is “the world’s largest website for all things plastic surgery, beauty enhancement, and anti-aging. With [one] million members and over 300,000 unique visitors per month, Make Me Heal is a one-stop portal for all the products, services, and information resources needed by the consumer” (www.MakeMeHeal.com 2010). Based in Los Angeles, MMH “[serves] all major countries in the world” and has “a million members and [has]

attracted over 18 million people to the site” (www.MakeMeHeal.com 2010). The website is an international hub for beauty enhancement. It promotes social networking among its users and strives to equip surgery consumers with knowledge and information. Although part of the website sells products, it also aims to promote a community environment where users are treated like friends throughout their journeys. It aims to educate and empower consumers, as evidenced in this statement: “By eliminating the black holes in the understanding of preparation and recovery, our services can help you have the fastest and safest recovery, obtain the best cosmetic outcome, feel in control, and have peace of mind during your important journey” (www.MakeMeHeal.com 2010).

MMH features a variety of services. It sells and reviews body-altering beauty products, such as compression garments, scar reduction ointments, and pillows that aid surgery recovery. It describes available cosmetic procedures, and provides a section of before-and-after photographs. One section includes gossip about celebrities who may have gotten surgery. Another section lists a consumer-rated directory of surgeons. Users can pose questions to experts in another forum. One interactive section on the website allows users to post images of themselves and poll other users about whether they should get surgery. At MMH, users have access to an abundance of information about cosmetic body enhancements. Given these factors, MMH represented an ideal place to learn about cisgender consumers of surgical body modification.

The message boards on MMH contained discussions on more than 80 topical threads. The subjects were diverse. They dealt with specific surgeries, nonsurgical cosmetic procedures, surgery products, skin care, healing techniques, and more. Although the message boards contained different topics, the sections dedicated to surgical procedures far outnumbered the others. Based on the number of posts throughout the course of a day, MMH was a popular

resource for the cisgender surgery community. For example, on July 15, 2010, seven of the 24 surgery-specific message boards I analyzed in this research hosted messages posted on this day. Four boards had posts within the last three days, six within the last week, and the remaining seven included posts within the last month.

The message boards designated 24 sections for surgery-specific topics. Three of these included male-specific surgeries. In addition to these 24 boards, I examined three boards: 1) New Procedures, Surgeries, and Treatments, 2) Male Plastic Surgery: Dr. Rick Silverman, and 3) Facial Ethnic/Black Plastic Surgery: Dr. Monte O. Harris. I expected that these specialized boards might provide additional insights. In total, I read 445 threads. The posts under each thread ranged from zero to over 20. The most active surgery board was Tummy Tuck / Abdominoplasty, followed by Breast Augmentation / Breast Implants, and Liposuction. The least active surgery board was Cosmetic Foot Surgery / Hand Rejuvenation. Also inactive were Male / Man Tummy Tuck and Penis Enlargement / Augmentation (phalloplasty), which may have been because men appeared to post messages less often than women. In my files, I retained the titles of the threads read (the comprehensive threads are available online). MMH lists title, number of replies, number of views, and date of last post.

Table 2.1 shows the figures obtained when I accessed the site to collect data on July 16, 2009. The “Topics” column indicates how many threads were contained under that surgery on July 16. The “Posts” column indicates total posts, which includes replies to original topics. The “Months Reviewed” column shows the dates of the posts analyzed. The “Total Threads Read” shows how many threads I included in the analysis.

An Online Cisgender Surgery Community – Data Analysis

On July 16, 2009 I accessed MMH and retrieved lists of message board thread titles posted from January through March 2009. I read at least 10 threads and up to 20 in each surgery-specific message board. In the most popular discussion boards, I read 20 threads. In the least trafficked boards, I read at least 10, aiming to cover January through March 2009. To reach 10, I sometimes had to read threads dated after March and before January 2009. I did not analyze topics that were blatant advertisements, cross-posted topics, off-topic threads, or irrelevant threads (e.g., New Year's greetings).

I intended the review of internet message boards to be a preliminary step. Although I did not do a detailed analysis of the content of each post, I noted themes. I studied the cisgender community's interests in and motivations for surgery in the posts. I paid extra attention to anything related to gender and sexuality, and to themes that seemed apparent in both the cisgender and transgender surgery communities. This analysis allowed me to learn more about this community and helped make the interview schedule more applicable to their concerns.

Transgender Surgery Protocols – Data Collection

Published protocols that regulate surgical body modifications represented the second source for content analysis. Although I wanted to compare transgender and cisgender surgery protocols, I could not locate any published regulations specifically targeting cisgender consumers of surgical body modification. I contacted numerous professional organizations devoted to the plastic surgery, but none provided protocols beyond basic surgery preparations. I found similar basic surgery health prerequisites – such as weight maintenance and smoking cessation – when I searched individual providers' websites. Thus, this content analysis focused exclusively on

protocols for transgender people seeking surgeries, of which I located 15 publications. I used content analysis to interpret the different ways psychomedical institutions manage surgeries. The research questions that guided this inquiry included: How is surgical body modification among transgender people regulated by healthcare authorities? What standards of care exist for transgender surgical body modifications?

To locate published surgery protocols for transgender people, I began by reviewing protocols already known to me. I reviewed these documents for references to other protocols. I then searched for other publications through electronic library databases and through the Google search engine. Internet and library search engines generated 10 sources for analysis. I then requested assistance for locating additional protocol from an online community of trans academics. Although this community did not suggest any additional publications suitable for the analysis, I continued searching the internet and found five more sources. At that time, I located Goldberg's (2003) review of transgender services. I reviewed the 35 service providers Goldberg (2003) listed and other protocol beyond what the sample lists.

To be included in the sample, the protocol needed to meet several criteria. First, the protocol needed to describe qualifications for surgery. Often, published transgender healthcare protocols do not address surgery, such as the Tom Waddell Health Center Transgender Team (2006) protocols. Next, the source document needed to be published and publicly accessible. The source needed to be applicable to a large body of healthcare providers (e.g., an entire province, country, or international community). Individual providers and clinics may use different protocol, but these policies are typically not published and are not applicable to people outside of the clinic. The source also needed to appear to have current relevance (e.g., practicing professionals cite them as resources). Finally, the source needed to be in English or translated to

English. Two protocols (of Germany and Spain) were excluded from the sample due to language of publication. In total, I analyzed 15 protocols.

Based on extensive searches for eligibility and readiness criteria for transgender people's surgeries, the sample of 15 protocols approached exhaustion. I strived to analyze an exhaustive compilation of all formal professional guidelines and standards of care that have been created to monitor and control transgender people's access to surgeries. However, it is likely that other publications in non-English languages or within non-English-speaking organizations exist. After finding protocols, I saved them into a file on my computer. The protocols are ordered in Table 2.2 by publication date, beginning with the oldest publication.

Transgender Surgery Protocols – Sample Description

The sample includes 15 protocols. The protocols varied by place of authority. The largest group of protocols included five documents related to the United States. Four of these were books published by American presses (Sources 1, 2, 7, 12), and another by the American Psychiatric Association (Source 6). Two protocols related to practices in Canada (Sources 8, 15), two protocols related to the United Kingdom (Sources 9, 13), and two touted international applicability (Sources 2, 5). Four protocols related to Australia, Finland, Italy, and Japan, respectively. The protocols also varied by length. Four sources were detailed books over 200 pages long (Sources 1, 2, 7, 12). The other 11 sources were more brief and straightforward. These sources were typically under 100 pages. Individuals without disclosed organizational affiliations authored six documents in the sample (Sources 1, 3, 4, 7, 11, 12), individuals with disclosed organizational affiliations authored three documents (Sources 6, 8, 10), and organizations or organizational committees published six sources (Sources 2, 5, 9, 13, 14, 16).

The median publication year of the protocols in the sample was 2006. Although it is difficult to measure the popularity of any one protocol, some documents are mentioned more often in the literature than others and were easier to locate. Based on cross-referencing within the protocol and literature, the most well known protocols appear to be the WPATH Standards, Bowman and Goldberg's *Care of the Patient Undergoing Sex Reassignment Surgery*, the ICTLEP Standards, and Lev's *Transgender Emergence*.

Transgender Surgery Protocols – Data Analysis

For each protocol, I recorded basic information: publication title, publication year, authorship and organizational affiliation, country of origin, and length of protocol. In the analysis, I paid attention to how the protocols discussed surgery, and noted any eligibility and readiness criteria outlined in the document. In addition to these features, I noted whether each protocol referenced the WPATH Standards, modeled medical/prescriptive or harm reduction/client-centered approaches, established age minimums for surgeries, required therapy and/or an authorizing therapy letter, required consistent use of hormones and/or a real-life experience, recommended reconciliation with family and/or employment/school, requested knowledge of risks and benefits of procedures (informed consent), set atypical readiness criteria (e.g., requirement surgery applicants to be free of serious mental health problems), posted requirements for surgeons themselves (e.g., special training in transgender healthcare), and any other noteworthy points.

I analyzed each individual protocol on its own, writing detailed notes about its regulations and philosophies. Because of their popularity, the analysis featured the WPATH Standards (Source 6) as the central point of comparison. I compared all other protocols to these

guidelines, noting key similarities and departures between the WPATH Standards and all other protocols.

Interviews with Consumers of Surgical Body Modification – Data Collection

I obtained the key data in this project through structured, open-ended interviews with consumers of surgical modification services. I aimed to interview 20 cisgender consumers (10 cisgender women, 10 cisgender men) and 20 transgender consumers (10 transgender women, 10 transgender men). I created two separate calls for transgender and cisgender research participants (Figures 2.1 and 2.2). I expected that these communities viewed surgeries differently and required different recruitment language. To locate and recruit research participants, I relied primarily on snowball sampling techniques and word-of-mouth announcements about my research. Figure 2.3 outlines the sampling paths explained below. For each of the four gender subgroups, I attempted to sample for diversity in terms of identity and surgery experience. I recruited in diverse areas and through diverse media. When I could choose the last few respondents in each group, I tried to include people who would contribute more diversity to the sample. Attempting to “match” respondents in each gender group would be difficult due to complex variations in identity, status, and surgery experiences.

Recruiting transgender respondents required contact through specific social networks. At two different times, I sent my call for transgender respondents to two Atlanta-based transgender listservs. These announcements yielded 13 of the 20 interviews with transgender respondents. In an attempt to include more trans people of color, I contacted five leaders of local organizations that service these groups. I also contacted several people directly who I knew had multiple contacts in the local trans community. In addition, I asked respondents to suggest other people

who might be interested in participating in the research. Two trans men whom I knew accepted my personal invitation to participate in the research. I invited one of these respondents because I knew he recently had surgery and had previously talked to me about his experiences. I invited the other respondent because I knew he had masculinized through a process he called “natural transition.” He achieved a masculine appearance through weight training, diet, and supplements that contain testosterone enhancers without the help of prescribed or illegal testosterone. I wanted to see if his decision to masculinize through this alternative means affected his surgery experiences. Through these efforts, I was able to secure interviews with all 20 transgender respondents.

To recruit cisgender respondents, I started with a known respondent. I interviewed one cisgender woman whom I knew had surgery. To ensure the interview questions were appropriate, I also asked this respondent for feedback on the interview design. She provided feedback after the interview and relayed minor concerns about wording. This respondent referred me to two women she knew who had surgery and passed along my call for participants to her social networks on multiple occasions. After interviewing her, I then contacted several friends who told me to get in touch with them when I began interviewing because they said they knew people who might want to participate. I sent my calls for participants to these individuals and asked them to forward the information to anyone they thought would be interested. After meeting with respondents for interviews, I asked them to send my contact information to anyone they thought might be interested in the research. In addition to these methods, I recruited participants by sending my call for cisgender respondents to 20 plastic surgery centers in the Atlanta area. I also posted the call on the Atlanta Craigslist Volunteer message board multiple times and sent it to my neighborhood listserv. These data collection methods represented the first stage of my

recruitment strategies. Most interviewees obtained in this stage came from word-of-mouth communication about my study.

As time passed, I realized that cisgender men who had surgery would be the most difficult group to recruit for the study. In response, I began to recruit in more targeted ways. I began posting flyers at local cafés, gyms, markets, college campuses, and salons. I sent emails to several representatives from neighborhood organizations in an upscale part of Atlanta. I asked for the help of a surgery consultant who offered personalized assistance in choosing surgeons. None of these strategies led to interviews. I then distributed the call to my broad personal networks through email and a social networking website. I stressed to people I talked to that I needed cisgender men to complete the sample. I received suggestions from people in my network to contact people who knew people. I contacted people referred to me and informed them about the study. Many people in my social network helped by passing along my call through email, social networking websites, in classrooms, and through conversations. Through these efforts, I was able to include five more men in the study. Although I was able to establish communication with a handful of other men who qualified, these prospective respondents did not follow through with interviews. After exhausting my networks, I decided that I needed to broaden my data collection to allow for interviews over the telephone. I had already completed interviewing everyone in the other sample subgroups. The option of interviewing over the telephone would allow me to interview men outside of the Atlanta area. I amended my research proposal, obtained Institutional Review Board approval for phone interviews in November 2010, and completed the study sample that month with three telephone interviews.

Among the 40 people interviewed, five people had direct relations to me. Of these five, I asked four of them to participate. The other respondent approached me upon hearing about my

study. These five respondents included one cisgender woman, one cisgender man, two trans men, and one trans woman. I know two of these five people well, but the other three are acquaintances whom I rarely see. Two of these respondents knew that my study involved a comparison of surgery among cis and trans surgery consumers, but they did not frame their answers in relation to the other gender group. In this way, these direct contacts did not bias the central objective research. In addition, each of these respondents provided data that related to themes in the study, but their data spread across different themes and were not proportionate to the data in the general sample. For example, regarding their feelings toward the body before surgery, the themes present among these respondents included feeling hatred (4), self-conscious (4), inhibited (3), trauma (2), useless (1), fat (1), ugly (1), okay (1), and mixed (1). This group of direct respondents, then, tended to have more intense negative feelings toward their bodies before surgery (i.e., hatred, trauma, useless, fat, and ugly). I did not expect these results. Although feeling hatred was one of the main three themes among the general sample, the rest of these intense negative feelings were not. In addition, feeling okay was the most commonly reported feeling in the general sample and it was uncommon among the five direct contacts. Given these characteristics, I concluded that the direct contacts did not bias the research in any meaningful way.

In order to foster greater trust and rapport, I interviewed 37 participants in person. I asked participants to choose the time and location for the interview. I met most respondents in their homes. Other interview locations included respondents' friends' homes, respondents' offices, my office, college campuses, cafés, restaurants, and in two cruise ship cabins. All interviewees signed informed consent documents. I maintained a list of counseling resources in case respondents experienced negative reactions during the interview. Fortunately, all interviews went well and counseling referrals were unnecessary. I recorded interviews on a digital voice recorder.

During interviews, I took minimal notes to avoid affecting conversational flow. I used the interview schedule to guide questioning, but remained flexible by allowing respondents to discuss meaningful issues as they arose. After interviewing, I asked respondents to choose pseudonyms to protect their confidentiality.

Interviews occurred from February through November of 2010. The interviews ranged in length from 21 minutes to over four hours. The longest interview was cut short and warranted a second meeting at a different time. After interviews were transcribed, I sent transcripts to respondents to verify accuracy and to pose any necessary clarifying questions. This member-checking strategy (Erlandson et al. 1993; Lincoln and Guba 1985) also gave respondents the opportunity to edit their responses, elaborate on their answers, and relay additional information.

Interviews with Consumers of Surgical Body Modification – Sample Description

I aimed for a sample of 40 respondents, including 10 transwomen, 10 transmen, 10 ciswomen, and 10 cismen.² I stopped collecting interview data once I interviewed 10 respondents for each of the sample subgroups.

The sample of surgery consumers was fairly diverse. Respondents ranged in age from 18 to 85. Thirty-three respondents lived in Georgia, in the Atlanta area (28) or in small towns and rural parts (five). Three respondents lived in North Carolina, two respondents lived in California, and one respondent each lived in Alabama and Kansas. In terms of race, 34 respondents were white, three identified as Hispanic, two were multiracial, and one was African American. Most of the respondents (23) worked in full-time jobs. Five respondents were retired. Five attended

² I originally thought I could use data from transmen interviewed in my previous research. After analyzing data from transmen interviewed for this research, I realized that the data were too dissimilar. Thus, all 10 transmen in this study were new interviewees who were not included in my previous research.

school full-time and four of them worked part-time jobs. Seven were unemployed, underemployed and looking for work, or on disability.

In terms of gender and sexuality, the sample varied. Twenty-eight respondents had gender expressions they described as conventional or somewhat exaggerated (e.g., a girlie girl). Over half of respondents (22) also believed that others consistently perceived them as conventionally masculine or feminine. The respondents' sexual identities varied. Fifteen identified as heterosexual or primarily heterosexual, 11 identified as gay or lesbian or primarily gay or lesbian, nine identified as queer or pansexual, three identified as bisexual, one identified as almost asexual but attracted to women, and another said her current sexual identity was in flux. Twenty-one respondents were in committed relationships, 10 were single, seven were divorced and single, and two were casually dating. Sixteen respondents had children.

The respondents qualified for the study based on a wide variety of surgeries. The number of surgeries each respondent got varied from one to five, but 23 respondents reported having surgery on only one part of the body during one surgical session. In total, 18 surgeries were represented in the sample. The most common surgeries were liposuction (nine) and chest reconstruction (nine), followed by breast augmentation (eight), rhinoplasty (six), blepharoplasty or eyelid surgery (five), and breast reduction (five). The less popular surgeries included facial feminization (four), facelift (three), abdominoplasty (three), hair transplant (two), otoplasty or ear pinning surgery (two), orchiectomy or testicle removal (two), vaginoplasty (two), labiaplasty (two), tracheal shave (one), chest skin removal (one), thigh lift (one), and dental³ (one). Twelve respondents reported that health insurance covered their surgeries in part or whole.

³ The cosmetic dental surgery reported by this respondent included \$40,000 worth of implants, caps, and bone grafts that gave her "nice pretty teeth."

This sample description captures the demographic characteristics of the respondents as a whole. In the Appendix, I provide a more detailed description of the sample that considers how differences among the sample subgroups might affect the interpretation of the research findings. Tables 2.3 and 2.4 provide details about the sample. Overall, the sample groups were very similar in key areas. In the chapters that relay interview data, I discuss where sample differences could have impacted findings.

Interviews with Consumers of Surgical Body Modification – Data Analysis

I applied grounded theory techniques to analyze interview data, but I also used other interpretative analyses typical in qualitative research. Due to my previous research on trans men's healthcare experiences, traditional or purist grounded theory methods were unrealistic for data analysis. I already studied gatekeeping and read extensive scholarly literature on the regulations around surgical body modifications. Thus, my grounded theory techniques included using open and axial coding strategies, writing reflective, methodological, and analytical memos, and diagramming concepts to facilitate data comparison and identify central themes. These choices apply grounded theory techniques "flexibly and creatively," as encouraged by Strauss and Corbin (1998:14).

Data analysis began with reading through interview transcripts. Each transcript had space alongside the right margin for writing notes. I started by analyzing each interview holistically, reading transcripts in their entirety to develop general impressions. I then applied open coding techniques to all 40 interviews. I read each interview transcript line-by-line, jotting codes in the margins and marking indicators of codes. After applying open coding to the first two interview transcripts of each sample subgroup, I re-read the transcripts while thinking about comparison

points between the groups. I noted these thoughts in the margins in different colored ink. Throughout open coding, I wrote reflective memos about possible comparisons. For the remaining interviews, I read them first holistically and noted any interesting points in the margins. I then entered all interview transcriptions into the qualitative research software program Qualrus. In this program, I coded the remaining interviews and added new codes to my expanding code lists. Although Qualrus was an effective and efficient tool for organizing data, I did not use the program's analytical tools. Throughout open coding, I paid close attention to emergent themes (Strauss and Corbin 1998). During this process, I wrote reflective, coding, and methodological memos about the data. Open coding of 40 interviews resulted in 10 drafts of code lists. The final pre-axial code list contained 301 codes.

Typically, grounded theory methods strive for theoretical saturation. My data reached theoretical saturation when interview data did not contribute new substantive and meaningful information (Strauss 1987; Strauss and Corbin 1998). Due to needing equal numbers of respondents in the comparison groups, I did not stop data collection due to theoretical saturation. The codes established from the first half of respondents represented the core themes of the study. The last half of respondents enriched the data by providing more depth to the existing codes. However, coding the last 10 interviews yielded very little new information that had not already been captured conceptually. Indicators from these respondents reflected ideas previously expressed by other respondents and differed only in minor details. I concluded that the study exhausted comparative relationships between the groups and saturated the conceptual themes in the data.

After open coding, I began axial coding by studying each group of codes. I organized the codes based on a trajectory of surgical body modification experiences. Most codes fit into stages

related to respondents' experiences before surgery, during attempts to access surgery, actual surgery experiences, and postsurgical experiences. I first analyzed each stage separate from the others. Within these stages, I organized codes according to different themes. For example, when analyzing the presurgical stage, I created a group of codes related to respondents' feelings toward their bodies before surgery. Within this group, I then organized subgroups codes based on neutral/mixed feelings (e.g., feeling okay about the presurgical body), negative cosmetic associations (e.g., describing the presurgical body as fat or ugly), and negative psychological associations (e.g., feeling self-conscious about or hating the presurgical body). I used this analytic system for each of the stages, ultimately organizing data into three stages of surgical body modification. This system organized over 800 pages of indicators based on 301 codes.

As I identified these stages, I began to compare the sample of cisgender and transgender respondents in depth. I began with a preliminary analysis of the major themes in each stage. At this point, I wrote a preliminary analysis of findings. I then returned to the data to analyze all of the themes using the constant comparative method (Glaser 1965; Glaser and Strauss 1967). I examined codes more closely, noting their dimensions and interconnected properties (Strauss and Corbin 1998). I continued writing about these comparisons. I reorganized codes by consolidating codes with few or no unique indicators into other codes. For example, I collapsed six specific but shallow codes about surgery prerequisites into one code for physical health-related surgery prerequisites. I also re-categorized codes or trimmed codes irrelevant to the central emergent story. Creating more precise codes helped to abstract them into explanatory categories which captured the varying characteristics of surgical body modification. For example, I broke the general code of "therapy experiences" into seven separate, meaningful codes, such as "getting diagnosed in therapy" and "describing the therapist as financially motivated." I also diagrammed

the emergent relationships between codes and categories of codes within and across each stage in the trajectory. I diagrammed categorical connections on a corkboard, which allowed me to envision alternative relationships between concepts. With this, I was able to develop themes and generate categories based on interpretative analyses (Berg 2000). By the end of axial coding, I reorganized the codes from over 300 to about 150. For each of these codes, I noted how many indicators stemmed from transgender and cisgender respondents. The final post-axial code list that includes comparison details for the sample groups is in Figure 2.4.

Throughout axial coding, I examined how each individual category linked to other categories on conceptual and dimensional levels (Strauss 1987). I began to understand the broad story of surgical body modification by systematically connecting categories beyond superficial descriptions. This process helped me detect systematic interconnections between categories (Charmaz 1983) and enabled theory-building (Strauss and Corbin 1998). I was able to connect codes in different stages of surgical body modification, such as linking respondents' satisfaction with surgery to their motivations for surgery. This analysis helped me explain how, for example, the surgery effect of "feeling better" linked to postsurgical feelings of confidence and comfort and presurgical feelings of self-consciousness and unattractiveness. By examining interrelated categories, I was also able to enrich theoretical explanations. For example, the psychological effect of "feeling better" was inseparable from the positive cosmetic effects that surgery achieved.

The final step of analysis involved identifying a core category through selective coding (Strauss and Corbin 1998). At this stage, I integrated theory into the analysis to refine a model of "enhancing the self through the body." With this core category, surgical body modification represented an embodied process defined by dialectical cosmetic and psychological factors. The

analytic power of the core category – enhancing the self through the body – effectively connected the relationships between categories across the trajectory of surgical body modification. This central category met the criteria for selecting a core category in that it was central, appeared frequently, logically explained categorical relationships, lent general theoretical relevancy, produced strong explanatory power, and accounted for variation (Strauss 1987; Strauss and Corbin 1998). The core category of enhancing the self through the body facilitated sociological interpretations related to gender, embodiment, and healthcare disparities.

To strengthen the accuracy of the findings, I used a variety of strategies. After interviews, I sometimes chatted casually with respondents about the research and they often shared their thoughts on different themes. I asked respondents to review the transcripts of the interviews to verify accuracy. I also provided them with the opportunity to clarify answers and relay additional information if needed. As part of qualitative inquiry, I checked and re-checked the data to ensure consistency during analysis. Verification procedures included making deductions and checking them with the data (Strauss 1987). I continually examined the data to support, confirm, or challenge ideas developing throughout analysis. Given that gender status was a key factor in this study, I interrogated the motivations for and satisfactions with surgery that related to gender identity or expression. For example, I analyzed the indicators for the code that captured the surgery motivation “to change gendered appearance” to ensure those quotations could not be better explained by other factors. I wanted to ensure that gender-specific codes effectively captured gendered experiences. Finally, my writing incorporated rich quotations to provide readers with a greater sense of respondents’ experiences as they described them.

Methodology Limitations and Strengths

The limitations of the content analyses related to dealing with fixed, textual information. The internet message boards contained brief communications set in particular moments. I did not interact with the users. When I encountered confusing messages, I could not ask for clarification. In addition, the board users represented a type of surgery consumer that was not often represented in my actual sample of interviewees. Only five interviewees reported involvement with this type of online community, and most of them reported that they just read the boards to gather information. Thus, the themes present on the board were not identical to issues expressed by respondents.

Regarding the content analysis of the transgender surgery protocol, my interpretations relied on fixed documents with limited contextual information. I did not have much information about the sociocultural and historical processes that informed these regulations. For example, it was difficult to understand why the British government's publication seemed to favor informed consent, flexibility, and gender diversity compared to the restrictive document drafted by the United Kingdom's Royal College of Psychiatrists. In addition, my analysis was limited to documents available in English.

The limitations of the interview data were based on the sample. The small, nonrandom sample precludes generalizability. In addition, racial minorities – specifically cisgender African Americans and people of Asian descent – were under-represented in the sample. The findings from this study may differ from their experiences with surgical body modification. Another limitation of interviewing meant having to rely on self-report data instead of witnessing the experiences reported firsthand. Asking respondents to reflect on their bodies before surgery may have been affected by their satisfaction with surgery.

The qualitative methods I employed also offered advantages. Data from the content analyses and interviews provided information about surgery experiences in depth and detail. Collecting data from three different types of sources helped present a more rounded interpretation of surgical body modification. By employing feminist methods, I was also able to privilege respondents' perspectives through extensive quoting (Reinharz 1992). Finally, grounded theory methods allowed the themes to emerge directly from the data instead of forcing the data to fit predetermined hypotheses. Although I expected that cisgender and transgender people would encounter different barriers to surgery, I was surprised to learn how similar they were in other ways.

In sum, the methods used provided an effective tool for understand surgical body modification and the people who pursue it. The content analyses provided a solid foundation for exploring issues with people during live interviews. The data support the central themes of the study are strong.

The next section presents research findings. Chapter 3 presents the findings from the content analyses. Chapter 4 introduces the first findings based on interview data which relate to respondents' motivations for surgery. Chapter 5 presents findings related to the effects of surgery for respondents. Chapter 6 explores how respondents pursued surgery. Chapter 7 relays their experiences with justifying their surgical decisions to psychomedical authorities. The dissertation closes with theoretical contributions and policy implications.

Table 2.1 Content Analysis of MakeMeHeal.com

Message Boards N = 24	Topics	Posts	Month(s) Reviewed/ Year	Total Threads Read
Arm lift, brachioplasty, reduction	532	2424	1/09	20
Breast Augmentation, Breast Implants	17218	145549	1/09	20
Breast Lift, Mastopexy	2139	10284	1/09	20
Breast Reduction	9248	71249	1/09	20
Buttocks Augmentation, Lift, Buttock Implants	4009	39665	1/09	20
Cheek Implants, Lift, Augmentation	278	1011	1-3/09	13
Chin/Jaw Implants, Augmentation	477	2086	1-2/09	20
Cosmetic Foot Surgery, Hand Rejuvenation	32	105	4/08-3/09	10
Eyelid Surgery, Blepharoplasty	2600	15534	1/09	20
Facelift (Mid, Lower, Mini Face Lift)	4053	38596	1/09	20
Forehead Lift, Brow Lift	307	1304	1-5/09	13
Hair Restoration, Transplant, Loss	82	189	1-3/09	10
Lip Augmentation/Injections	276	1064	1-2/09	20
Liposuction	10311	72400	1/09	20
Lower Body Lift	150	554	1-3/09	20
Male/Man Breast Reduction (Gynecomastia)	72	147	9/08-3/09	13
Male/Man Liposuction	75	215	1-6/09	10
Male/Man Tummy Tuck	53	128	10/08-12/09	10
Nose Surgery, Nose Job, Rhinoplasty	9208	59507	1/09	20
Otoplasty, Ear Surgery	370	1563	1-4/09	20
Penis Enlargement, Augmentation	58	219	6-11/09	15
Thigh Lift, Thighplasty	315	1477	1-4/09	20
Tummy Tuck, Abdominoplasty	39396	399198	1/09	20
Vaginoplasty, Labiaplasty	663	3182	1-2/09	20
Total				414

Additional Message Boards

New Procedures, Surgeries, & Treatments	179	681	1-3/09	10
Male Plastic Surgery: Dr. Rick Silverman	98	221	10/08-11/09	11
Facial Ethnic/Black Plastic Surgery: Dr. Monte O. Harris	43	120	1-3/09	10
Total				31
GRAND TOTAL				445

Table 2.2 Sample of Transgender Surgery Protocols, N = 15

Source Number	Document Title	Publication Year	Author or Organization	Place of Authority
1	<i>True Selves: Understanding Transsexualism – For Families, Friends, Coworkers, and Helping Professionals</i>	1996	Brown and Rounsley	Not specified, American publisher
2	<i>International Conference on Transgender Law and Employment Policy Health Law Standards of Care for Transsexualism</i>	1997	Health Law Project, ICTLEP	International
3	<i>Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts</i>	1997	Israel and Tarver	Not specified, American publisher
4	<i>Italian Standards of Care for Sex Reassignment in Gender Identity Disorder</i>	1998	Ravenna	Italy
5	<i>The Standards of Care for Gender Identity Disorders, 6th Version</i>	2001	World Professional Association for Transgender Health Committee	International
6	<i>Treatments of Psychiatric Disorders, 3rd Edition, Volume 2</i>	2001	American Psychiatric Association	United States
7	<i>Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families</i>	2004	Lev	Not specified, American publisher
8	<i>Care of the Patient Undergoing Sex Reassignment Surgery</i>	2006	Bowman & Goldberg; Vancouver Coastal Health, Transcend Transgender Support & Education Society, Canadian Rainbow Health Coalition	British Columbia, Canada
9	<i>Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria</i>	2006	Royal College of Psychiatrists Intercollegiate SOC Committee	United Kingdom and Republic of Ireland
10	<i>Guidelines for Consultation and Treatment for Gender Identity Disorder</i>	2006	Nakajima Toyoji and The Japanese Society of Psychiatry and Neurology	Japan
11	<i>On the Care of Transsexuals in Finland</i>	2006	Veronica Pimenoff	Finland
12	<i>Principles of Transgender Medicine and Surgery</i>	2007	Ettner, Monstrey, and Eyler (Eds.)	Not specified, American publisher
13	<i>Guidance for GPs and Other Clinicians on the Treatment of Gender Variant People</i>	2008	National Health Service and Gender Identity Research and Education Society	United Kingdom
14	<i>Principles and Standards for the Management of Gender Identity Disorder in Queensland</i>	2008	Australian Transgender Support Association of Queensland	Queensland, Australia
15	<i>CAMH Gender Identity Clinic: Criteria for Those Seeking Surgery</i>	2009	Centre for Addiction and Mental Health (CAMH)	Canada

Table 2.3 Sample Demographics:⁴ Ciswomen Group

Gender; Gender expression; Conventionally feminine	Age	Race	Sexual Identity	Relationship status, # children	Residence	Occupation	# of Surgeries / # of Sessions	Surgeon location, Gender	Estimated surgery cost to respondent	Cost covered by insurance (amount if known)	Future surgery plans
Woman; More femme; Yes	26	White	Lesbian	Single, 0	Urban GA	Pharmaceutical sales	1 / 1	GA, Man	\$5,000	No	No
Queer femme; Traditional feminine; Partially, tattooed, queer	30	White	Queer	Married, 1	Urban GA	Business owner	2 / 2	NC, Man	\$1,000; \$4,000	No	Maybe
Woman; Pretty girlie; Yes	31	Hispanic	Heterosexual	Single, 0	Urban GA	Clinical neuro- physiologist	1 / 1	GA, Man	\$0	Yes: total (\$10,000)	No
Woman; Girlie girl; Yes	40	White	Heterosexual	Married, 2	Suburban GA	Accountant	3 / 1	GA, Woman	\$16,000	No	Maybe
Woman; Feminine; Yes	40	White	Heterosexual	Single, 0	Urban GA	Digital media director	1 / 1	GA, Woman	\$0	Yes: total (\$8,000)	Maybe
Woman; Womanly, not feminine; No	44	White	Heterosexual	Married, 2	Urban GA	Wellness coordinator	1 / 1	GA, Man	\$5,500	No	No
Woman; Depends on mood; Yes	44	White	Heterosexual	Married, 3	Suburban GA	Stay-at-home mother	3 / 3	GA, 2 Men	\$4,000	Yes: partial; Yes: partial; Yes: total	No
Woman; Feminine; Yes	54	White	Heterosexual	Divorced, 0	Suburban NC	Executive administrator	2 / 1	NC, Man	\$4,000	No	No
Woman; Feminine; Yes	62	White	Heterosexual	Divorced, 2	Rural GA	Music publishing	2 / 2	GA, Man	\$0; \$12,000	Yes: total (\$20,000); No	No
Woman; In middle of femininity scale; Yes	62	White	Heterosexual	Divorced, 3	Suburban NC	Retired nurse	3 / 2	NC, Man	\$2,000; \$5,000	No	No

*The first column indicates all gender variables: respondents' self-identified gender, gender expression, and whether they view themselves as conventionally feminine or masculine.

⁴ To protect confidentiality, I list respondents' demographics without their chosen pseudonyms. I also include information about surgeries in a separate table. Because some respondents had unique surgeries, or were open about some surgeries and not others, listing surgeries alongside demographics would reveal confidential information.

Table 2.3 Sample Demographics: Cismen Group

Gender; Gender expression; Conventionally feminine	Age	Race	Sexual Identity	Relationship status, # children	Residence	Occupation	# of Surgeries / # of Sessions	Surgeon location, Gender	Estimated surgery cost to respondent	Cost covered by insurance (amount if known)	Future surgery plans
Male; Relatively masculine; Hope so, maybe	18	White	Gay	Partnered, 0	Urban GA	Student, assistant accountant	1 / 1	GA, Man	Unknown	Yes: most (\$14,379)	No
Male; Mostly masculine; Probably	23	White	Gay	Partnered, 0	Urban GA	Marketing specialist	2 / 2	GA, Man; GA, Man	\$100; \$0	Yes: most; Yes: total (\$8,000)	No
Male; Lean towards effeminate; Depends on context	29	White	Gay	Single, 0	Suburban GA	Student, actor	1 / 1	AL, Man	\$4,000	No	No
Male; Masculine; Yes	32	Mexican	Heterosexual	Engaged, 0	Urban CA	Mortgage consultant	1 / 1	CA, Man	\$500	Yes: most	No
Male; Masculine; 5-6 on a scale of 10	34	White	Gay	Single, 0	Urban GA	Interior designer	3 / 2	GA, Man	\$11,000; \$6,000	No	No
Male; On more masculine side; Yes	40	White	Gay	Single, 0	Urban GA	Real estate	1 / 1	GA, Man	\$7,500	No	Maybe
Male masculine; Towards masculine but not super masculine; No, atypical body movements	40	White	Gay	Partnered, 0	Urban KS	Graduate student, teaching assistant	1 / 1	KS, Man	\$2,600	No	Maybe
Male; Average masculine; Yes	41	White	Heterosexual	Married, 3	Urban NC	Solutions consultant	2 / 2	NC, Men	Unknown; \$4,000	Yes: most; No	Maybe
Male; Masculine, in the middle; Yes	49	White	Gay	Dating, 0	Urban GA	Vice-president strategy and innovation	1 / 1	GA, Man	\$6,500	No	No
Male; Masculine; Yes	85	White	Heterosexual	Married, 1	Urban GA	Retired professor	1 / ~2	GA, Man	Unknown	Yes: most	No

Table 2.3 Sample Demographics: Transwomen Group

Gender; Gender expression; Conventionally feminine	Age	Race	Sexual Identity	Relationship status, # children	Residence	Occupation	# of Surgeries / # of Sessions	Surgeon location, Gender	Estimated surgery cost to respondent	Cost covered by insurance (amount if known)	Future surgery plans
Transgender woman, woman, second-type woman, two-spirit; Pretty feminine; Yes, new age hippie	33	White	Pansexual/bisexual	Single, 0	Urban GA	Artist	1 / 1	GA, Woman	\$1,900	No	Maybe
Female; Ultimate girlie girl; Yes	36	Mexican	Heterosexual	Dating someone, 0	Suburban GA	Student	1 / 1	GA, Man	\$6,600	No	Maybe
Female; Femme; Probably not	38	White	Poly, omni	Open relationship, 0	Small town GA	Attorney	2 / 2	WI, Man	\$17,000; \$6,000	No	Maybe
Woman; Mostly feminine; Depends on context	40	White	Mostly lesbian	Partnered, 0	Urban GA	Unemployed graphic designer, temp work	2 / 1	GA, Men	\$4,500, \$10,500	Yes: small portion	Yes
Female, transwoman; Feminine, lipstick; No	42	White	Lesbian	Partnered, 0	Urban GA	Temporary work	2 / 2	GA, Men	\$5000; \$1,500	No	Yes
Female (living part-time); Pretty feminine; Yes	51	White	Attracted to women, almost asexual	Divorced, 5	Urban AL	Financial manager government	1 / 1	TX, Man	\$9,600	No	Yes
Funny, interesting, female; Dominant female; No	57	White	Bisexual	Divorced, 2	Suburban GA	Retired technician	2 / 2	CA, Man; Thailand, Man	\$23,000; \$14,900	No	Yes
Transsexual female; Not quite girlie girl; Yes	57	White	Slightly bi, slight more attraction to men	Divorced, 2	Suburban GA	Software developer	3 / 2	GA, Man	\$29,500; \$17,000	No; Pending	Yes
Female; Girlie girl; Yes	62	White and American Indian	Bisexual, lean toward partnering w/men	Partnered, 4	Small town GA	Retired repairs, unemployed looking for work	5 / 4	MD, Men and Woman TN, Woman	\$40,000; \$6,000; \$7,000; \$6,500	No	Yes
Female; Unsure; Yes	63	White	Changing; formerly partnered w/women, now attracted to men	Divorced, 2	Suburban GA	Retired, changing career	1 / 1	CA, Man	\$35,000	No	Yes

Table 2.3 Sample Demographics Transmen Group

Gender; Gender expression; Conventionally feminine	Age	Race	Sexual Identity	Relationship status, # children	Residence	Occupation	# of Surgeries / # of Sessions	Surgeon location, Gender	Estimated surgery cost to respondent	Cost covered by insurance (amount if known)	Future surgery plans
Male; Femme, queer; No feminine gay man	22	White	Queer bisexual	Open relationship w/partners, 0	Urban CA	Receptionist, artist, sex worker	1 / 1	MD, Woman	\$4,000	No	Maybe
Male (defined broadly); Classic old man; No people see masculine but question it	25	Multiracial	Attracted to women	Single, 0	Urban GA	Student	3 / 2	Iran, Man; FL, Man	\$2,000; \$5,700	No	Yes
FTM, female-to- male; More masculine; Yes	26	African American	Lean toward straight	Single, 1	Suburban GA	Assembly	1 / 1	FL, Man	\$5,700	No	Maybe
Genderqueer; transgender; More masculine, sometimes genderqueer; No, conventionally faggy	27	White	Pansexual	Poly and partnered, 0	Urban GA	Barista	1 / 1	GA, Man	\$7,000	No	No
Mostly male, trans; Pretty feminine guy, kind of in middle; No, present somewhat strangely	28	White	Mostly gay	Married, 4	Small town GA	Underemployed consultant, researcher	1 / 1	GA, Man	\$3,150	Yes; most (\$16,850)	No
Trans; Trans, not man-identified, faggy; No, faggy	31	White	Queer	Poly and lives with partner, 1	Urban GA	Library associate	1 / 1	GA, Man	\$7,600	No	No
Male, FTM; transgender; Metrosexual; Yes, but trendy	31	White	Straight but queer	Married, 0	Urban GA	Unemployed	1 / 1	FL, Man	\$5,700	No	No
Male, transman, FTM; Masculine dial on 60, 65%; No, gay man	32	White	Queer	Engaged, 0	Urban GA	Software trainer	1 / 1	GA, Man	\$5,800	No	No
Confusing; Androgynous; No	33	White	Confusing, queer	Married, 0	Rural GA	On disability	1 / 1	GA, Man	\$0	Yes; total	Maybe
Queer, more male- oriented; More masculine, a little faggish; No, little gay punk boy	34	White	Hard to say, queer	Single, 0	Urban GA	Bartender, manager	1 / 1	FL, Man	\$5,800	No	No

Table 2.4 Respondents' Surgeries

Cisgender Respondents' Surgeries, Age	Respondent's only surgery?	Transgender Respondents' Surgeries,* Age	Respondent's only surgery?
Rhinoplasty, 16	Yes	Full body liposuction, 21	No
Breast reduction, 16	Yes	Rhinoplasty, 21	No
Liposuction neck, 18	No	Chest reconstruction, 22	Yes
Otoplasty, 18	No	Chest reconstruction, 25	No
Otoplasty, 18	Yes	Chest reconstruction, 25	Yes
Rhinoplasty, 19	No	Chest reconstruction, 26	Yes
Rhinoplasty, 20	No	Chest reconstruction, 27	Yes
Liposuction neck, 21	No	Chest reconstruction, 28	Yes
Rhinoplasty, 21	Yes	Vaginoplasty, 29	No
Liposuction thighs, 24	No	Labiaplasty, 29	No
Hair transplant, 26	No	Chest reconstruction, 30	Yes
Breast augmentation, 26	Yes	*Breast reduction, 32	Yes
Liposuction torso, 30	Yes	*Chest reconstruction, 32	Yes
Abdominoplasty, 31	No	Orchiectomy, 32	Yes
Abdominoplasty, 31	No	Chest reconstruction, 34	Yes
Chest skin removal, 31	No	Breast augmentation, 36	Yes
Breast reduction, 34	No	Breast augmentation, 38	No
Liposuction torso, 34	Yes	Tracheal shave, 38	No
Thigh lift, 34	No	Breast augmentation, 40	No
Breast reduction, 36	Yes	Orchiectomy, 40	No
Breast augmentation, 37	No	Facial feminization, 47;	No
Liposuction thighs, 37	No	Facial feminization, 51	Yes
Blepharoplasty, 37	No	Vagino-labiaplasty, 56	No
Breast reduction, 38	No	Abdominoplasty, 57	No
Breast augmentation, 40	Yes	Breast augmentation, 57	No
Liposuction torso, 47	No	Dental, 57	No
Liposuction neck, 47	No	Facial feminization, 57	No
Blepharoplasty, 48	No	Rhinoplasty, 58	No
Liposuction neck, 48	No	Blepharoplasty, 59	No
Blepharoplasty, 49	No	Breast augmentation, 59	No
Facelift, 49	No	Face lift, 59	No
Blepharoplasty revision, 49	No	Facial feminization, 62	Yes
Hair transplants, 55	Yes		
Facelift, 60	No		
Total parts modified	34	Total parts modified	32

* Two respondents also had hysterectomies as part of their medical transitions, but the data associated with these surgeries was not used in order to preserve the comparable “cosmetic” surgical body modifications obtained by all groups.

**attention people who have had
c o s m e t i c s u r g e r y :**

Have you had surgery to change your appearance?

Are you a man or woman who has gotten any type of
cosmetic, plastic, or aesthetic surgery to change your body type
to something you found more appealing?

If so, you are invited to participate in a study
that seeks to examine people's experiences accessing cosmetic surgery.*

The researcher seeks to interview people who have had some type of cosmetic surgery to reflect a more appealing body type. The researcher wants to understand people's experiences with surgical body modifications.

Interviews will be done in person around Atlanta, Georgia.

All information you provide is strictly confidential.

You do not need to use your real name.

This research has been authorized by the Institutional Review Board of Georgia State University (Protocol H09065).

If you want to participate in this research or have questions, please contact the researcher:

Elroi J. Windsor ewindsor@gsu.edu (404) ###-####

Georgia State University

Department of Sociology

P.O. Box 5020

Atlanta, GA 30302-5020

*Surgeries may include breast augmentation, liposuction, hair transplant, thigh lift, labiaplasty, rhinoplasty, face lift, male breast reduction, buttock augmentation, calf implant, phalloplasty, pectoral implant, blepharoplasty, tummy tuck, vaginoplasty, chin/jaw implants, brow lift, arm lift, and more.

Men and women of all ages are invited to participate.

[tear-off tabs omitted]

Figure 2.1 Flyer for Cisgender Research Participants

c a l l f o r t r a n s g e n d e r

RESEARCH PARTICIPANTS

The researcher seeks to interview transgender* people who have had some type of surgery to reflect their gender identity and/or expression. The researcher wants to understand transgender people's experiences with surgical body modifications (such as motivations, prerequisites, satisfaction, interactions with providers).

If you are a transgender person who has gotten surgery to reflect your desired gendered body, or if you had surgery as part of your medical transition, then you are invited to participate in a study that seeks to learn about transgender people's experiences with surgery.

Transgender surgeries may include: top surgeries (chest/breast), bottom surgeries (gender-confirming surgeries like orchidectomy, vaginoplasty, labiaplasty, phalloplasty, metaoidioplasty, scrotoplasty, vaginectomy), facial surgeries (nose, brow, chin, cheeks), hair transplant surgeries, tracheal surgeries, liposuction, and more.

All information you provide is strictly confidential.

You do not need to use your real name.

This research is being done by a person who identifies as transgender.

Interviews will be done in person around Atlanta, Georgia.

This research has been authorized by the Institutional Review Board of Georgia State University (Protocol H09065).

If you want to participate in this research or have questions, please contact the researcher:

Elroi J. Windsor ewindsor@gsu.edu (404) ###-####

Georgia State University

Department of Sociology

P.O. Box 5020

Atlanta, GA 30302-5020

* The term "transgender" is broad and used here for the sake of brevity. For the purposes of this study, "transgender" includes anyone whose gender identity or expression does not conform to expectations associated with their assigned birth sex. Transgender may include people who identify as trans, of transgender experience, MTF, FTM, transsexual, transman, transwoman, transmasculine, transfeminine, crossdresser, genderqueer, transvestite, T, TG, AG, two-spirit, having Harry Benjamin Syndrome, new woman, new man, woman, man, and more. All preferred identity terms will be honored.

Figure 2.2 Flyer for Transgender Research Participants

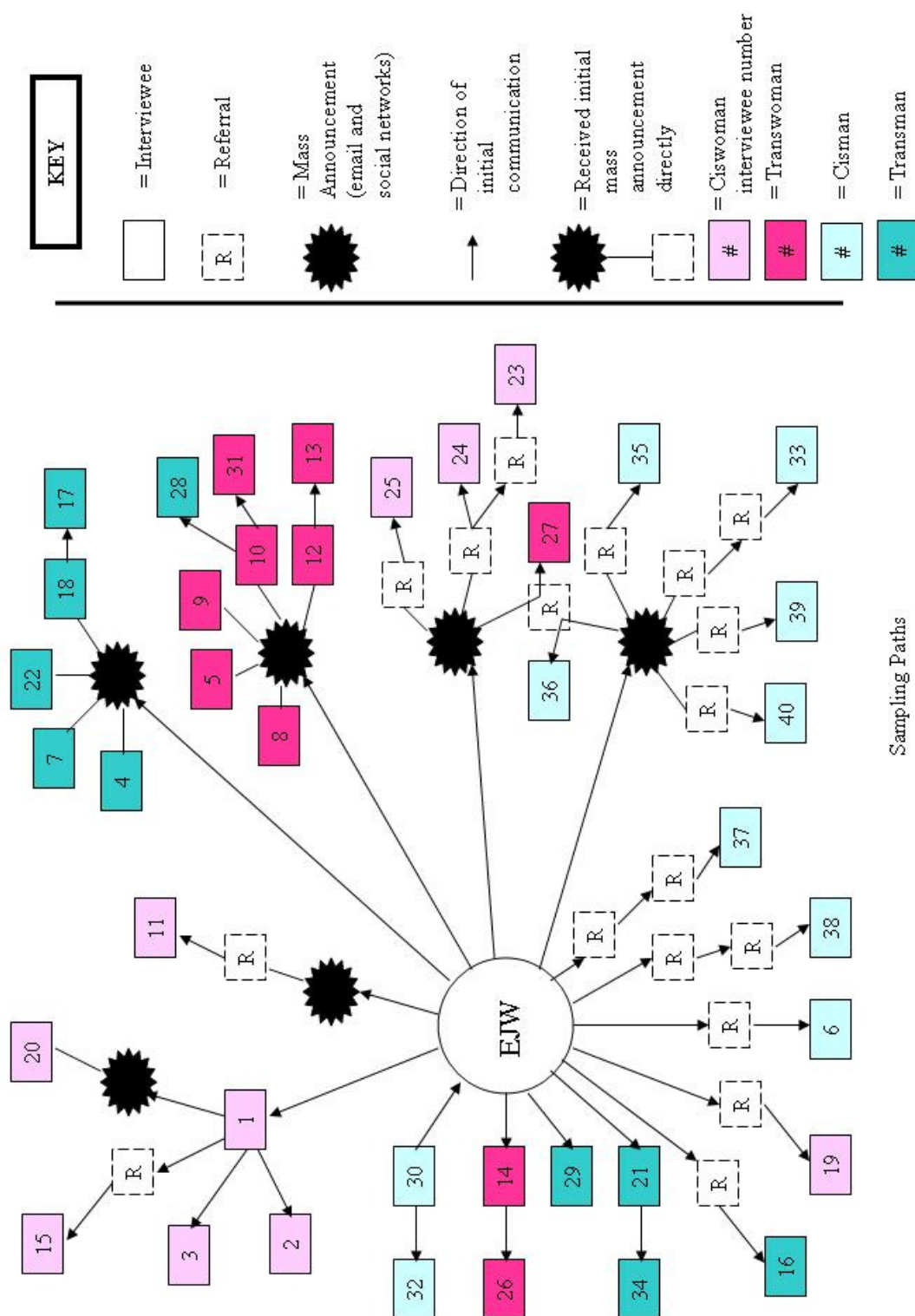


Figure 2.3 Sampling Paths

Post-Axial Codes – Comparison Details

KEY: N=#, # cis, # trans; # ciswomen, cismen, transwomen, transmen

PRE-SURGERY BODY AND SURGERY MOTIVATION

Feelings toward Pre-Surgery Body

Neutral/mixed:

BodyOk R described affected body as okay

N=22: 12 cis, 10 trans; 5, 7, 6, 4

BodyMixed R had mixed feelings about affected body

N=5: 1 cis, 4 trans; 1, 0, 1, 3

Negative cosmetic associations (overall n=16: 13 cis, 3 trans; 6, 7, 1, 2):

BodyFat R described affected body as fat

N=9: 8 cis, 1 trans; 4, 4, 1, 0

BodyUgly R described body as unattractive

N=7: 5 cis, 2 trans; 2, 3, 0, 2

BodyHanging R described affected body as hanging

N=5: 3 cis, 2 trans; 2, 1, 1, 1

BodyOld R described affected body as old

N=2: 2 cis, 0 trans; 2, 0, 0, 0

Negative psychological associations (overall n=29: 15 cis, 14 trans; 5, 10, 6, 8)

BodySelfCons R felt self-conscious about body part

N=21: 13 cis, 8 trans; 4, 9, 3, 5

BodyHate R felt hatred toward body

N=12: 6 cis, 6 trans; 4, 2, 3, 3

BodyInhibit R felt body part inhibited overall self-image

N=10: 8 cis, 2 trans; 2, 4, 1, 1

BodyUnhap R felt unhappy about body part

N=8: 6 cis, 2 trans; 2, 4, 1, 1

BodyTrauma R felt body was severely traumatic / haunting

N=7: 3 cis, 4 trans; 2, 1, 2, 2

BodyUseless R felt body part was useless

N=3: 0 cis, 3 trans; 0, 0, 1, 2

BodyHide R hid the pre-surgery body with concealers, shaping devices, strategic clothing and positioning

N=27: 11 cis, 16 trans; 6, 5, 7, 9

Motivations for Surgery

MotSurgTime Surgery due to it “being time” to get surgery

N=17: 8 cis, 9 trans; 5, 3, 5, 4

MotSurgHealth Surgery to prevent or address health problem

N=13: 9 cis, 4 trans; 5, 4, 2, 2

MotSurgWhyNot Surgery due to having opportunity

N=6: 5 cis, 1 trans; 4, 1, 1, 0

Cosmetic motivations (overall n=36: 19 cis, 17 trans; 9, 10, 10, 7):

MotSurgLookBetter Surgery to look better

N=31: 19 cis, 12 trans; 9, 10, 6, 6

MotSurgYoung Surgery to look/feel younger

N=4: 4 cis, 0 trans; 3, 1, 0, 0

MotSurgChangeGen Surgery to change gendered appearance

N=15: 3 cis, 12 trans; 2, 1, 8, 4

Psychological motivations (overall n=29: 13 cis, 16 trans; 7, 6, 7, 9):

MotSurgFeelBetter Surgery to feel better about self

N=24: 13 cis, 11 trans; 7, 6, 5, 6

MotSurgComfort Surgery to feel more comfortable

N=9: 3 cis, 6 trans; 2, 1, 1, 5

MotSurgMatch Surgery to make outsides match inner sense of self

N=6: 3 cis, 3 trans; 2, 1, 2, 1

MotSurgSex Surgery to aid sexual self (e.g., inspire people to touch breasts)

N=2: 0 cis, 2 trans; 0, 0, 2, 0

ACCESSING SURGERY

Messages about Surgery

RelSurgComm Respondent had relationship to surgery community

N=25: 5 cis, 20 trans; 1, 4, 10, 10

Messages about basic or general requirements:

SMsgHealth Messages about being in optimum health before surgery (weight, smoking, drinking)

N=15: 6 cis, 9 trans; 3, 3, 4, 5

SMsgIns Messages about insurance coverage for surgery

N=2: 1 cis, 1 trans; 0, 1, 0, 1

Messages about factors that could limit autonomously choosing surgery:

SMsgAge Messages about needing to fulfill age requirement before surgery

N=2: 1 cis, 1 trans; 0, 1, 0, 1

SMsgTherapy Messages about needing therapy prior to surgery

N=13: 1 cis, 12 trans; 0, 1, 6, 6

Messages that related to gender expectations:

SMsgGender Messages about gender expression affecting surgery eligibility

N=8: 0 cis, 8 trans; 0, 0, 2, 6

SMsgRLE Messages about doing a real-life experience before surgery

N=9: 0 cis, 9 trans; 0, 0, 4, 5

SMsgHorm Messages about surgery related to needing to be on hormones

N=4: 0 cis, 4 trans; 0, 0, 0, 4

SMsgStealth Messages about needing to go stealth post-surgery

N=2: 0 cis, 2 trans; 0, 0, 1, 1

Reasons for Choosing Surgeon

SurgnChoiceShop R shopped around for surgeons

N=24: 10 cis, 14 trans; 3, 7, 5, 9

SurgnChoicePract Surgeon choice due to practical reasons (location, cost)

N=15: 4 cis, 11 trans; 0, 4, 4, 7

SurgnChoiceReput Surgeon choice due to surgeon's reputation

N=34: 18 cis, 16 trans; 9, 9, 8, 8

SurgnChoiceTrans Surgeon choice due to surgeon's relation to trans community

N=4: 0 cis, 4 trans; 0, 0, 2, 2

SurgnChoiceSkill Surgeon choice due to surgeon's skills (experience, talent)

N=24: 10 cis, 14 trans; 5, 5, 6, 8

SurgnChoiceBedside Surgeon choice due to surgeon's bedside manner

N=20: 9 cis, 11 trans; 4, 5, 4, 7

SurgnChoiceGen Surgeon choice due to surgeon's gender

N=3: 2 cis, 1 trans; 2, 0, 1, 0

Convince Role of others in R's surgery decision

N=3: 2 cis, 1 trans; 2, 0, 1, 0

RAnxiety R felt anxious about getting surgery

N=7: 4 cis, 3 trans; 3, 1, 0, 3

SupportNeed R needed support from others for surgery decision

N=11: 6 cis, 5 trans; 3, 3, 2, 3

Provider/Patient Interactions – General

SurgnExplain Surgeon explained what surgery will and won't do

N=31: 18 cis, 16 trans; 9, 9, 8, 8

SurgnGendDiffs Surgeon discussed gender differences related to surgery

N=2: 2 cis, 0 trans; 0, 2, 0, 0

SurgnLook Surgeon told R surgery will make R look

N=10: 8 cis, 2 trans; 5, 3, 0, 2

SurgnFeel Surgeon told R how surgery will make R feel

N=4: 3 cis, 1 trans; 3, 0, 1, 0

SurgnRecommend Surgeon recommended R get other surgery

N=11: 5 cis, 6 trans; 4, 1, 4, 2

RAskOther R asked surgeon about doing other procedures

N=8: 5 cis, 3 trans; 4, 1, 0, 3

SurgnDiscount Surgeon offered R discount for surgery

N=4: 0 cis, 4 trans; 0, 0, 2, 2

HIns R explained health insurance coverage for surgery

N=12: 9 cis, 3 trans; 4, 5, 1, 2

SurgnCode Surgeon coded surgery in way to aid insurance coverage

N=6: 3 cis, 3 trans; 1, 2, 1, 2

SurgnLetter Surgeon provided R with letter post-surgery

N=3: 0 cis, 3 trans; 0, 0, 1, 2

SurgnAftercare Surgeon provided aftercare

N=9: 4 cis, 5 trans; 1, 3, 2, 3

SurgnRev Surgeon did revision of procedure

N=5: 2 cis, 3 trans; 0, 2, 1, 2

Positive bedside manner (N=19: 8 cis, 11 trans; 4, 4, 3, 8):

SurgnProf R described surgeon as professional

- N=17: 10 cis, 7 trans; 7, 3, 4, 3
- SurgnComfort** Surgeon made R feel comfortable
N=11: 6 cis, 5 trans; 5, 1, 1, 4
- SurgnLikable** R described surgeon as likable (funny, cool)
N=8: 0 cis, 8 trans; 0, 0, 3, 5
- SurgnUnderstand** Surgeon understood what R wants
N=5: 4 cis, 1 trans; 3, 1, 0, 1
- SurgnSensitiveHist** Surgeon seemed sensitive to R's history
N=2: 1 cis, 1 trans; 1, 0, 0, 1
- SurgnRelLGBTComm** Surgeon's relationship to LGBT community made him/her sensitive to R's needs/wants
N=8: 1 cis, 7 trans; 0, 1, 3, 4
- SurgnBeyond** Surgeon went above and beyond capacities as a surgeon
N=4: 1 cis, 3 trans; 0, 1, 0, 3
- Negative bedside manner (N=9: 6 cis, 3 trans; 2, 4, 1, 2):*
- SurgnInsen** R described surgeon as insensitive to R, to R's wants/needs
N=2: 0 cis, 2 trans; 0, 0, 2, 0
- Surgn\$** R described surgeon as financially motivated
N=8: 2 cis, 6 trans; 1, 1, 3, 3
- SurgnGen** Surgeon did gender for R
N=4: 1 cis, 3 trans; 1, 0, 2, 1
- SurgnSexual** Surgeon made sexual/flirty remark about R
N=5: 1 cis, 4 trans; 1, 0, 3, 1

Provider/Patient Interactions – Gatekeeping

- HealthProb** R had health problems (physical and mental) that could have affected access to surgery
N=17: 6 cis, 11 trans; 4, 2, 5, 6
- SReqsHealth** Surgeon ensured good, general physical health (internal exam, intake form disclosures, smoke, drink, weight, stop hormones)
N=35: 15 cis, 20 trans; 9, 6, 10, 10
- SReqsTherapy** Surgeon required therapy or therapist letter
N=8: 0 cis, 8 trans; 0, 0, 3, 5
- Therapy** R had counseling before surgery where surgery discussed
N=20: 3 cis, 17 trans; 2, 1, 9, 8
- TherapyForLetter** R pursued therapy in anticipation of needing letter
N=17: 0 cis, 17 trans; 0, 0, 9, 8
- TherapyLetter** R described getting authorization letter for surgery
N=18: 0 cis, 18 trans; 0, 0, 9, 9
- TherapyDiag** R described getting diagnosed in therapy
N=6: 2 cis, 4 trans; 2, 0, 1, 3
- TherapistLax** R described therapist as lax about requirements, supportive
N=12: 1 cis, 11 trans; 1, 0, 7, 4
- TherapistQuestion** R said therapist questioned R's decisions/pursuits

N=9: 2 cis, 7 trans; 1, 1, 2, 5

Therapist\$ R described therapist as financially motivated

N=4: 0 cis, 4 trans; 0, 0, 0, 4

TherapistNeg R described therapist as harmful

N=2: 0 cis, 2 trans; 0, 0, 1, 1

SurgnLax R described surgeon as lax regarding regulations

N=15: 4 cis, 11 trans; 2, 2, 5, 6

SurgnQuestion R said surgeon questioned R's surgery decision or request

N=9: 5 cis, 4 trans; 3, 2, 2, 2

SurgnDeny R said surgeon denied services to R

N=4: 0 cis, 4 trans; 0, 0, 2, 2

RUnderstandGate R understood/excused gatekeeping

N=4: 0 cis, x=4 trans; 0, 0, 2, 2

POST-SURGERY EXPERIENCE

Factors that Aided Access to Surgery

Individual presentation (from most to least common):

FactorAidConf Exuding confidence or self-determination aided access to surgery

N=21: 10 cis, 11 trans; 4, 6, 7, 4

FactorAidFem R's normative gender expression aided access to surgery

N=17: 4 cis, 13 trans; 4, 0, 6, 7

FactorAidSane Being viewed as a sane person aided access to surgery

N=2: 1 cis, 1 trans; 1, 0, 0, 1

FactorAidLike Being likeable aided access to surgery

N=2: 0 cis, 2 trans; 0, 0, 2, 0

FactorAidLuck Being lucky aided access to surgery

N=2: 0 cis, 2 trans; 0, 0, 1, 1

Access to resources (from most to least common):

FactorAid\$ Financial resources aided access to surgery

N=30: 16 cis, 18 trans; 9, 7, 10, 8

FactorAidTiming Having time aided getting surgery

N=16: 10 cis, 6 trans; 6, 4, 3, 3

FactorAidResearch Having ability to research surgery aided surgery

N=15: 9 cis, 6 trans; 1, 8, 2, 4

FactorAidSupport Having support of others aided surgery

N=14: 8 cis, 6 trans; 3, 5, 4, 2

FactorAidSurgn Having access to good surgeon aided getting surgery

N=6: 4 cis, 2 trans; 1, 3, 0, 2

FactorAidProx Having surgeon nearby aided access to surgery

N=4: 1 cis, 3 trans; 0, 1, 3, 0

FactorAidRecov Having a place to recover aided access to surgery

N=1: 0 cis, 1 trans; 0, 0, 1, 0

Factors that Prevented or Stalled Surgery

Individual presentation (from most to least common):

FactorPreventDoubt R's own doubts stalled surgery

N=10: 8 cis, 2 trans; 3, 5, 1, 1
FactorPreventHealth Having a health issue stalled surgery
 N=3: 0 cis, 3 trans; 0, 0, 2, 1
FactorPreventAge Age restrictions stalled surgery
 N=2: 1 cis, 1 trans; 0, 1, 0, 1
Access to resources (from most to least common):
FactorPrevent\$ Lacking financial resources stalled surgery
 N=15: 2 cis, 13 trans; 1, 1, 5, 8
FactorPreventTiming Timing issues stalled surgery
 N=6: 2 cis, 4 trans; 1, 1, 3, 1
FactorPreventSupport Lacking support stalled surgery
 N=5: 2 cis, 3 trans; 0, 2, 1, 2
FactorPreventDeny Healthcare providers denied services
 N=5: 1 cis, 4 trans; 1, 0, 2, 2
FactorPreventTherapy Having to get therapy stalled surgery
 N=2: 0 cis, 2 trans; 0, 0, 0, 2
FactorPreventProx Location of surgeon stalled surgery
 N=1: 0 cis, 1 trans; 0, 0, 1, 0

Others' Reactions to Surgery

From most to least common:
Reactions+Support Others supported surgery
 N=28: 12 cis, 16 trans; 8, 4, 7, 9
Reactions-Unsupp Others did not support surgery
 N=16: 4 cis, 12 trans; 2, 2, 5, 7
Reactions+Praise Others praised R about surgery results
 N=15: 9 cis, 6 trans; 5, 4, 4, 2
Reactions-Judge Others negatively judged surgery decision
 N=14: 8 cis, 6 trans; 5, 3, 5, 1
ReactionNeutSurprise Others surprised about surgery decision
 N=12: 8 cis, 4 trans; 3, 5, 3, 1
ReactionNone Others had no reaction to surgery
 N=8: 6 cis, 2 trans; 5, 1, 1, 1
Reactions-Adjust Others had hard time adjusting to R's surgery
 N=6: 1 cis, 5 trans; 0, 1, 1, 4
Reactions-Risk Others told R surgery is risky
 N=5: 4 cis, 1 trans; 2, 2, 1, 0
ReactionsNeutAwk Others reacted awkwardly to surgery news
 N=1: 0 cis, 1 trans; 0, 0, 0, 1

Respondents' Thoughts on Surgery

From most to least common:
ViewSTransform Viewed surgery as transformative
 N=15: 9 cis, 6 trans; 5, 4, 4, 2
ViewSNorm Viewed surgery as normative
 N=10: 7 cis, 3 trans; 3, 4, 1, 2

ViewSIndpt Viewed surgery as independent decision

N=8: 6 cis, 2 trans; 4, 2, 2, 0

ViewSPerform Viewed surgery as performative

N=6: 2 cis, 4 trans; 1, 1, 4, 0

Respondents' Thoughts on Gatekeeping

YesBDDGID Felt like BDD/GID applied personally (possibly or definitely)

N=13: 4 cis, 9 trans; 2, 2, 4, 5

GIDDisorder Supported GID being classified as disorder

N=3: 0 cis, 3 trans; 0, 0, 3, 0

DiagIns Considered use of diagnosis and insurance

N=11: 0 cis, 11 trans; 0, 0, 6, 5

YesTherapy Definitely supported counseling/therapy before surgery

N=7: 7 cis, 0 trans; 4, 3, 0, 0

OkTherapy Somewhat supported counseling/pre-surgery screening

N=10: 5 cis, 5 trans; 1, 3, 3, 2

NoTherapy Generally did not support counseling/therapy before surgery

N=6: 4 cis, 2 trans; 1, 3, 2, 0

NoPathol Rejected/questioned pathologization of gender diversity

N=14: 0 cis, 14 trans; 0, 0, 6, 8

The Effects of Surgery

Satis Satisfaction with surgery

Very Satisfied N=23: 12 cis, 11 trans; 7, 5, 7, 4

Satisfied N=11: 5 cis, 6 trans; 2, 3, 1, 5

Not satisfied N=1: 0 cis, 1 trans; 0, 0, 0, 2

Mixed satisfaction (due to multiple surgeries) N=5: 3 cis, 2 trans; 1, 2, 2, 0

SatisCompar Satisfaction with surgery compared to others

Better N=15: 8 cis, 7 trans; 2, 6, 5, 2

About same N=19: 10 cis, 9 trans; 8, 2, 4, 5

Worse N=1: 0 cis, 1 trans; 0, 0, 0, 1

SEffectHealth Surgery improved R's physical health

N=3: 3 cis, 0 trans; 0, 3, 0, 0

SRegret R had regrets related to surgery

N=9: 5 cis, 4 trans; 3, 2, 4, 0

SEffectNeg Surgery had a negative effect

N=14: 5 cis, 9 trans; 3, 2, 5, 4

SEffectPain Surgery/recovery was painful

N=11: 5 cis, 6 trans; 3, 2, 4, 2

OtherProc Other procedure was better than surgery

N=2: 0 cis, 2 trans; 0, 0, 1, 1

Cosmetic benefits:

SEffectNoBigDiff Surgery did not make a big difference

N=7: 3 cis, 4 trans; 2, 1, 4, 0

SEffectLookDiff Surgery made R look different

N=4: 3 cis, 1 trans; 2, 1, 1, 0

SEffectLookBetter Surgery made R look better
N=40: 20 cis, 20 trans; 10, 10, 10, 10

SEffectAttention Surgery brought R attention
N=4: 2 cis, 2 trans; 2, 0, 1, 1

SEffectYoung Surgery made R look younger
N=6: 3 cis, 3 trans; 3, 0, 3, 0

SEffectEnhanceFem Surgery enhanced gender expression
N=25: 11 cis, 14 trans; 8, 3, 7, 7

SEffectPass Surgery helped R pass as preferred gender (matching/congruence between inner and outer self)
N=14: 2 cis, 12 trans; 2, 0, 7, 5

Psychological benefits:

SeffectFeelBetter Surgery made R feel better
N=34: 16 cis, 18 trans; 10, 6, 10, 8

SEffectConf Surgery made R feel confident
N=13: 7 cis, 6 trans; 4, 3, 2, 4

SEffectComf Surgery made R feel comfortable
N=11: 4 cis, 7 trans; 1, 3, 2, 5

SEffectFeelFree Surgery helped R feel free
N=8: 2 cis, 6 trans; 2, 0, 3, 3

SEffectSex Surgery affected R's sexuality: drive, confidence, sensation, ability to attract
N=10: 5 cis, 5 trans; 2, 3, 4, 1

FutureSPlans R's plans for future surgery
Yes N=8: 0 cis, 8 trans; 0, 0, 7, 1
Maybe N=12: 6 cis, 6 trans; 3, 3, 3, 3
No N=20: 14 cis, 6 trans; 7, 7, 0, 6

OTHER

Out Being out about surgery (or not)

OutTrans R's degree of being out as trans

Pass R discussed ability to pass as preferred gender (unrelated to surgery)

ImptFemin Importance of R's gender expression to R

Horm R discussed hormone use

Figure 2.4 Final Post-Axial Code List with Comparison Details

CHAPTER 3 – LEARNING COMMUNITY NORMS

To better understand the nature of surgical body modification, I conducted preliminary analyses of two media: an online cisgender surgery community and a collection of surgery protocols for transgender people. Content analyses of these two components preceded interviews with people who had gotten surgery. The findings from these content analyses helped inform interview schedules, providing a more thorough understanding of surgical body modification and enriching subsequent data collection. Ultimately, they illuminated norms regarding transgender and cisgender surgical body modification.

Themes from an Online Cisgender Surgery Community

The online cisgender surgery community at MakeMeHeal.com (MMH) hosted many different discussions about surgeries. Much of what the MMH community discussed related to presurgical anxieties and postsurgical healing. These topics were so common that they became mundane. Topics such as these framed the basics of the message boards. These topics consisted of prospective surgery consumers seeking information about surgery types, methods, and costs. They also sought insider information on specific surgeons, often those close to their residences. Some posts focused on presurgical anxieties. People questioned whether surgery was the right decision. They worried about surgery risks, and wondered how much time they should devote to recovery before returning to work. Many posts included detailed concerns about postsurgical experiences. Users discussed the recovery process, endlessly asking if the swelling, scarring, and pain they were experiencing was normal. People discussed healing aids, such as compression garments, creams, vitamin regimens, exercise, and massage. Some wondered about the type of clothing to wear during recovery, and how long before they could resume physical activities such

as working out and having sex. Others wondered if they needed revisions to their surgeries and discussed the logistics of these procedures. Some users asked others about when they needed to contact surgeons about their concerns, and the appropriate frequency of such communications. Other mundane posts included users who posted before-and-after photographs for readers' comments. In response, they usually received supportive and congratulatory feedback. Occasionally, responders agreed with posters who asked if viewers thought they needed a revision.

Most of the surgery boards were women-dominated. Perhaps this is why the operators created threads specific to a few men's surgeries. Despite this gender imbalance, both women and men discussed positive receptions from their partners following the surgery, and these posters often alluded to positive sexual repercussions. At times, some women posted about partners who did not want them to pursue surgery. Overall, posters seemed to exhibit a good amount of reflexivity. They often discussed how, due to their own body issues, they obsessed more about their features than others actually noticed.

A few posts stood out as less ordinary and unique. One theme that emerged was that people interested in buttock augmentation tended to be women of color. In most threads, race was not easy to interpret because users rarely identified their races. But in addition to a username, MMH users could also create an avatar. These avatars were photographs, animated people, or inanimate objects. Most of the avatars in threads devoted to buttock augmentation were clearly raced. In the buttock augmentation section, users appeared to be mostly Latina and African American women based on the races of the avatars used by the posters in the threads. This race difference suggests that the gendered aspects of surgical body modification are also raced.

Another noteworthy theme was that people seemed more concerned about the healing of facial surgeries. Procedures like rhinoplasty, otoplasty (ear surgery), and facelifts seemed to generate more of a panicked tone in users concerned about postsurgical issues like swelling and bruising. This may be because the face is generally not covered, unlike the torso or limbs. Complications on the face are not as easy to disguise. Another explanation may be that people look at their faces more than other body parts and may be more aware of any irregularities.

Cisgender-Transgender Connections in an Online Surgery Community

The overall research project is comparative. With this in mind, the analysis of MMH included attention to possible connections between transgender and cisgender surgery consumers. Although I did not analyze any transgender-specific message boards, my previous research and existing literature informed the comparative analysis of MMH. The analysis included noting potential similarities between transgender and cisgender populations. Some themes were evident across different types of surgeries. Others were concentrated in specific surgery types. The MMH community demonstrated six main themes that appeared related to transgender concerns: a community of support, membership exclusivity, an “us” versus “them” mentality, alienation from the body, emphasizing bodily autonomy, and psychotherapy solutions.

A community of support. Throughout the different types of surgeries, the cisgender community appears similar to the transgender community in one main way. The MMH forum is a community of support. Users seek and offer support from others who have been through similar experiences. They laud each other’s successes and lament each other’s tribulations. At MMH, users can discuss their experiences openly and honestly, without judgment. This sense of community through shared experiences is common among transgender people (Schrock, Holden,

and Reid 2004). Like transgender people who seek surgical transition, MMH community members bond over transforming their bodies in similar ways.

Membership exclusivity. The MMH community appears similar to transgender surgery consumers based on themes evident in surgery-specific threads. One theme is that of membership exclusivity. For example, the breast augmentation board frequently referenced a special community to which all breast augmentation recipients belonged. Members welcomed others into “the boobie club” and invoked “girl power” in their camaraderie. Together, they celebrated exciting new clothing possibilities. These types of online communications seemed similar to the congratulatory ethos among transgender people who undergo gender-confirming surgeries.⁵ Some transgender people celebrate the cross-gender journey as special and unique (Towle and Morgan 2006).

“Us” versus “them” mentality. Within this exclusive community, MMH users often distinguished themselves from others who did not or could not understand their desires for surgery. For example, in the breast augmentation boards, women often challenged people who criticized their decisions. They relayed examples of what to tell unsupportive employers, family members, or random rude men who felt obligated to comment on their choices. Here, users talked about stigma and the need to educate others. Posters in the breast reduction boards also bonded over the insensitivity of others. In these stories, MMH users solidified their online communities by distinguishing themselves from others who could not personally relate to their experiences, or, in some cases, objected outright to their surgeries. Within transgender communities, people often talk about having to deal with outsiders who do not understand transgender experiences and desires for surgical transition. Transgender people often report

⁵ For examples of this ethos, see this thread from an online transgender forum (<http://www.susans.org/forums/index.php?topic=66305.0>) and the comments on this YouTube.com post (http://www.youtube.com/verify_age?next_url=http%3A//www.youtube.com/watch%3Fv%3DqEKPz5zuDjc).

encountering resistance from others when they live in their desired gender (Schrock, Holden, and Reid 2004). They also discuss the need to fight against stigma through educating others about their experiences. Many transgender people reported having to educate their own healthcare providers about their needs (Grant et al. 2010).

Alienation from the body. Some users in MMH discussed how alienated they felt from their own bodies. They discussed how their bodies did not fit or seem right, and expressed the need to fix their appearances. For example, a MMH poster in the cosmetic hand/foot surgery boards expressed feeling like a freak due to having short fingers. He talked about hiding his hands due to this shame. In the male breast reduction boards, men wrote about feeling emotionally devastated for having breasts. They wore loose-fitting shirts to conceal their shapes. This alienation and shame associated with the body led some people to seek surgery. A common narrative among transgender people is that of feeling “trapped in the wrong body” and needing to change one’s gendered embodiment (Meyerowitz 2002).

Emphasizing bodily autonomy. A theme that often followed MMH users invoking the “us-versus-them” mentality was that of emphasizing personal autonomy over one’s own body. MMH members frequently challenged critics’ resistance by stressing that they could do whatever they wanted to their own bodies. For example, in the blepharoplasty (eyelid surgery) boards, MMH members lamented that others believed surgery was about vanity. They stressed that surgery was about feeling disillusioned, disappointed, and even disfigured, and then doing something to change that. Another MMH user in the breast augmentation boards asserted that it was not wrong to do something for herself after nursing three children. Users like these often stressed that they should be able to control their own bodies. They asserted that surgery consumers were honest for admitting their struggles and brave for choosing to make changes.

MMH users frequently discussed their research of the types and technicalities of surgeries without any sense of defensiveness or uncertainty. Consumers valued decisions to change their bodies with convictions that were often unflinching. Although they may have been certain about their choices, they may have also felt compelled to rationalize an unpopular body modification. But like the MMH users, transgender people often state that they should be able to have control over their own bodies (Spade 2006; Stryker 1997).

Psychotherapy solutions. Within the analysis, one thread included a narrative about a doctor who suggested that a MMH user get counseling prior to getting labiaplasty. Unlike transgender people, cisgender surgery consumers typically are not required to get therapy to authorize surgery (Hausman 1995; Spade 2006). But this instance, however rare, suggests that some healthcare providers may suggest counseling prior to surgery – especially genital surgery.

The above six themes helped illuminate possible similarities and differences between cisgender and transgender surgery communities. They provoked contemplation of comparisons between the two groups and made me more attentive to issues related to costs of procedures, insurance coverage, respondents' relationship to surgery communities, importance of support for surgery, feelings about the body before surgery, hiding body parts before surgery, others' reactions to surgery, and surgery's effect on feeling masculine/feminine during interviews.

Overall, the analysis of the MMH message boards resulted in a deeper familiarity with the central concerns of cisgender surgery community, especially concerning their interests in and motivations for surgery. It also facilitated a greater sense of preparedness in conducting interviews with people who have gotten these surgeries. Finally, it confirmed the importance of interviewing people who have had diverse types of surgery (e.g., more gendered surgeries like breast augmentation versus less gendered procedures like liposuction).

Themes from Transgender Surgery Protocols

Regulations of surgeries for transgender people are numerous. Various organizations and countries have published guidelines for treating people seeking gender-confirming medical and surgical procedures. In contrast, regulations of cisgender surgeries are scant. Some guidelines exist for specific cisgender surgery patients, such as children with cleft or craniofacial conditions⁶ (Kapp-Simon 2006). Other than these guidelines for surgery on specific bodily manifestations, no standards exist for all cisgender people who want surgery. To verify the lack of a standard protocol for cisgender surgical body modification, I contacted the American Academy of Cosmetic Surgery, the American Society of Plastic Surgeons, the American Association of Plastic Surgeons, the American Society for Aesthetic Plastic Surgery, the American Society of Plastic Surgical Nurses, and the American Cosmetic Surgery Network. None of these organizations provided information about standards of care. However, a representative from the American Board of Plastic Surgery said that ASPS and ASAPS have standards of care. I was unable to locate any standards published by these groups other than the ASPS's professional code of ethics (ASPS 2009). In addition, a 2006 textbook of psychological issues in surgical body modification includes information about professional, ethical, and legal considerations, but it does not list formal, specific guidelines outlining the appropriate steps for cisgender consumers to complete before surgery (Sarwer et al. 2006). Aside from meeting basic presurgical requirements, such as maintaining healthy weight, obtaining medical clearance, and quitting smoking, cisgender surgery consumers encounter few obstacles to their desired procedures. As shown in the analysis of the online surgery message boards, few consumers of surgeries discussed having to meet any surgery pre-requirements. Few mentioned having their

⁶ These standards of care focus on pediatric surgery, and refer to mental healthcare as a supportive aid in psychosocial development, not as an absolute presurgical requirement (American Cleft Palate - Craniofacial Association 2009).

decisions regulated or even questioned by surgeons. These different regulations for transgender and cisgender consumers represent the central justification for this dissertation research project.

Although transgender people's surgeries provoke special regulations among healthcare providers, these regulations are not uniform. After reviewing 15 policies related to these surgeries, the WPATH Standards became the central point of comparison. The WPATH Standards are widely recognized as the authoritative standards of care for people who seek medical assistance in cross-sex gender expression (Brown, 2001; Brown and Rounsley 1996; Ettner, Monstrey, and Eyler 2007; Gorton, Buth, and Spade 2005; Lev 2004; Oriel 2000). Their name implies that they are also internationally governing. For these reasons, they provide a useful starting point from which to compare all other protocols.

WPATH: The authoritative protocol. The Standards of Care published by the World Professional Association for Transgender Health (WPATH) represented the starting point of this analysis. WPATH is the leading multidisciplinary and international organization dedicated to transgender healthcare. Previously, their name was the Harry Benjamin International Gender Dysphoria Association. The WPATH Standards, also known as *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorder*, are the 6th version of the standards of care produced by this organization. An 18-member committee constructed this 2001 publication which provides "flexible directions" for mental and medical healthcare providers in assisting transgender clients (Meyer et al. 2001:1). The WPATH Standards outline eligibility and readiness criteria for medically regulated hormonal and surgical transition.

The WPATH Standards recommend that surgeons receive training in transgender healthcare. The Standards distinguish between top surgeries (male-to-female breast augmentation

and female-to-male chest reconstruction) and lower or bottom surgeries (genitals and internal sex organs). Although the WPATH Standards mention facial surgeries for trans women as feminizing, they do not focus on the importance of the face in transgender transitions. Instead, they exclude facial feminization surgeries from needing external authorization therapy letters (Meyer et al. 2001). This omission ignores the importance of “face work” in doing gender (Talley 2008).

The WPATH Standards treat top surgeries as similar to hormones, describing both as “relatively irreversible” (Meyer et al. 2001:20). To get top surgeries, trans people should be at least 18 years old. For those under 18, they must first negotiate a two-year real-life experience (RLE) in their desired gender. Adult surgery candidates should have lived for three months in the desired gender or have three months of psychotherapy. Trans people should also be able to demonstrate further consolidation of their desired gender, knowledge of the risks and benefits of the surgery, and improved or stable mental health. Before top surgery, the WPATH Standards recommend that trans people secure one letter from a therapist who can provide authorization for surgery. The letter should include the following seven points:

1. The patient’s general identifying characteristics;
2. The initial and evolving gender, sexual, and other psychiatric diagnoses;
3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
4. The eligibility criteria that have been met and the mental health professional’s rationale for hormone therapy or surgery;
5. The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;
6. Whether the author of the report is part of a gender team;
7. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document (Meyer et al. 2001:7-8).⁷

⁷ The “gender team” referenced in the sixth point is defined as “an interdisciplinary team of professionals who specialize in gender identity disorders” (Meyer et al. 2001:19). This team includes healthcare providers who assist transgender people during the transition process, such as therapists, endocrinologists, and surgeons.

Despite these specifications, the WPATH Standard state that therapy is not always required before starting medical transition.

The WPATH Standards view genital surgeries as irreversible and serious: “Genital surgery is not a right that must be granted upon request” (Meyer et al. 2001:20). The protocol for genital surgery is more restrictive. Prior to genital surgery, prospective patients must stay on hormones continuously for one year and consistently live in the desired gender identification for that year. The WPATH Standards suggest that genital surgery candidates should have adequately dealt with interpersonal issues regarding work and family, resulting in improved wellbeing. A person must reach the legal age of majority for genital surgery and should have consolidated living as the desired gender. For bottom surgeries, the WPATH Standards “generally” (Meyer et al. 2001:8) require two therapy letters. However, they state that therapy itself is not required, but that therapists and clients may agree to meet according to their own arrangements. Candidates should express knowledge about surgery costs and surgeons. The WPATH Standards advise surgeons to obtain necessary background medical information from patients and their providers.

The guidelines in WPATH are largely prescriptive and invoke a model of psychomedical authority. The WPATH Standards contain detailed specifications for transgender people seeking surgeries, which are useful for comparing other protocols. Among the remaining 14 protocols, three types existed: those that used the WPATH Standards, those that rejected the WPATH Standards, and those that did not mention the WPATH Standards.

Protocols that used the WPATH Standards. Most commonly, the existing protocols for surgeries among transgender people stated that they follow the WPATH Standards. Of the 14 other sources in the sample, 10 protocols referenced using the WPATH Standards to some degree (Table 2.2, sources 1, 6, 7, 8, 10, 11, 12, 13, 14, 15). Among these 10 protocols, one

source cited the WPATH Standards, but it is unclear how they influenced policy (source 10). Two of the 10 protocols appeared to follow the WPATH Standards exactly, but also provided more details about transition processes (sources 1, 12), such as relaying issues affecting transgender people throughout the life course, discussing insurance coverage, and providing age-specific medical screenings. Seven of the 10 protocols referenced using the WPATH Standards, but amended them in some way (sources 6, 7, 8, 11, 13, 14, 15). Some of these protocols recommended consulting the WPATH Standards, but offered additional guidelines as well. Some protocols only slightly amended the WPATH Standards to suit national healthcare systems. Others referenced different published standards as additional guides. In a somewhat unusual endorsement, two sources recommended using the WPATH Standards but also critiqued them. Of these two documents, one distrusted that WPATH based their guidelines on research from restrictive gender clinics, but emphasized using them because of their inherent flexibility. Another lamented the inconsistencies of the WPATH Standards and rejected not making therapy a requirement. Thus, protocols that used the WPATH Standards did so in diverse ways that belie the uniform authority of WPATH. However, the inherent flexibility asserted within the WPATH Standards set the stage for such divergent applications of these guidelines.

Protocols that rejected the WPATH Standards. Out of the other 14 protocols, 2 explicitly rejected the WPATH Standards (sources 2, 3). Source 3 critiqued the WPATH Standards as too narrow and pathologizing, but then introduced guidelines very similar to those standards. Source 2 rejected therapy requirements as a central part of their critique of the WPATH Standards, but listed other recommendations like suggested time on hormones before surgery. These standards appear to have been created in response to limits of the WPATH Standards.

Protocols that did not mention the WPATH Standards. Two protocols in the sample did not mention the WPATH Standards at all (sources 4, 9). Both of these protocols offered parameters for treatments. The Italian standards (source 4) listed brief guidelines for treatment. For example, this protocol requires treatment of other psychiatric conditions prior to starting medical transition. It also indicates that SRS warrants a court order after two years of starting transition. Despite these restrictions, the Italian standards promote an ideology of self-determination and allow changing criteria under certain circumstances. In the second case, the draft document published by the Royal College of Psychiatrists (source 9) in the United Kingdom promoted an acceptance of transgender diversity. But it outlined various recommended courses of treatment, such as counseling before and during the RLE and two referrals for both top and bottom surgeries. Because this draft is not yet official policy, these conclusions are tentative. Although these two protocols do not reference the WPATH Standards in print, they appear to be influenced by them in that they use similar language and treatment trajectories as what appears in WPATH. Experts on trans healthcare in the United Kingdom state that although the WPATH Standards carry some authority, as evidenced by legal proceedings that have referenced them (King 2010), the final publication of the Royal College of Psychiatrists will carry more authority than the National Health Service guidelines (source 13) (Wylie 2010).

These three types of protocols demonstrate the popularity of the WPATH Standards. Most of the protocols in the sample used them to some degree. Even in explicit critiques or rejections of the WPATH Standards, their status as a primary reference point for other authorities is apparent. At least seven countries have created protocols that use the WPATH Standards. These protocols suggest that the WPATH Standards have international relevance.

Although many of the protocols reference the WPATH Standards, some have modified the requirements for surgeries. Flexibility and case-by-case assessments are inherent in the WPATH Standards. Other authoritative bodies may claim to base protocols on the WPATH Standards even when they alter them. The WPATH Standards outline specific procedures, but these are guidelines. Clinicians may choose to impose additional restrictions or may require fewer criteria to be met before conferring surgery. The intrinsic flexibility of the WPATH Standards allows for universality. Agencies may loosen requirements, or create additional ones. This flexibility, however, also lessens their power. The WPATH Standards are paper tigers that lack legislative authority over healthcare providers. They lack consistent, uniform application. This situation leaves both providers and consumers with competing interpretations of documents that claim to follow the WPATH Standards. For example, CAMH (source 15) requires prospective surgery applicants to be at least 21 years old and undergo a two-year RLE before surgery. CAMH staff members are the only authorities who can refer Canadian applicants to surgery. In contrast, Lev's *Transgender Emergence* (source 7) recommends – but does not require – therapy before surgery. She does not require that applicants meet a minimum age or specific time in the real life experience. Instead, Lev describes her guidelines as an empowerment model based on informed consent. Both doctrines claim to use the WPATH Standards, but they offer starkly different protocols for treatment.

The universality of the WPATH Standards is also limited when considering several cross-cultural issues. Although the WPATH Standards are heralded as international guidelines, some countries still need to create their own protocols. In addition to the sources included in the sample, Germany, Spain, and Brazil have devised their own treatment plans. The German Society for Sexual Research produced national standards more applicable to Germans than the

WPATH Standards (Becker et al. 1998). The Andalusia Gender Team in southern Spain also established its own criteria (Dickey 2010). An online counseling service, or “e-therapy” center, based in Brazil criticized the WPATH Standards as ineffective in many cultures around the world. This center asserted that the WPATH Standards are unrealistic in most Latin American countries where the provider-patient ratio is hugely disproportionate. Practicing the year-long RLE may also have dangerous outcomes for people in marginalized communities (Gendercare Gender Clinic 2006).

The situation for transsexuals in Thailand presents another challenge to the WPATH Standards. In 2009, the Medical Council of Thailand passed legislation that regulates transsexual surgeries. The Medical Council is the healthcare arm of Thai government. It created rules to protect Thai transsexuals and to streamline previously unorganized healthcare practices on transsexuals (Lolaeka 2009b). Before getting SRS, a person must get approval from at least two psychiatrists. Non-Thai foreigners that have obtained psychiatric evaluations in their home countries must also be evaluated by a Thai psychiatrist (Lolaeka 2009a). Historically, Thailand has been a popular destination for non-Thai transsexuals who sought affordable surgeries with lenient practitioners. This legislation may affect Thailand’s reputation as an SRS destination. In addition, the legislation supersedes WPATH as an international authority.

To conclude, protocols for transgender people’s surgeries vary widely. Even when protocols follow the WPATH Standards, guidelines may differ based on the needs of the authorizing agency. A transgender person’s access to surgery will depend on the treatment philosophies held by surgeons. Depending on the practitioner, transgender experiences with surgery requirements will vary. However, several eligibility criteria frame most transgender surgeries. Most candidates for surgery need to be at least 18 years old. They need to have spent

time in therapy and procured an authorizing letter from a therapist. They need to be established on hormones in most cases, and need to demonstrate that they have lived in their desired gender for about a year.

Surgery Norms among Two Communities

This research began with two content analysis projects. Both projects revealed a series of norms related to cisgender and transgender surgical body modification. In the online community of cisgender consumers, users discussed issues important to them in getting surgery. Rarely did these users discuss negotiating surgery requirements such as age, counseling, mental health certification, employment stability, or documented gendered experiences. Instead, cisgender consumers focused on the best types of surgeons and surgeons. They worried about healing properly and recovery times. In contrast, the protocols for transgender people's surgeries rarely discussed these mundane realities that preoccupied the cisgender users within the online community. The protocols revealed a series of regulations, establishing criteria transgender consumers must meet prior to surgery. Thus, the community norms marking each component of the content analyses reflect different core issues. Although they are different media – message boards and healthcare protocols – they exist because of one uniting pursuit: body-changing surgery.

The online cisgender community and the surgery protocols for transgender people demonstrate the different ways psychomedical institutions manage surgical body modification. Cisgender people can access surgery without negotiating mental health prerequisites. The online surgery community of cisgender people rarely mentioned concerns about being approved for surgery. Getting authorization for surgery from a therapist was not an issue they needed to worry

about. Instead, they inquired about the technical aspects of surgery and mused about how surgery would benefit them. When surgeons posted to these boards, they answered queries professionally and openly, without regard for assessing if surgery was appropriate for people based on their mental health. The numerous protocols for transgender people seeking surgery, however, demonstrate a primary concern for determining trans people's eligibility for surgery. These publications, coupled with the absence of protocols outlining cisgender people's eligibility for surgery, illustrate the need to regulate surgical body modification only among trans people. Unlike cisgender surgery consumers, these protocols suggest that trans people do not have nearly as much autonomy in pursuing surgery.

The next chapters explore connections between the transgender and cisgender surgery communities. Through interviews with people who had surgical body modification, key points of comparison emerge. These points provide depth to what the internet message boards and healthcare protocols allude. The next chapter examines respondents' experiences before surgery. It relays the beginning stage of surgical body modification by exploring respondents' feelings towards their bodies and motivations for surgery.

CHAPTER 4 – ENHANCING THE SELF THROUGH GENDERING THE BODY: FEELINGS TOWARD THE BODY THAT MOTIVATED SURGERY

In this chapter, I detail findings on the embodied experiences of respondents before they accessed surgery. Transgender and cisgender respondents reported similar feelings about their bodies before surgery. Both groups had members who reported they felt okay, felt self-conscious, and hated their bodies before surgery. In addition, both cisgender and transgender people tried to alter their bodies in nonsurgical ways prior to surgery. When describing motivations for surgery, both groups reported cosmetic and psychological objectives. Data revealed that trans and cis people who choose surgical body modification were in similar psychological and emotional states before surgery. Both groups were as likely to report mild discomfort as well as severe dysphoria. This finding challenges assumptions about cisgender surgery experiences as more cosmetic and transgender experiences as more psychological.

Feeling Okay, Self-conscious, and Hatred: Respondents Feelings toward the Body before Surgery

Respondents reported a range of feelings towards their bodies before surgery. These feelings varied in intensity. Many people reported feeling okay about their bodies before surgery. Others described both negative and positive feelings toward their bodies. Respondents reported feelings related to negative cosmetic associations (feeling fat, unattractive, old, and that the body was hanging) and negative psychological associations (feeling self-conscious, hating the body, feeling unhappy, feeling that the body was inhibiting oneself, and experiencing the body as traumatic or useless). It is important to note that respondents' narratives were not consistently isolated into one type of embodied experience. Instead, respondents reported feelings toward

their bodies that often overlapped across categories. For example, someone might describe feeling okay about her body, but also describe feeling self-conscious about it. Or, someone might describe his body as fat and say that he hated it. Due to these overlapping feelings, these experiences should be viewed as dimensions along a continuum of embodiment. On one end of the continuum people reported feeling okay. On the other end, people described hating their bodies and feeling traumatized by them. Overlaps in feelings toward the body occurred in places where these feelings were not too conceptually distant. Thus, there were no overlaps between respondents reporting feeling okay and also hating the same affected body part. These overlaps account for numbers of respondents in each category that do not add up to 40. More importantly, overlaps in presurgical feelings show that respondents' embodiment before surgery was complex. People typically did not simply dislike their bodies and want to change the way they looked. They experienced a range of sometimes contrasting emotions affected by self-perception, others' reactions, and psychological negotiations. For example, although many respondents felt okay about their bodies, they also reported other embodied experiences that suggest feeling "okay" was complicated by more negative associations.

Data from these common presurgical feelings toward the body show that both transgender and cisgender people experienced bodily discomfort. Their discomfort ranged in intensity, and similarly affected both groups. The congruence between gender groups suggests that cisgender and transgender respondents felt similarly about their bodies. Cisgender and transgender people were just as likely to feel fine about their bodies as they were to feel psychologically impaired. The most commonly reported feelings toward the body before surgery included feeling okay about the body, feeling self-conscious about the body, and feeling hatred toward the body.

Feeling okay about the body before surgery. Surprisingly, the most common reported feeling toward the body before surgery was feeling “okay.” Twenty-two respondents (12 cis, 10 trans) reported that they felt fine about their bodies before they had surgery. Feeling “okay” or “fine” about the body meant that respondents were not that unhappy with their bodies; they just wanted to change them. These respondents tended to have less intense feelings toward their presurgical bodies. Although they all felt their bodies had flaws, their dissatisfaction was not severe. Cis and trans respondents reported similar reactions toward their bodies before they had surgery.

It was just something that, you know, just didn’t obsess me, but just was a part of my body that I wasn’t thrilled with. . . . I mean it’s not something I sort of like dwelled on for years and thought about doing it, it was sort of opportunity arose.
*–Julie, ciswoman, breast augmentation*⁸

I would probably say on like a scale of 1 to 10, like a 4. I mean it didn’t impact my daily life, but it was like - when I would go get dressed up to go out or something, I would look in the mirror and be like, man, if only my ears were a little smaller, I’d feel a little bit better about the situation. So, it wasn’t that big of a deal.
–Anthony, cisman, otoplasty

I just basically wanted much larger boobs. . . . I didn’t like the way they were shaped. I mean, you know, I’m a hottie! [laughs] I mean I’m smoking! [laughs] Let’s face it. I am like on fire with sex appeal. But I always wanted to have these porn star boobs. I wanted the bigger, I wanted the more offset rounder breasts. Now I loved having my hormone breasts just as well, because they were full, B, nice shaped hormone breasts. And they were big, and no one ever questioned the fact if I was a guy. . . . I feel much better about my breasts now, just because they’re the breasts that I wanted, but I didn’t feel bad about my breasts before.
–Eva, transwoman, breast augmentation

It wasn’t like a huge ordeal, but it was enough to where it bothered me. It was definitely more of a bother living in the south, because it’s hotter here. [laughs] So, like having to

⁸ All names are pseudonyms, most of which respondents chose. Quotations are followed by three descriptors: the pseudonym of the respondent quoted, whether the respondent was in the ciswoman, cisman, transwoman, or transman gender group, and the surgery or surgeries to which the respondent referred in the quote. Note that respondents had multiple surgeries and sometimes experienced them differently. In addition, respondents’ self-described gender identities sometimes differed from the general gender subgroup name listed after quotations. In cases where respondents had unique surgeries, such as a cisman who had chest skin removal, I changed the surgery name to the most similar type of surgery in these quotation identifiers to protect confidentiality.

wear two or three t-shirts in the middle of August when it's 95 degrees was definitely not so fun.

–*Jack, transman, chest reconstruction*

As these data illustrate, both trans and cis respondents reported feeling that their affected body parts did not cause them intense despair. Despite the dominant narrative that trans people are always traumatized by their bodies, data from this study show that trans people were as likely as cisgender people to feel okay about their bodies before surgery. These data complicate assertions that transgender people hate their bodies before they are able to change them through surgery. The data also contrast with research that asserts cisgender people pursue surgery due to low self-confidence (e.g., Ricciardelli and Clow 2009).

Feeling self-conscious about the body before surgery. Other respondents reported more moderate discomfort with their presurgical bodies. Twenty-one respondents (13 cis, 8 trans) reported the second most common theme: feeling self-conscious about the presurgical body. These respondents believed their bodies had flaws and became especially aware of these feelings when in the company of others. Although more cisgender respondents reported this experience, the quality of the data in both groups was similar. Both trans and cis respondents described feeling self-conscious in similar ways.

It was just like you could not walk in a room without people noticing them, commenting on 'em, thinking about 'em. I work in sales and so, you knew that every salesman that I worked with was like, "Oh, yeah, she's the one with the big tits." You know? It was just a part of my identity that I didn't really like.

–*Ruth, ciswoman, breast reduction*

Everyone around me was telling me, "You look fine. There is nothing wrong here." And objectively I couldn't look at myself in the mirror and sort of see . . . that I was probably on the good-looking side of that, love handle-wise, I mean. But I was so fixated on it compared to the rest of my body, and so certain that if I had this surgery I would be back to my former self, that no one could dissuade me.

–*William, cisman, liposuction on torso*

I always was kind of self-conscious about [my neck] even when I was a guy.

–*Lauren, transwoman, liposuction on neck*

No matter what I felt like, I was hiding with my shoulders hunched. And at the gym where some people could just wear wife-beater tank tops, whatever, I'd have my binder to hide it and the way I looked with baggier shirts. That was also uncomfortable and I'd do certain exercises and I'd look in the mirror and think, oh no. And I'd always keep telling myself, oh, it just looks like your pec muscles. But in my head I'm like, [are] people looking at me?

–*Tyson, transman, chest reconstruction*

Respondents who reported feeling self-conscious tended to feel stronger dissatisfaction than those who reported feeling only slightly bothered. This finding suggests that both transgender and cisgender people who seek surgical body modification can experience psychological discomfort before surgery. During social interactions, they may become increasingly aware of their bodily flaws. Both trans and cis respondents reacted to how they perceived others viewed them and their bodies. Self-consciousness became an embodied process. Respondents attributed the cause of distress to the body. Changing the body, then, was a logical solution to alleviate the distress.

Hating the body before surgery. The final most common feeling toward the body before surgery involved severe, negative psychological associations. For 12 respondents (6 cis, 6 trans), hatred framed their feelings toward their presurgical bodies. These respondents reported feeling tormented about their bodies. Trans and cis respondents were equally likely to hate their bodies or experience them as traumatizing.

The worst of my body problems have always been about my thighs. And you know that was, it was traumatic for me, like it haunted me my whole life. Like as early as the first grade, I remember sitting on a desk next to my friend who was much tinier than me . . . , and I remember thinking that my legs spread out on the table and hers didn't and mine [were] so fat because they did that. . . . I have always totally hated my legs. . . . I despised them. I felt like they were the cause of much despair. I just felt like if it weren't for those body parts, I would feel so much better about myself.

–*Sophie, ciswoman, liposuction on thighs*

I hated it. Reminder of a past life that I wanted to forget about as far as – not life, but past body, I guess is a better example. I was . . . embarrassed and ashamed and not comfortable. –*Aaron, cisman, abdominoplasty*

The primary area of dysmorphia for me was always my breasts. I loathed being flat-chested. I always wanted boobs. I was fixated from pretty much since the beginning of puberty. . . . I remember having an epiphany when I was like 12 or 13, where the neighbor girls started developing breasts and it suddenly dawned on me that I was not going to. And I was horribly depressed.

–*Samantha, transwoman, breast augmentation*

I hated it, absolutely hated it my entire life. . . . I didn't like the way that it looked. I didn't like the fact that it made my back hurt. I didn't like the fact that it made me not be able to pass as a guy, because I felt really torn. I always felt really torn with my gender. And so the inability to be able to pass really bothered me a lot, and I just felt like if I could've just cut them off myself, I would have.

–*CJ, transman, chest reconstruction*

These data show that trans people were just as likely to report extreme psychological discomfort as cisgender people before getting surgery. Although transgender narratives about hating the body are commonly portrayed in media and scholarly literature, cisgender people are often portrayed as getting surgery due to vanity. The psychological pain experienced by some cisgender people prior to surgery is not often visible.

The ways respondents described feeling about their bodies before surgery demonstrate their different psychological and emotional states. Although many respondents felt okay about their bodies, others experienced psychological distress and some experienced their bodies as severely traumatizing. Similar reports of distress and trauma among both cisgender and transgender respondents challenge healthcare protocols that require psychological evaluations for transgender people only. Standards of care that exist only for trans people who want surgery suggest that all transgender people – and no cisgender people – will experience surgery as life-changing and transformative. They assume that all trans people experience great distress over their presurgical bodies and need to be evaluated by a mental health professional before taking

on the serious endeavor of irreversible surgery. In addition, no standard of care for cisgender surgery consumers assumes that they do not experience their bodies as traumatic wherein surgery is indeed transformative. A lack of protocol for cisgender people does not account for psychological distress among some cisgender consumers of surgery. This finding also demonstrates that transgender people sometimes want to change their bodies for cosmetic reasons. It shows that trans people do not always view surgery as grave, but may instead want surgery to look better, just as some cisgender people report.

Temporary Relief: Hiding the Body before Surgery

As the data in the previous section showed, respondents reported complex and contrasting feelings toward their bodies. For most of them, surgery was not the obvious first choice to deal with these feelings. Before pursuing surgery, respondents tried to cope with their bodies using other nonsurgical strategies. They lived within their bodies for long periods of time before resorting to surgery. Some discussed their body issues with psychotherapists. Most commonly, respondents tried to find comfort through less invasive modifications. Twenty-seven respondents (11 cis, 16 trans) reported that they concealed or altered their bodies before surgery using nonsurgical strategies. Most commonly, respondents used shaping devices such as compression garments or padded clothing. They also wore clothing in purposeful ways. Transgender and cisgender respondents used similar strategies to hide their presurgical bodies. For example, consider the narratives from Ruth, a cisgender woman, and Charlie a transgender person, who tried to minimize their chest sizes:

You just wear big clothes or . . . wear sports bras instead of regular bras, because they made them a little bit flatter, not much at that size. There was not a lot I could do to hide them. –*Ruth, ciswoman, breast reduction*

I wore a binder everyday for a few years and would just wear specific clothes to not reveal it much.

–Charlie, transman, chest reconstruction

In addition, cisgender respondent Aaron and transgender respondent Brian both used clothing as a disguise:

When I first came out as trans, I dressed a little differently. I wore a lot baggier clothes, a lot of button down shirts that usually have patterns and stuff, anything that would really conceal bulges and that sort of thing. . . . I would be really particular about what kinds of clothes I would wear so that it would minimize the appearance of breast as much as possible. But I did a pretty good job binding, so I could wear things that were pretty tight and not have a problem later on.

–Brian, transman, chest reconstruction

Well, I just wouldn't go to the pool, you know, the way things fit. Try to get things that would push and tuck and kind of camouflage. Low lights, never naked in front of anyone or try not to be naked in front of anyone. . . . They hadn't come out with man Spanx at this point. But, yeah I should or would have, definitely.

–Aaron, cisman, abdominoplasty

Both cisgender and transgender respondents grew tired of disguising their bodies. They complained about discomfort and felt like they were participating in a daily masquerade. These data suggest that both trans and cis respondents struggled emotionally and physically with inhabiting bodies they disliked. Both groups used nonsurgical body modifications to achieve a more desirable appearance. Surgery was not the first option for the majority of respondents in this sample. They tried to deal with their bodies in other ways, but could not experience the permanent relief that surgery promised.

Enhancing Gender and Assuaging the Psyche: Respondents' Motivations for Surgery

Eventually, all respondents became motivated to get surgery. The most common reasons respondents gave for wanting surgery were to look better and to feel better. Both cisgender and transgender respondents gave cosmetic and psychological motivations for choosing surgical

body modification. They viewed surgery as enriching oneself superficially and emotionally. Medical justifications were also primary motivations for some respondents. Cisgender respondents more commonly reported medical reasons for surgery. Other salient motivations for surgery included having surgery due to opportunistic timing or just because people wanted to do it.

To “look better” by enhancing gender. The most commonly reported motivation for surgery was cosmetic, or to “look better.” Thirty-six respondents (19 cis, 17 trans) reported that they wanted to get surgery to look better. Transgender and cisgender respondents were both motivated to get surgery to improve their appearances. For some, looking better related to youthfulness. Others wanted to be thinner. For both trans and cis respondents, surgery promised a change in gendered appearance. In general, both groups believed that surgically modifying various body parts could help them achieve more appealing looks through altering various parts of the body.

I think the only thing that motivated me was [to] be more attractive to the opposite sex. And thinking that in getting my nose adjusted, even though it was just a very minor adjustment, I thought would make me more outwardly attractive.

–Matt, cisman, rhinoplasty

I wanted to look better in a button-up. That’s pretty much it. [laughs]

–Jasper, transman, chest reconstruction

I was happy with my face for years and years and years. I mean, it’s okay. I don’t hurt anybody when you look at me. But, it’s just gotten to the point – you know, I just looked in the mirror and it was mainly frown lines. . . . It looked like I was tired-er or whatever. And in my mind’s eye, I’m not! . . . I didn’t want to look like that 63 year-old woman with gray hair and curls, not doing anything because she’s quote “old.”

–Lilly, ciswoman, facelift

I was a really good B and I went to a D, which was 400cc’s, and then actually grew a little bit more. So, I was thinking afterwards . . . well maybe I should have just went ahead and just not gotten any and just waited for them to grow. But I wanted to be more voluptuous . . . for my class reunion, which was in ’07.

–Evelyn, transwoman, breast augmentation

As these quotes illustrate, cis and trans respondents described similar motivations to look better through surgery. The desire to “look better” meant different things for individual respondents, but cosmetic motivations were common among both trans and cis groups. These motivations confirm assumptions about cisgender people’s reasons for surgery, but they further challenge ideas that trans people are motivated to get surgery to change gender.

In this study, no transgender respondents reported wanting surgery to change gender. They had already realized their gender identities through other measures, such as name changes, hormones, and coming out. In addition, surgery did not represent any particular step among the respondents, as some had surgeries before hormones and before living full-time in their social gender identities. They sought various types of surgery to complement decisions they already comfortably made. As such, transgender respondents sometimes hoped that surgery would help others recognize them as the genders they wanted to present. They also thought surgery could help them feel more authentically gendered.

[My reason for getting surgery] was just to confirm myself as a man and to get rid of those things that were getting in the way of my seeing myself as such. . . . It’s hard to feel like a manly man when you’ve got 38 double-Ds strapped to you.

–*Errol, transman, chest reconstruction*

I wanted to perform sexually as a female. And . . . I wanted to get rid of my testicles.

–*Merlot, transwoman, genital surgery*

The purpose of FFS – facial feminization surgery – is to make one look more feminine by removing male features. So that is the whole intent of that. . . . I see the visual presentation as more important than anything else.

–*Helen, transwoman, facial feminization*

There’s a lot of trans people that don’t understand that it’s not the bottom piece that’s the most important. The most important is what people see everyday, and how they interact with you, and how you end up presenting to other people. So, reducing the male features in my face was my number one priority, because I wanted to be able to be accepted as a woman. And no one goes and lifts your skirt to determine . . . what you got down below, if you’ve got a third leg or not. So, to me the number one priority was the face. The number two priority was having breasts and an abdomen that presented and gave the

illusion of a female. Because that's where you interact with society all the time. And I was getting – to be honest with you – I was getting really, really tired of spending 30 minutes in front of the mirror every morning, so I could take the damn garbage out.

–Ann, transwoman, *facial feminization, breast augmentation*

Transgender respondents were more likely to report gender-based cosmetic motivations than cisgender respondents. But cis people also reported wanting surgery to achieve a specific gendered effect. Like trans respondents, cisgender people did not view surgery as gender-changing. They also had names and hormonal configurations that matched their senses of gender. Unlike trans people, they had longstanding social gender identities that matched their personal gender identities. But they still believed surgery could enhance their gender expressions, help them conform to normative gendered embodiment, or deemphasize overtly gendered physical features.

I was probably searching to be more feminine than I had been.

–Re, ciswoman, *facelift and blepharoplasty*

I think what probably really caused to tip the scales to get it done was knowing that at the same time they could make my nose look a little bit what I felt like, more masculine and attractive.

–Matt, cisman, *rhinoplasty*

I hated [my breasts]. . . . I think they started growing when I was in 8th grade, and so this was at the end of my junior year . . . I was like a triple D I think. So, I'm five feet tall, that's pretty remarkable growth over – and you know high school is wretched, when it comes to young guys. So yeah, I was definitely ready to get that, get it done. . . . I had no idea what [my surgeon] could do. And so I remember after he examined me and I was asking him what size I would be and he said a C, it was, I think I cried I was so excited. I was like, I don't even remember the last time I was a C.

–Winnie, ciswoman, *breast reduction*

Although cisgender respondents already identified and passed as men and women, they also felt that making gendered changes to their bodies could aid them in social interactions. These respondents viewed surgery as helping them maintain a gender presentation that matched their inner gendered selves. As such, both cis and trans groups were motivated to make their external

bodies match their internal self-concepts. They believed surgery would change their gendered appearances and aid their social gender identities. Both groups wanted to use surgery to affect a more desirable gender presentation that others could respond to more favorably, and neither group viewed the surgery itself as gender-changing. Before surgery, they all had inner senses of their gender identities, or stable personal gender identities. They used surgery to bring their social gender identities in line with their personal gender identities.

To “feel better” by assuaging the psyche. In addition to cosmetic reasons, many respondents reported that they wanted surgery to “feel better.” Twenty-nine respondents (13 cis, 16 trans) said that they wanted to get surgery to feel better about themselves. Data from these motivations show that “feeling better” described psychological motivations that related to establishing more comfort within the self through the body, aligning the external body with the inner image of oneself, and aiding the sexual self. Respondents who reported psychological objectives to “feel better” through surgery aimed to assuage the negative feelings they had toward their bodies. They wanted to become less self-conscious about their bodies. Some wanted to alleviate feelings of hatred and trauma toward the body. Respondents who wanted surgery to feel better, then, hoped to assuage the psyche.

The extent to which both trans and cis respondents believed that surgery would help them feel better varied, as feeling better represented several emotional and psychological benefits. Some felt only mildly self-conscious and were motivated to get surgery to feel generally better about themselves.

It’s not like I had to have ’em. I wasn’t like completely flat-chested. I just kind of more wanted them for myself and I think it was always since I was like 16 years old. I’m like, you know what? One day, I’ll have boobs. And I never did. And so I was like, I’m 26. There’s no one pressuring me to do it. No one even was like, “Hey, you should go get

boobs.” It was just more for me, for I guess more of a self-esteem or more confidence than what I had previously had.

–*Michele, ciswoman, breast augmentation*

I was still smaller chested, but *I* knew what I looked like in the mirror. Somebody else could tell me different, but I know how it really feels. So, basically [the] only thing I could say is that’s something I really needed to do.

–*TJ, transman, chest reconstruction*

Most respondents who reported getting surgery to feel better about themselves gave responses like TJ and Michele. For them, feeling better represented improved self-comfort or feeling more comfortable interacting with others. But a few respondents in both cis and trans groups used the surgery to feel better about themselves in more profound ways. These respondents envisioned surgery as potentially more transformative than those who were not as troubled by their bodies. These respondents often reported more negative presurgical associations, such as hatred and trauma. The following narrative from a trans woman is one often portrayed in media and scholarly literature:

The discomfort – this constant pressure and fantasy about being who I was physically not, you know getting my body to – and it wasn’t even like trying to get my body to conform to who I was. I just felt this discomfort and this constant, *constant* thought process that went on about this. That’s what I felt. And I don’t even know how to – I wish I could describe that better to you, but it involved fantasy, it involved daydreaming, it involved my life. You know? It occupied so much.

–*Caroline, transwoman, facial feminization*

Caroline’s description invokes the dominant narrative that transsexuals can feel trapped in the “wrong” body. She hoped surgery could help match her external body to her internal self. But the intensity of these feelings among some transgender respondents was also apparent among some cisgender respondents. For example, Luke explained his motivation for having liposuction and his decision to have it without general anesthesia:

My goal is this, not necessarily to be thin, but it was therapeutic from the standpoint as, I want to remove these negative thoughts. . . . I wanted to remove this and I wanted . . . all that negativity that had grown in me, I wanted to remove that from my life. So I knew

that if I didn't work on a tandem track and deal with the history, that I knew making this [gestures to body] thin, looking in the mirror wasn't going to change. . . . And so part of the procedure of me sitting there and really wanting to be awake through this . . . , I was able to sit there . . . and really allow the negativity of all those words to leave my body. And so I consciously, as it was going out of my body, I was consciously saying I must release all those mean things. I'm not fat. My brothers didn't mean it that way. I wasn't fat. I just had a different body type and my body type is healthy and I'm healthy. And it was more for me about releasing and letting go.

–*Luke, cisman, liposuction on torso and neck*

The intense psychological and emotional harm that can motivate cisgender people to get surgery is apparent in these data. As Luke's narrative illustrates, "cosmetic" surgery for cisgender people can be pursued for its potential to be psychologically transforming. But in contrast to dominant trans narratives, the motivations for common surgical body modifications among cisgender people are not often viewed as healing, as evidenced in stereotypes about cisgender consumers as vain and selfish.

To improve health (with cosmetic benefits). Another motivation for surgery reported by respondents is worth addressing. Thirteen respondents (9 cis, 4 trans) reported wanting elective surgery due to medical reasons. These respondents typically emphasized medical justifications for surgical body modification. They cited pain, headaches, breathing impairment, vision impairment, and risks of long-term hormone use. Among those who cited medical benefits to surgery, five were men who had rhinoplasties (four cis, one trans), four were cis women who had breast reductions, two were trans women who had orchiectomies, one was a trans man who had chest reconstruction, and one was a cis woman who had blepharoplasty. All trans and cis respondents who said they had surgery for medical reasons also believed that surgery would yield cosmetic benefits. Although most of these respondents did not immediately link cosmetic and medical benefits, the quotations from the following three respondents made this connection within making the same point.

I was kind of thinking okay, well if we're going to go break this thing and get it right, let's make it straight. [laughs] And [the surgeon] was like, "We're not worried about making it straight. We're making it so that you can breathe." And he made it very clear that was not about the aesthetic aspect, at all.

—Anthony, *cisman, rhinoplasty*

[My surgery] was more out of necessity, because I severely broke my nose. . . . This was probably the third time that it was bad. I broke it when I was a child, again in high school, and then again when I was 21 just before the surgery.

EJW: Ok, so you got the surgery as a result of the broken nose, so you hadn't been researching it, it was something you needed to get?

Well, there was, that was the part that was debated whether or not it was medically necessary. And I didn't have a deviated septum . . . , I had what I would call like a large knuckle on my nose. And it was not straight because of the break.

—Rick, *cisman, rhinoplasty*

I had a very high possibility of cancer. So I'm sitting here going well . . . , I am a 34 quadruple D. . . . I could either get them off or get them reduced. And I said, well, if I go for the reduction and then later say I desperately want them all gone, it's going to be more scars. . . . And if I have cancer - if I am going to get cancer, which is pretty likely, it can be much harder if I have almost no breast tissue. . . . I get less scars if I just go for the mastectomy.

—Nikanj, *transman, chest reconstruction*

The respondents who wanted surgery due to physical health benefits believed the procedures would result in improved physical wellbeing. Often, their surgeons and health insurance companies concurred and they were able to cover the surgery's cost. Some of these respondents described relatively minor health problems associated with their presurgical bodies. For example, one cis woman justified blepharoplasty because she anticipated having the same vision trouble experienced by her mother who had not had her eyes surgically corrected. In addition, both cis and trans respondents who cited physical health benefits of surgery also believed surgery would yield more desirable cosmetic results. Understanding medical benefits to surgery is important because these surgeries are often eligible for insurance coverage. The slight difference between trans and cis medication justifications may be because cisgender people had more physical health problems than the trans people in the sample. Or, this difference may exist because cisgender

respondents felt they needed a “good” reason to justify elective surgery. Procedures to alleviate breathing issues, broken bones, and back pain may carry less stigma than surgeries to assuage emotional trauma and distress through aesthetic alterations. As cisgender people whose bodies are not viewed as in need of correction, they may have felt like they needed to exaggerate health gains and downplay cosmetic effects. Although these interpretations are difficult to justify when analyzing motivations for surgery, they will become clearer when examining how respondents who cited medical justifications were able to access surgery and how they described the surgery’s effects.

Both cisgender and transgender respondents reported wanting surgery for cosmetic, psychological, and medical reasons. People who chose surgical body modification believed they could alter their bodies and lives in meaningful ways. These motivations reflected respondents’ desires to enhance the self through the gendered body.

Enhancing the Self through Gendering the Body

When comparing transgender and cisgender respondents, many similarities exist. In terms of respondents’ embodied feelings before surgery, both cis and trans respondents described similar experiences. Both groups included people who reported feeling okay and self-conscious about their bodies. Both groups also included people who hated their bodies before surgery. They also tried to cope with their bodies using nonsurgical techniques. Consequently, both groups had similar motivations for surgery. Transgender and cisgender respondents both sought surgery for its perceived cosmetic and psychological benefits. The congruous data from this study suggest that, in terms of presurgical body image, cis and trans people were in similar psychological and emotional states. Respondents’ self-reported mental health compounds this finding. Although

their mental health histories varied, when asked to describe their mental health at the time of surgery, most respondents (17 cis, 18 trans) said they were fine or in good mental health.

But trans and cis consumers of surgery differed in one important way. Transgender respondents' cosmetic motivations for surgery included changing the appearance in more overt gendered ways. This difference warrants further exploration. Transgender experiences inherently involve gendered transitions. A person who is transgender often experiences discomfort with their gendered embodiment before they begin to live in their desired genders, or before they allow their personal gender identities to coalesce with their external social identities. Before taking steps to reveal their inner identities, they can feel betrayed by their bodies. Their bodies convey social identities that do not accurately represent their inner senses of self. Coming out as transgender often involves acts that affirm personal gender identity: changing the name, wearing different clothing, starting hormones, and having surgery. Surgical procedures are part of these transitions from one gendered embodiment to another. Thus, it is not unusual that some trans people in this study hoped surgery would change their gendered appearance. But the surgeries in and of themselves were not envisioned as gender-changing. Instead, trans respondents believed that surgery would enable others to more accurately view their personal gender identities. If they believed others would perceive them as their correct personal gender identities after surgery, then surgery also promised to facilitate a more identifiable social identity. Thus, surgery helped affirm transgender respondents' personal and social gender identities.

A cisgender person's body, however, is typically not in conflict with an inner sense of gender. Cisgender personal gender identities are conveyed through the body before surgery even when people felt their bodies failed to meet ideal gendered embodiment. Fewer cisgender respondents wanted surgery to affect gendered cosmetic benefits because of the privileges that

accompany their normative gendered status as cisgender. Having a cisgender experience meant respondents were less likely to seek surgery for this reason. Cisgender gendered embodiment is taken for granted. Although cisgender people reported gender-based cosmetic motivations for surgery less often than trans respondents, they were not exempt from relaying this reason for surgery. Thus, even cisgender embodiment can be experienced as the “wrong” body. For some respondents, living in cisgender bodies sometimes means failing to reveal to others one’s inner perception of the ideal gendered self.

It is also important to point out the rich gender diversity that existed in the sample. As the first columns in Tables 2.1 through 2.4 show, both cisgender and transgender respondents described their personal gender identities, personal gender expressions, and social gender presentation in rich and varied ways. While the transgender respondents tended to describe their genders using less binary-based terminology (e.g., second-type woman, funny, genderqueer, and trans) more often, the cisgender respondents did not always identify as woman/feminine/conventionally feminine or man/masculine/conventionally masculine. One woman in the cisgender group, for example, described her personal gender as “queer femme,” her personal gender expression as “traditionally feminine,” and her social gender presentation as only partially conventionally feminine due to her tattooed body and queer sexual identity. Being cisgender did not mean representing some universal identity of womanhood or manhood. Thus, popular beliefs that transgender people want surgery to change gender ignore the complex ways gender shapes personal and social identities.

This finding challenges assumptions about transgender and cisgender surgeries. Healthcare systems manage surgeries for trans people as gender-changing. But some cisgender respondents in this study reported gender-based motivations for surgery. This finding suggests

that the experience of changed gendered embodiment is not limited to trans people. Cisgender people may desire to change their social gender identities in similar ways. Although they do not want to transition from the social identity of man to woman or woman to man, they may want to transition from the social identity of hyper-feminine woman to average feminine woman, for example. Or, they attempt to transition from less masculine man to more masculine man. These transitions also help affirm cisgender people's inner sense of self – their personal gender identities. In this way, cisgender and transgender respondents are similarly motivated to get surgery to change their gendered appearances.

Based on these data, transgender and cisgender people had similar histories with their bodies before surgery. Their presurgical embodiment represented varied experiences with no starkly different patterns between cis and trans surgery consumers. These findings cannot be explained by inherent differences between the sample groups, such as class or type of surgery. In sum, transgender and cisgender consumers of surgical body modification felt similarly toward their bodies before surgery and were similarly motivated for surgery. Both groups wanted to enhance the self through gendering the body, and all of them used surgical body modification to achieve that objective. This finding provides evidence that both cisgender and transgender individuals have similar goals in surgery, and should be evaluated similarly.

CHAPTER 5 – THE ENHANCED, EMBODIED, GENDERED SELF: RECIPROCAL COSMETIC AND PSYCHOLOGICAL EFFECTS OF SURGERY

Before getting surgery, respondents in this study anticipated a range of cosmetic and psychological benefits. This chapter details how surgical body modification affected respondents. I begin by discussing the levels of postsurgical satisfaction reported by respondents. Most transgender and cisgender respondents reported satisfaction with the results of surgery, a few respondents reported dissatisfaction, and some relayed negative surgery experiences that typically related to the ways the surgery healed. Next, I show that both cisgender and transgender respondents reported cosmetic and psychological benefits of surgery. The cosmetic outcomes of surgery often related to an enhanced sense of gendered embodiment – marking gender on the flesh – for both transgender and cisgender respondents. The psychological outcomes related to an embodied sense of confidence and comfort. By doing gender directly onto the body through surgery, respondents embodied – or physiologically manifested – psychosocial wellbeing. Cosmetic and psychological outcomes were dialectical, or reciprocal, effects of surgery. For respondents, improved aesthetic effects yielded improved wellbeing, which in turn inspired more comfort and confidence in presenting the aesthetic self. Similar surgery effects in both cisgender and transgender respondents challenge disparate regulation of their surgeries. These findings also complicate categorizing surgical body modification as strictly “cosmetic” when the surgeries are also emotionally healing. The findings have implications for health insurance policies that only cover surgeries that yield physical health benefits.

Respondents' Postsurgical Satisfaction

Most people in this study reported feeling satisfied with their surgical results. Although only a few expressed dissatisfaction with the results of surgery, more reported negative surgery experiences ranging from minor issues like scarring to more serious problems like necrosis. Data on consumer satisfaction are important to consider because concerns about dissatisfied and vengeful patients justify restrictive gatekeeping protocols.

Vast satisfaction with surgery. The outcomes of surgery were overwhelmingly positive for most people interviewed in this study. I asked respondents how satisfied they were with their surgeries. Twenty-three respondents (12 cis, 11 trans) reported being very satisfied, and 11 (5 cis, 6 trans) reported being satisfied.

[My breasts are] amazing. It could not have turned out any better at all. . . . It was what I expected and then some.

–*Ruth, ciswoman, breast reduction*

I'm very satisfied, very, very satisfied. And I even, I sent a note to the doctor. I said, you know, to tell you that I am satisfied or I am happy with the surgery is really to damn you with faint praise. I said, you did an amazing job, and I am very, very happy with the results. And I said, you really are a maestro. And I said, so, thank you very, very much. I was very happy.

–*Caroline, transwoman, facial feminization*

Well, considering how fast it healed, I'm pretty satisfied with it. But you know, I've felt no regrets about it. . . . That's a pretty easy one really for that surgery.

–*Calliope, transwoman, genital surgery*

I have to say that it's nothing I really think about. I mean it's not that I look in the mirror and think, wow you look so much younger. I don't really think about it. Am I glad that I had it done? Yes I am. Absolutely I am. Because my eyes – if I were to – if I looked at

them now and were to look back six years earlier, to me I would not have liked it at all. So I look at them now and I see eyelids, and I like that. But that's pretty much it.

–*Suzanne, ciswoman, blepharoplasty*

I also asked respondents how satisfied they were with their surgeries compared to others who had similar procedures. Nineteen respondents (10 cis, 9 trans) felt their results were about the same as others, and 15 (8 cis, 7 trans) believed their results were better. Only one respondent believed others had better results, and the rest had no basis for comparison. These data illustrate respondents' overall satisfaction with surgery. Respondents felt good about having had surgery, and both trans and cis respondents were likely to be satisfied.

Limited dissatisfaction with surgery. In contrast, dissatisfaction among respondents was rare. Only one respondent reported being unsatisfied (0 cis, 1 trans), and five (3 cis, 2 trans) reported mixed satisfaction due to having multiple procedures. Most of respondents' dissatisfaction related to negative cosmetic effects.

The legs didn't turn out the way I hoped. They're not that smooth kind of like magazine cover looking legs, like Barbie smoothness. And you know, in retrospect maybe that doesn't exist. Maybe that's a total pipe dream that only exists in airbrushing. But I don't really know because I feel like I'll see women in strip clubs or at the beach who look perfect. But then sometimes I look in the mirror and think, oh it's not that bad. But then I change the lighting and I'm like, whoa! Never mind, that's wrong. So you know, like it definitely didn't give me the fix that I was hoping. I still tend to cover my legs whenever I can. But on the other hand, I am glad that I did it because I can't sit here and say, well if only I had gotten that leg surgery I wouldn't have gone through all of this.

—Sophie, ciswoman, liposuction on legs

I'm not entirely happy with the results. . . . Right now, I have somewhere kind of in-between kind of male chest. . . . I don't really like it in a female way, it doesn't really cut it in a male way. I can wear a tight shirt and easily pass [as a man]. So, that's a positive that I didn't have before. . . . I don't regret it in terms of, I'm pretty sure I would have had it either way. . . . So I'm not, because I am not fully happy with the results, I don't really regret it. But I am not really 100% satisfied. I think I got the best I could with my insurance and with this doctor. . . .

—CJ, transman, chest reconstruction

Although these respondents were not completely satisfied with their surgery results, they did not regret having surgery. They were unhappy that the cosmetic effects of the surgery did not result in a more appealing appearance.

Poor surgery outcomes and regret. Although only a few people were unsatisfied with the surgery, 14 respondents (5 cis, 9 trans) reported poor outcomes mostly related to the way the surgery healed. These negative postsurgical effects did not necessarily compromise consumer satisfaction. Poor outcomes included minor issues that were common risks of surgery, such as scarring and decreased sensation. But respondents also reported more serious problems such as regaining consciousness during surgery, severe bleeding several days after surgery, necrosis of neo-labial tissue, being unable to close the eyelids, and loss of one's singing voice.

Despite these problems, no respondents regretted having surgery. When I asked respondents if they had any regrets related to surgery, seven respondents said they regretted not having surgery sooner or that they did not have an additional procedure done at the same time. One cisgender woman wished that she had been in a better psychological state at the time of her surgery. One transgender woman had lingering doubts over not preserving sperm prior to her orchiectomy. One cisgender man who was not open about having had rhinoplasty regretted that he had "a skeleton in the closet" regarding a procedure that did not significantly change his appearance. Overall, reports on regret were rare, even among those who had problems with their surgeries.

Data regarding surgery satisfaction and regret are important. The literature that supports restrictive protocols to regulate access to cisgender surgery emphasizes the risks of consumer dissatisfaction (e.g., Hodgkinson 2005; Pertschuk et al. 1998; Phillips et al. 1993). Yet despite similar rates of dissatisfaction between cisgender and transgender respondents in this study, cisgender consumers do not endure extensive gatekeeping, as Chapters 6 and 7 will show. In addition, stories about regretful transsexuals circulate widely within transgender communities. Some trans people in this study believed that they had to endure restrictive gatekeeping because

of uninformed people who regretted surgery and then blamed doctors for their decisions. As Evelyn said, “You always got that one bad apple out there, and that kind of ruins everything for everybody else.” Similarly, Samantha mused:

They really have to get the [authorization] letter for insurance purposes, because if I have buyer’s regret, and I sue, then they need something to fall back on to go, “Hey, the therapist said it was okay.” That’s where the whole issue comes from. It’s from morons who come before me who go, [whiny voice] “Oh no, I had a sex change and it didn’t solve *all* my problems! Wah! And now I feel bad, it’s *your* fault! I am going to sue *you* for enabling me!”

Despite these strong opinions that blame fellow trans people, the WPATH Standards – the most commonly used healthcare protocols for trans people seeking surgeries – do not justify surgery restrictions with data on surgery regret. Regret and severe dissatisfaction, then, do not seem to be the main issue. Indeed, experiences of regretting surgery are uncommon. The data in this study support other research that attributes surgery regrets among trans people to poor cosmetic outcomes of the surgery (Lawrence 2003) and not the decision to surgically adjust gendered embodiment (Pfäfflin and Junge 1998; Smith et al. 2005). In addition, regretful surgery consumers also exist within cisgender surgery communities. For example, Heidi Montag, a reality television star from MTV’s *The Hills*, publicly regretted the ten surgeries she had to change her body (Fitzpatrick 2010). But despite high-profile accounts of regret and botched surgery, psychomedical institutions have not established regulatory protocols for cisgender consumers. In addition, data in this study on cisgender surgery satisfaction suggest that cisgender people’s regrets associated with surgery relate to both aesthetic and psychological issues. Although the data on surgery regrets in this study is limited, the vast satisfaction reported by transgender and cisgender respondents challenges the need for restrictive protocols for transgender consumers only.

Enhancing Gendered Embodiment: Respondents' Cosmetic Surgical Outcomes

Respondents' satisfaction with surgery always related to cosmetic benefits. All 40 respondents reported that surgery helped them improve their physical appearances. For example, respondents reported that surgery made them look younger (3 cis, 3 trans) and brought them more attention (2 cis, 2 trans). But the most common cosmetic effect of surgery, however, was that surgery enhanced respondents' gender expressions and identities. Twenty-five respondents (11 cis, 14 trans) reported that surgery enhanced their gender expressions as masculine, feminine, and/or trans and 14 respondents (2 cis, 12 trans) revealed that surgery helped them pass in their preferred gender. Thus, the rewarding cosmetic benefits of surgery often related to an enhanced sense of gendered embodiment. Of course, enhancing the external gendered self is not unusual among transgender people. Narratives like these are common:

It has affected [my sense of feeling masculine]. . . . It was unreal to me and I just looked at myself in the mirror and it just all clicked. . . . I'm like, oh my God! I just saw myself more male. You know? And it's funny because I feel like it's actually really carried through with me being just more confident in my everyday life. So, it's been really awesome.

–Tyson, transman, chest reconstruction

It increased [my sense of feeling feminine], because I can actually wear styles I've always been wanting to wear. It just really enhanced it even more.

–Lauren, transwoman, breast augmentation

Without doubt, some trans respondents like Tyson and Lauren felt more masculine or feminine after surgery. But the gendered effects of surgery for transgender people more often capitalized on already existing and stable gender expressions and identities. In other words, trans people in this study already felt secure with their inner gender selves. Surgery just enhanced the gender that was already there, as exemplified in these interview excerpts:

I would have thought of myself as a man one way or the other, but I feel like a fuller man, if that make sense. . . . I feel less feminized with my chest gone. So, I feel more masculine mowing the lawn for the first time the other day with no shirt on, that felt very

manly. But of course, I didn't finish and go beat my chest and snarf a bunch of beers down or anything. But I would say that, yeah, I felt like more of a man being able to do that.

–*Errol, transman, chest surgery*

I mean [surgery] made me feel more masculine if anything, but not any less. . . . Because I had a solid [male identity] before. It's just that that part [of my body], that area was holding me back from feeling complete. So once I got it done, I just felt complete.

–*TJ, transman, chest surgery*

The boobs have helped and actually the smile, you know, and overall it did boost [my femininity] up. It did boost it up. Yeah, but I kind of always felt feminine anyway. It just sort of strengthened it.

–*Evelyn, transwoman, breast augmentation*

It's given me sort of an internal permission to feel what I feel, and what I've been feeling for a long time. . . . And I don't have to feel guilty about it or monitor it or worry about it. . . . To me, it feels like it's just allowing me to be who I've always been. . . . It's allowed me to take more action in my true gender. It's allowed me to live in my true gender identity.

–*Caroline, transwoman, facial feminization*

All of it [affects my sense of feeling feminine] a little bit. But once again, just like sex, sex is between your ears, well femininity and albeit everything else. . . . [Surgery] makes everything easier. It makes you feel more molded. Yeah, but once again it's mostly psychological more than anything else. . . . If you were to do these operations to a normal male, he would not feel more feminine, I don't think. He'd feel butchered or something. So, the operation in and of itself is really designed to help get your head on straight and be what you want to be. So it's enhancing, but it's enhancing between your ears, and it does make it easier to get by in the world. My profile has changed, my face has changed, you know. Gender surgery, I mean, it gives you a little more, it makes you feel more rightfully female. . . . It certainly helps, but it wasn't, my genitals didn't define me as a female or my face didn't define me as a female. My brain defined me as a female.

–*Alexis, transwoman, facial feminization, genital surgery*

These narratives from trans respondents highlight how surgery achieved a desirable cosmetic effect that helped align personal gender identities with social gender identities. Even respondents who had genital surgeries reported that these procedures were not about changing sex or gender. For trans respondents, surgery did not change gender; it affirmed gender. And although trans people more commonly reported that surgery helped align their inner and outer selves, this effect

was not unique to trans respondents. Winnie explained how the breast reduction she had at age 16 helped her body match how she felt inside:

I think I looked more my age. I know I have a young face but I guess just like my body, I didn't feel like my body matched my face. I felt like I had, I don't know, some porn star body or something, you know, and I had a 16 year-old face. . . . So, it felt more proportionate and that I looked more my age. . . . I felt . . . like hyper feminine I guess before. . . . I guess I would just associate that with just being very much a female, just being a female that size. . . . I thought I looked more teenager-ish than womanly, which it seems would be important when you're 16, as opposed to even 18 or 19.

–Winnie, *ciswoman, breast reduction*

Winnie's age compounded her sense of gendered embodiment when she elected to have surgery. After surgery, she felt appropriately embodied as a 16 year-old instead of feeling like a teenager in a more womanly body. Neither Winnie nor her surgeon voiced concerns about her inevitable aging out of teenager years into womanhood, and how her desire to change her size at age 16 might shift as she matured. But Winnie's experience highlights how surgery could also benefit cisgender respondents by making their bodies conform to their inner senses of self. Thus, surgery also aligned the body with the mind for some cisgender people.

Like surgery's ability to enhance one's inner sense of self, the ability of surgery to enhance gender expression was also not unique to transgender respondents. Eleven cisgender respondents explained that surgery enhanced their gender expressions as feminine or masculine. For them, surgery helped them fit more conventional standards of attractiveness.

I had no idea I was going to feel like this when I was done, could not stop looking in the mirror at myself, feeling like I was more of a woman. I had never had boobs before and all of a sudden I felt shapely, and it was the best feeling in the world. I loved it. I could not stop looking in the mirror. I was like, oh my God, this is what a woman looks like! I have boobs now! I mean, I felt, I loved it. I *loved* it. I didn't know that's what it felt like to carry around boobs.

–Chrissy, *ciswoman, breast augmentation*

It makes me feel more sexy. . . . I like to wear clothes that are more revealing. . . . Just a little bit more confidence and that sort of sexuality.

–Julie, *ciswoman, breast augmentation*

I'm way more likely to dress not as conservatively, way more. Like I could never wear dresses because you couldn't get anything that fit. . . . It was horrible. And now I can wear dresses and I wear them a lot, because I think, look! Look what I can wear! [laughs] It all fits, and I didn't have to get it tailored and it's just great. So, actually I think I dress girlier now than I did before. . . . I call more attention to my body now, because I like it better.

–*Ruth, ciswoman, breast reduction*

I guess it has [affected my sense of feeling masculine] really, because excess skin on your chest is really not masculine at all [laughs]. . . . I think it has [affected my sense of being a man or feeling like a man] in that it's just given me the confidence to go on. Like after that I started lifting weights and . . . building more muscles which . . . that is sort of intimidating if you are flopping around and you have this bad body image and you don't feel confident enough to do it. So, it's given me the confidence to go ahead and do that, because I know that results will be shown off.

–*Aaron, cisman, liposuction on torso and abdominoplasty*

There's something about a body shame or exposing the body that seems to have a premium placed on it . . . in the gay male world. . . . And I don't feel that shyness or anything like that anymore. There's a sort of trophy-ing, that I don't even know how to explain. . . . I go on [Atlantis cruises] with a lot of my friends. . . . And there's a sort of bar that's placed as to, you know, how many Speedos you take, and how tan you are, and I don't mean labels. I just mean like how far you'll take the Speedo thing. And I feel perfectly comfortable entering into that sort of implicit competition and feeling quite secure that I'm doing well in it. . . . Here's how [surgery affected my sense of being a man]. Not so much body focused, but in the ability to attract. . . . After I had the surgery, I felt like I was back on, back in the game again, which is all very masculinist sort of language, I know. But I felt like I was sexually viable again, back in the game again and able to sort of nab the people that I wanted to sleep with or meet or have sex with or be emotional with or whatever.

–*William, cisman, liposuction on torso*

In these excerpts from cisgender respondents, surgery's ability to enhance gender expression related to the ability to more freely express conventional femininity and masculinity. Women felt able to reveal their bodies through clothing and men felt confident to expose more muscular bodies. Among trans respondents, surgery often enhanced gender expression both by aligning the external self with the internal self and by enhancing gender expression. For cisgender respondents, however, surgery that enhanced gender expression was less often about reconciling the inner and outer self. Cisgender people who reported enhanced gender expression felt that

surgery made them *more* conventionally attractive women and men. While surgery helped trans people release what they felt was already there, it introduced a new sense of gendered embodiment for cisgender people. In this way, surgery for cisgender people offered more unanticipated cosmetic results.

Of course, social subjectivities informed respondents' conceptions of an "inner" sense of self. Errol's feeling like "a fuller man" but not a chest-beating, beer-snarfing man, Winnie's distaste for her adolescent "porn star body," and Aaron's exposing his Speedo-clad body as a trophy all demonstrate how social realities informed their bodily comfort. The distress respondents reported in embodying a misaligned inner and outer self represented a struggle between personal and social identities that was as much about internal turmoil as it was about external gender trouble. The desire to change or improve one's gendered embodiment inherently exposes a hierarchy of appropriate or acceptable bodily forms. In this way, respondents' surgically-enhanced embodiment reflected their perceived social positions, a modern-day example of the classic looking-glass self (Cooley 1902). They wanted to reconcile a personal identity with a social identity that is always already socially constructed based on the present-day meanings of ideal gendered bodies. Respondents' often essentialized narratives then reflected an embodied subjective reality.

These data illustrate that the cosmetic effects of surgery for both cisgender and transgender respondents were typically gendered effects. When respondents said that they "looked better" after surgery, they conveyed ways their gendered embodiment improved. For many, surgery enhanced the gender expression they already felt inside. It aligned the gendered body with the gendered self. For others, surgery freed a new gendered self through the body. Postsurgical gendered embodiment meant achieving new levels of attractiveness. These data

show respondents' invocation of "bio-power" (Foucault 1978) in their articulations of surgically-enhanced bodies.

Embodying Confidence and Comfort: Respondents' Psychological Surgical Outcomes

While all respondents reported cosmetic benefits of surgery, most respondents also reported psychological benefits. Thirty-four people (16 cis, 18 trans) stated that surgery made them "feel better" in some way. The psychological effects of "feeling better" related to feeling more comfortable, confident, and free after surgery. Respondents also reported that surgery aided the sexual self in terms of self-confidence and their desired levels of attractiveness. In these ways, respondents embodied improved psychosocial wellbeing through surgically changing their bodies. Psychological benefits of surgery were common among both transgender and cisgender respondents.

And the breast reduction, so happy, so happy. Just to be able to run, to run around, is fun, and not have to worry about it. And there was a lot of just unwanted attention paid to my breasts that I could live without. . . . Like from men. . . . Comments. Everybody. It would be a topic of conversation with me sitting there. Like what's up with this? You know, if

anybody should be talking about my breasts, it should be me, [laughs] not you! So, yeah, and that's pretty much gone now, so that's nice.

—*Sheri, ciswoman, breast reduction*

I feel like I look pretty good. Like I feel really confident walking about and being shirtless. . . . I used to hate swimming because I just hated things clinging to me, and now I can wear shorts and go in. And it's like, I wish everybody could be topless and go swimming. But I mean, it's nice that I can and I enjoy my chest. And so yeah, I feel really good about it.

—*Charlie, transman, chest reconstruction*

I definitely think it's enhanced my appearance and it's made me more confident. There were just so many times where I would look at myself and be pretty upset because I knew that something so simple could be altered and I would be a lot happier. So, as a whole, I'm definitely happier.

—*Kris, cisman, rhinoplasty*

I think [surgery] gives you more confidence, the more you, I think look the part, it builds your confidence. When you have that confidence, it's an air that people read about you, and your body language that again reinforces that.

–*Helen, transwoman, facial feminization*

Even though my waist size might have been one inch smaller or four pounds or five pounds smaller when I had the surgery than I am right this minute, I still have no trouble today making coffee, or being naked, or making love, or looking at my body with the lights on or any of that stuff. It just doesn't bother me anymore. . . . I wanted that ability to be present with my partner, to be there and to get up in the morning with no clothes on and look at myself and go, you look nice. . . . So much has changed. . . . Even getting dressed this morning for me, take a shower, do my work and get dressed, and looking in the mirror, I didn't think about my body image. And you know, that's a good feeling.

–*Luke, cisman, liposuction on torso and neck*

I felt more sexually strident even without bottom surgery, all of a sudden there was that much less artifice to me. . . . The boob job was, by far, the first hurdle that honestly made me feel comfortable in my own body. . . . It made me feel more genuine. It made me much more comfortable with my own body. Suddenly I could brave having a sex life because there was a chunk of artifice that did not come off anymore. . . . I can still keep a wig on in the sack, but hey, check 'em out! [points to breasts] Okay, they are the strongest, secondary sexual characteristic. Period.

–*Samantha, transwoman, breast augmentation*

These data illustrate the psychological benefits that accompany “cosmetic” surgery. They demonstrate that changing the outer appearance of the body in desirable ways typically produced improved emotional and mental effects. Surgical body modification, then, cannot be conceived strictly as a cosmetic procedure. After surgery, respondents were not simply more beautiful. Their bodies did not just become more attractive. They felt better about themselves. Thus, the effects of surgery on the mind cannot be separated from the effects on the body. For both cisgender and transgender respondents, surgery resulted in improved mental health.

In addition to these effects, respondents reported a range of reactions from others upon revealing the decision to have surgery or that they had surgery in the past. More respondents reported positive reactions from others overall. Thirty-two respondents (14 cis, 18 trans) stated that others reacted well upon learning about the surgery. Respondents said that when they told

people about the surgery, they often received support and sometimes praise. Everyone in the study had at least one support person who drove them home after surgery, and many had friends or family help with aftercare. But 26 respondents (11 cis, 15 trans) also reported more negative reactions from others, such as passing judgment, discouraging surgery, or needing time to adjust to the surgery. Some respondents (8 cis, 4 trans) said others were surprised to learn about the surgery, and some (6 cis, 2 trans) reported that others did not comment on the surgery at all. These trends suggest that cisgender respondents were more able to hide having had surgery to others, whereas trans surgeries were more visible. Transgender respondents were more likely to find support for their decisions as well as to encounter negative reactions. This difference is likely due to trans people's inability to conceal surgical body modification decisions as they transition from one social gender identity to another. Overall, only 11 respondents (6 cis, 5 trans) said that they needed support for their surgery decisions. Most respondents viewed surgical body modification as a personal decision. But greater visibility of transgender surgical body modifications along with cisgender privilege in concealing gender-affirming decisions may contribute to disparate classifications of these surgeries. With the privilege to conceal surgeries that do not breach gender boundaries, cisgender people's surgical body modifications can continue to be classified as normative with no need for psychomedical regulation.

The Reciprocal Relationship between Cosmetic and Psychological Outcomes

The data about cosmetic and psychological surgery outcomes complicate distinctions in the psychomedical community between “cosmetic” and “sex reassignment” surgeries. If surgical body modifications among cisgender people yield effects beyond aesthetic improvements, then classifying the procedures as “cosmetic” surgery is inaccurate and misleading. This misnomer

conceals the psychological effects that these surgeries provide and promotes stereotypes about surgical body modification as vanity projects. It also discounts the psychological surgery motivations that many cisgender consumers report. Similarly, describing procedures among trans people as “sex reassignment” or “gender reassignment” surgeries ignores the realities experienced by transgender people who already have solid gender identities before getting surgery. Sex and gender “reassignment” classifications emphasize sex/gender-changing effects among transgender consumers of surgery. But this research has shown that the effects of surgery for trans people were not about changing sex or gender. Surgery did not magically transform transgender respondents from one gender to another. In contrast, the only respondent who proclaimed suddenly feeling like a woman after surgery was a cisgender woman. Cisgender respondents also reported marked changes in gendered embodiment after surgery, suggesting that some of their surgical experiences qualify as gender “reassignment.” Overall, trans and cisgender people experienced surgery similarly. Psychomedical institutions classify and regulate the surgeries differently without empirical evidence for doing so.

The data presented in this chapter indicate that the cosmetic benefits of surgical body modification frequently relate to gender. When respondents reported “looking better” after surgery, they typically described characteristics of conventional feminine or masculine standards of attractiveness. For both cisgender and transgender respondents, surgery was a way for them to “do” gender, or do gender better (West and Zimmerman 1987). Both groups reported that surgery enhanced their ability to express gender. It helped them make their social genders match their personal genders. Overall, surgical body modification enhanced bodies in gendered ways.

Positive cosmetic outcomes of surgery changed the psychological wellbeing of both transgender and cisgender respondents in this study. As most respondents were motivated to get

surgery to look and feel better, they were able to realize their goals. The effect of “looking better” dialectically informed the ways respondents also reported “feeling better.” Cosmetic and psychological effects were reciprocal. Surgery created more aesthetically appealing bodies, according to social conventions of attractiveness. These embodied enhancements created feelings of comfort, confidence, and freedom. This internalized psychological wellbeing allowed respondents to carry themselves outwardly with more confidence through dress, posture, and behaviors like working out at the gym. Surgery did not simply repair the body by smoothing wrinkled skin, extracting fatty tissue, and reshaping bone and muscle. It healed the self. It provided meaningful psychological effects that challenge the labeling of surgical body modification as “cosmetic” or “aesthetic” when performed on cisgender and transgender bodies.

Implications for Classifications of Surgical Body Modification

The mental health benefits of surgery, then, cannot be discounted. These benefits raise questions regarding insurance companies’ decisions to fund surgeries only for their anticipated physical health benefits. Although 13 respondents in this study reported that they wanted surgery to prevent or address a physical health issue, only three people reported that surgery resulted in a direct, positive effect on their physical health. The other people who wanted surgery for health reasons instead emphasized its cosmetic and psychological benefits. The three respondents who reported direct health benefits were cisgender men who had rhinoplasties and said surgery helped them breathe better after surgery. Although these benefits are noteworthy, the quality of mental health benefits reported by 34 respondents exceeded the physical health benefits reported by these few respondents. When insurance companies decide to cover procedures for documented health problems, they clearly conceive of “health” in limited terms. This decision reflects a long

history of insurance companies covering the costs of physical health problems more than mental health problems. Despite the 2008 passage of mental health parity legislation, coverage for mental health services still pales in comparison to coverage for physical ailments, largely due to stigmas associated with mental illness. Insurance companies also balk at covering conditions diagnosed through subjective testing, such as a therapist's interpretation of a client's feelings, compared to more standard measures like x-rays and blood work (Churchill 2010).

Overall, the similarities between transgender and cisgender consumers of surgical body modification are striking. Both groups have much in common regarding their feelings toward their bodies before surgery, their motivations for surgery, and the effects of surgery they experience. This research demonstrates that both groups are similarly likely to feel okay about their bodies, as they are to feel self-conscious or to hate their bodies before surgery. Both groups report cosmetic and psychological motivations for surgery, and both report these same effects of surgery. Cisgender and transgender respondents both went from hiding their bodies before surgery to showing them off after surgery. These data illustrate that transgender and cisgender people have remarkably similar embodied experiences before and after surgery. They share common experiences with gendered embodiment. For both groups, surgery enhances the self through the gendered body. With these similarities before and after surgery, disparate protocols that regulate access to surgery become suspect. It seems that one's gendered status – cisgender or transgender – determines one's ability to access surgery with or without psychomedical gatekeeping, as these findings cannot be attributed to other sample demographics. The next chapters detail the processes of accessing surgery for both groups. They reveal how protocols that regulate surgery only among transgender populations create barriers to care and unequal healthcare practices.

CHAPTER 6 – PURSUING SURGICAL ENHANCEMENTS: CISGENDER THOROUGHNESS AND TRANSGENDER GATEKEEPING

In Chapters 4 and 5, I established that transgender and cisgender consumers of surgical body modification reported similar embodied experiences before and after surgery. They reported similar feelings about their bodies before surgery, and both reported similar surgery effects. Despite these common experiences of surgery as cosmetically and psychologically healing, and connected to gendered embodiment, transgender and cisgender people's experiences pursuing surgery varied somewhat. In this chapter, I discuss the experiences of respondents as they found surgeons to change their bodies. I begin by examining the messages about surgery that respondents encountered. I then relay the factors that helped respondents choose surgeons. Finally, I detail the interactions respondents had with surgeons. Overall, many similarities existed between cisgender and transgender respondents. But a few key differences in these groups illustrate how the pathologization of cross-gender surgical body modification disadvantaged trans experiences and privileged cis experiences.

Healthy Standards and Trans Surveillance: Messages about Surgery from Surgery Communities

Before accessing surgery, most respondents in this study researched their options. They read online reviews of surgeons and learned about different surgical procedures. Transgender and cisgender respondents also researched surgery through different communities where they could interact with others who had surgery or were considering it. Within these communities, cis and trans respondents encountered different messages about surgery.

Communities as networks of information. Transgender respondents reported greater involvement with their surgery communities. Gender-affirming surgery is an important

experience for many transgender people. Information about surgeries proliferates throughout trans communities in support groups, on listservs, and at conferences. All of the trans respondents in this study reported some involvement with the larger trans community, and seven reported extensive involvement. Trans respondents' activities usually extended beyond socializing, including volunteering for trans organizations or attending and hosting support groups.

I feel pretty connected to the trans community. I try to attend a lot of trans groups and have a lot of trans friends. . . . Like a few small gatherings of trans-masculine gatherings where they talk about trans issues and stuff like that . . . going to [Southern Comfort Conference] and just kind of a part of that.

–Charlie, transman

I try to be [in the transgender community] as much as I can. I suppose you are familiar with the Southern Comfort Conference . . . [my partner and I are involved in that]. And I try to communicate as much as I can on the web, which I don't know how long ago, that has been 10 years ago. When I first got on to the internet and I found all these different sites and I'm like, oh my God, are you kidding me? How could it be possibly be this many of us out there? You know, it was almost overwhelming. So I keep that way, with different groups on the internet. And well we hope to go to Be-All [conference], that's in Chicago.

–Evelyn, transwoman

Although some trans respondents reported contentious relationships with the broader transgender community, none were completely isolated from it. These community relationships provided trans people with opportunities to interact with others about surgery.

The relationships reported by trans respondents contrasted with what cisgender people found. Although surgery communities exist for cisgender people – such as the online community MakeMeHeal.com analyzed in this study – only five cisgender respondents reported any relationship with them. Cisgender respondents' relationships to these communities were much less involved. As Luke explained:

I did [go to the cosmetic surgery message boards] prior to [surgery]. Never looked afterwards. . . . After I made the decision, I didn't look at it anymore, at those things. . . .

I wanted to read what real people had to say. And I think that's just as important as anything else in those experiences.

–*Luke, cisman, liposuction on torso and neck*

These data show that cisgender respondents had less sustained immersion in communities that discussed surgery. They had fewer personal contacts with other people who had surgery and did not attend events where surgery was discussed. Transgender respondents' community involvement allowed them to learn about surgery through a variety of resources, encounter more detailed messages about surgery, and engage with others who had gone through similar experiences.

Be healthy before surgery. To understand how respondents prepared for surgery, I asked them about messages they heard regarding surgery requirements. Respondents reported hearing three main types of messages about surgery requirements: messages about standard health requirements, messages about restrictive age and therapy requirements, and messages about gender expectations. Both transgender and cisgender respondents heard messages about basic requirements, but trans respondents more often heard about additional restrictions and gender expectations.

In total, 16 respondents (7 cis, 9 trans) reported hearing messages about surgery requirements that related to ideal health status. Both cisgender and transgender respondents reported hearing that they needed to be in optimum health before surgery. They learned surgeons could expect them to stop smoking or drinking, or maintain a healthy weight prior to procedures. For a few respondents, some of the health status messages related to ways to pay for surgery through insurance.

I had heard about requirements that you had, that some people had to meet prior to surgery, i.e., like if you were obese that you had to lose a certain amount of weight. So,

other people had told me that you really need to be at your goal weight prior to having this done. So I would hear things like that, but that's about it.

–*Sam, cisman, liposuction on torso*

I [had heard] to not smoke, which is not a problem for me, and drinking was kind of debatable.

–*Brian, transman, chest reconstruction*

I do remember hearing stuff . . . through magazines and news articles and stuff. . . . I of course heard, plastic surgery cosmetic surgery, I'd heard certain things like, don't take vitamin E, you have to be within a certain weight range, be free of heart conditions and all that sort of thing to go with any surgery.

–*William, cisman, liposuction on torso*

These messages refer to standard surgery protocol and health advice for anyone undergoing a surgical procedure. Based on these data, both trans and cis respondents knew they could be expected to fulfill standard health requirements before undergoing surgery.

Be of age and go to therapy before surgery (if you are transgender). Beyond basic messages, some people reported hearing that their access to surgery could be restricted by factors unrelated to physical health. Fourteen respondents (2 cis, 12 trans) reported hearing messages about age and therapy requirements. Two respondents who were under 18 years old when they knew they wanted surgery reported hearing about needing to reach a certain age to qualify for surgery. But most of the respondents who heard messages about restrictions reported hearing that surgeons could require counseling or an authorizing therapist letter prior to surgery. Messages about therapy requirements were inconsistent. Some respondents reported hearing that letters were required, but others reported hearing that they were not. A few people alluded to the WPATH Standards. The sole cisgender respondent who reported hearing about possible therapy requirements said he heard about a trend among surgeons to evaluate prospective surgery consumers. In general, nearly all respondents who reported hearing about age and therapy requirements were transgender.

I was quite surprised from my research, the only surgery that has a requirement is SRS, or G[ender] R[eassignment] S[urgery] as people refer to it. One can get facial feminization surgery, breast augmentation without any referrals or letters or anything. I will also say that it's also very easy to get an orchiectomy with just a relatively simple letter too.

–Helen, transwoman, facial feminization

I always heard that to get a boob job, you need a letter from your psychiatrist before you can get a boob job and stuff like that. And [my partner] said, “No, you don’t.” . . . I guess it depends on the doctor? I mean if the doctor can see it as, I guess the doctor can read you and if he sees that yeah, this isn’t for you, he’ll ask for a letter.

–Lauren, transwoman, breast augmentation

I heard that a letter was required. . . . I guess it was from going to surgeons, Doctor [A],⁹ on his website, it said he needed the letter. And then Dr. [B] said he needed a letter. So, I think it was just the surgeons saying it and because I guess I was thinking everyone needed a letter because of that. And then I realized, well maybe it’s state to state. And then I realized, well maybe it’s just them covering their ass, which I’d probably do if I was a surgeon.

–Tyson, transman, chest reconstruction

Trans people were more likely to hear about factors that could prevent them from accessing surgery autonomously. This finding was a major difference between the cis and trans groups. By hearing messages about needing to provide authorization from a psychotherapist, trans people learned that their surgery decisions were often not valued as independent and autonomous pursuits. Instead, they learned that their desires for surgery often needed external authorization.

Be the right gender before surgery (if you are transgender). In addition to messages about age and therapy requirements, transgender people were more likely to report hearing messages about gender expectations. Fifteen respondents, all transgender, reported hearing about having to meet gender expectations before surgery. These messages included having to live in the desired gender for a certain period of time, conform to gender norms, be established on hormones before surgery, and commit to going stealth – hiding one’s transgender status – before surgery. Like messages regarding therapy requirements, trans respondents reported hearing

⁹ The surnames of all healthcare providers have been replaced with the letter “A.” When respondents referenced multiple doctors in one quotation, the letters are alphabetized.

mixed messages about gender-related expectations. Of the messages they heard, few accurately depicted the eligibility criteria in the WPATH Standards.

I know ideally there's that whole, you have to have a year of living full time to qualify for GRS. But I know they shortened that to like six months if you're going to Singapore. . . . There's one doctor who does the majority of the work . . . in Thailand, and he only requires like six months and even then I think he's just taking your word for it or like, your money is American and green and he's happy.

–*Samantha, transwoman, breast augmentation, genital surgery*

[My therapist] was assuring me that [surgery] was going to take much longer. . . . I've heard different things that for a whole year that you have to have been on testosterone and my doctor, Dr. [A], he said, "No." You didn't have to be on testosterone to have surgery with him.

–*Slice, transman, chest reconstruction*

Though it was already sort of defined as antiquated by this time, [I had heard] that in the past there were more strict requirements or typically, there are often most strict requirements in ways that you're supposed to, you know, traditionally according to the Harry Benjamin Standards of Care . . . , androgyny is kind of looked down upon. And also generally heterosexuality in your preferred gender role is looked up upon.

–*Calliope, transwoman, genital surgery*

I think I had heard from people that you should be like a straight male, so you should probably seem as masculine as you should be [laughs]. . . . There were some people . . . who were like, you have to live stealth and be very masculine.

–*Charlie, transman, chest reconstruction*

Trans respondents often dismissed messages about rigid gender expectations as outdated practices that were no longer commonly enforced. Although they heard about less subjective gender expectations, such as time in the real-life experience in the desired gender or time on hormones, they knew some surgeons could waive requirements. Thus, trans respondents typically did not worry much about these restrictions. But information about gender expectations confounded other messages about surgery requirements. It reinforced characterizing surgery for transgender people as in need of scrutiny. In addition, messages about needing to pass as normatively masculine or feminine can cause trans people to feel anxiety about fulfilling gender

expectations in order to gain access to medical transition. This anxiety prompts some trans people to conceal non-normative narratives to avoid being denied services (Waszkiewicz 2006).

Awareness of surveillance (if you are transgender). In this study, both transgender and cisgender respondents learned about surgery from different sources. Trans respondents reported more sustained involvement within communities that frequently discussed surgery. This higher level of engagement made trans respondents encounter more messages about potential surgery requirements. Trans respondents learned that some surgeons could require them to provide external authorization to authenticate their desires for surgery, subjecting their desires for surgery to increased surveillance. Respondents also heard that gender expectations were sometimes part of this authorization experience. The different messages encountered by cis and trans respondents relate to disparate protocols for transgender and cisgender surgeries. While most cisgender respondents only heard about surgery requirements that related to physical health, transgender respondents learned about additional requirements before surgery. As Chapter 3 showed, clinical literature on cisgender surgery eligibility was nonexistent, which contrasted with the multiple protocols published for transgender surgery. The messages heard more by trans respondents referenced criteria outlined in the WPATH Standards. Although few trans respondents accurately relayed the prescribed criteria for surgery in the WPATH Standards, they knew that specific guidelines existed and regulated their access to surgeries. Consequently, learning about surgery meant that transgender people became aware of psychomedical discourses that discounted their agency in making decisions about their bodies. Both cis and trans groups learned about physical conditions that could preclude surgery. But only the transgender consumers learned that independently consenting to surgery could be insufficient for surgeons who require outside evaluation or a convincing gender presentation. Most cisgender respondents

learned that after meeting basic physical standards, they could consent to surgery. When learning about surgery, cisgender respondents did not hear that surgeons might question their decisions, assess their gender expressions, or ask them for a therapist's approval before doing surgery. Only transgender respondents encountered a discourse that framed their desires for surgery as needing surveillance – information derived from the WPATH Standards. As I show in Chapter 7, information about gatekeeping played out during respondents' interactions with psychomedical healthcare providers.

Selecting Surgeons: Prioritizing Reputation, Skill, and Bedside Manners

Armed with information learned from their research, respondents began selecting surgeons. Choosing surgeons was an important task for many respondents. Twenty-four respondents (10 cis, 14 trans) shopped around for their surgeons. They perused surgeons' websites, compared reviews, and went to multiple consultations. By comparing different surgeons, these respondents were able to make more informed choices. Overall, respondents mainly chose surgeons due to the surgeon's reputation, professional skill, and bedside manner. Other reasons for choosing surgeons were practical, like proximity and cost. Others chose surgeons due to gender preferences. Respondents often reported more than one reason for choosing surgeons.

The most common reason for choosing surgeons, reported by 34 respondents (18 cis, 16 trans), was the surgeon's reputation. Both transgender and cisgender respondents chose surgeons who were renowned by others in the community. Respondents heard about their surgeons from people who had successfully used their services previously. Others read positive reviews of their chosen surgeons online or in magazines.

My doctor was referred to me by a friend who had been to him and had good results. And so that's how I chose him. . . . And then [I] did additional research on the physician himself. . . . I had called his office and asked for a resume. And so then I looked him up online, read his bio, they also provided you with references. I contacted a couple of those references. . . . He was the only physician that I could get a personal referral to. I mean someone who had actually been to him and had the work, had the exact same procedure done.

–*Sam, cisman, liposuction on torso*

He came highly recommended. There is a woman that works in my office and her daughter actually used to work as a nurse for him and said he was very professional, very good at what he does, made a couple of the magazines here in the Atlanta area. So, it was more of a referral basis.

–*Michele, ciswoman, breast augmentation*

I saw [my doctor] online. I did enough research about him. He's the only doctor that I have seen a lot of video, fun YouTube videos, you know people. And he is really, really down-to-earth. He's willing to go under the camera, you can bring the camera right in there and he is very comfortable with what he is doing and I think he is very thorough too.

–*Slice, transman, chest reconstruction*

In addition to professional reputations, surgeons' experience, training, and quality of work were influential factors in choosing providers for 24 respondents (10 cis, 14 trans). For both cis and trans respondents, these "hard skills" mattered a great deal in their decision to choose surgeons.

He's just sort of known and we just used him and trusted him, saw his photos and it looked pretty good.

–*Ethan, cisman, otoplasty*

I felt at the time, looking at my own face and my own bone structure, that I really didn't need the services of someone like Dr. [A], who will basically peel your whole face off and rebuild your skull and then hook your face back to it. . . . I had seen their work on several other people, [my friend] had Dr. [B], and I thought she looked pretty good. I thought his work was, he did pretty good for her, she looks female.

–*Ann, transwoman, facial feminization*

I think he's the finest surgeon in the world for [SRS] and his aftercare is so much higher than anything else, I think probably in the world. There was really almost no other choice.

–*Alexis, transwoman, genital surgery*

Transgender and cisgender respondents both valued surgeons who had reputations for producing quality work. They preferred to have surgery with someone who had experience and talent in their surgical abilities. Several trans people also mentioned that they chose surgeons due to the surgeon's positive relationship with the trans community.

In addition to evaluating surgeons' technical expertise, respondents also valued surgeons' "soft skills," or their ability to relate interpersonally. Twenty respondents (9 cis, 11 trans) chose surgeons on the basis of their bedside manners. These respondents described surgeons using an array of terms that related to surgeons' personality and demeanor. The "right" bedside manner varied for individual respondents, but valued interpersonal qualities included surgeons who respondents described as nice, friendly, and professional. Respondents also appreciated surgeons who seemed caring, trustworthy, and warm. They reported choosing surgeons who were willing to work with them regarding their specific surgery requests or method of paying for the procedure.

Basically, I chose [Dr. A] because of [the surgery center], the way they treat the customers, the people there . . . the lady who meets with you and gets the dates and the prices and everything together. I guess she's a billing and coding receptionist, but she is really sweet. They treat you like royalty. They're really nice people. So, basically I could have went anywhere and got my breast implants, but I chose them because of their people skills and their customer service.

—*Eva, transwoman, breast augmentation*

His bedside manner and his phone manner was phenomenal. . . . And anytime if you had any kind of problem with getting anything, [his staff was] like, "Okay, we can do this, this, this and this, and let's help you get through this." So, they were real helpful, which is nice, because in that kind of situation you become stressed out. . . . You're trying to get everything done that you need to get done. And so, they were really trying to keep it relaxed. And it's like, "It's going to be okay. You just get this and this and this and this and then we got it all." So it was nice in that manner.

—*Jack, transman, chest reconstruction*

Trans and cis respondents both valued surgeons with pleasant bedside manners. When choosing surgeons, it was important for both groups to feel like they trusted their bodies with someone they liked.

In choosing surgeons, cisgender and transgender respondents differed in one way. Fifteen respondents (4 cis, 11 trans) said they chose surgeons based on practical reasons. They selected surgeons who offered competitive rates and were located nearer to their homes.

If I could have afforded to travel, I either would have gone to Florida or California where people had talked pretty highly about chest surgeons. I felt really scared going to someone that maybe hadn't done a lot of chest surgery. I had heard a lot of older trans guys talk about surgeries they had had they were extremely unhappy with. So, I didn't want to spend a whole bunch of money and then walk away upset. So, I chose Dr. [A] because he was close and I couldn't afford to travel and a couple people seemed really happy with his surgery.

–*Jasper, transman, chest reconstruction*

Dr. [A] was someone who I knew who had experience with top surgery. And so he would be covered by my insurance and he knew what I wanted and he was a nice guy and so I chose him. It was out of a, what I felt like was a very limited pool of providers.

–*CJ, transman, chest reconstruction*

The locational and financial accessibility of surgeons were more important for trans respondents. Trans respondents could not just go to any plastic surgeon because surgeons do not always offer procedures common among trans people, such as chest reconstruction and orchiectomy. And as a group, trans people in this study were of lower socioeconomic class than the cisgender respondents. Other research verifies this economic disparity. Transgender and gender nonconforming people are almost four times more likely to earn less than \$10,000 annually compared to the general population. They also have twice the rate of unemployment (Grant et al. 2011). Many trans respondents in this study could not afford to travel for surgery, or had to spend time saving money to do so. This finding reflects the socioeconomic differences between the sample subgroups.

Overall, both transgender and cisgender respondents valued the same qualities in surgeons. Both groups shopped around for surgeons with solid reputations, great skills, and good bedside manners. The major difference between the groups was in choosing surgeons due to practical reasons like cost and proximity. This difference can be attributed to the inherent class difference in the sample. Because trans respondents had higher rates of underemployment and worked in less professional sectors, cost and location of surgeons was more important in their decision-making. Trans respondents, then, faced one additional burden in choosing surgeons.

Interacting with Surgeons: Perceiving Good Doctors and Cautious Gatekeepers

Both cisgender and transgender respondents reported mostly favorable interactions with surgeons regarding their technical skills as professionals and interpersonal skills as people. Trans respondents, however, were more likely to identify specific problems with surgeons' demeanors. Although both trans and cis respondents reported that surgeons questioned their decisions for surgery, the nature of this questioning differed for each group. Trans respondents were also the only respondents who reported being denied surgery. These differences between cis and trans respondents showed that although both groups reported many similar and positive experiences with surgeons, trans people were more likely to encounter hostile environments during interactions with surgeons. Still, the majority of respondents reported positive experiences with their chosen surgeons.

Surgeons as skilled professionals. When respondents described positive interactions with surgeons, they typically said that surgeons demonstrated a range of technical skills during interactions. Respondents reported that surgeons relayed the intricacies of surgery and the possibilities for changing the body. Most respondents (18 cis, 16 trans) stated that surgeons took

time to explain what the procedures would and would not do for them. Specifically, they said that surgeons told them how surgery would make them look (8 cis, 2 trans) and feel (3 cis, 1 trans). Respondents (5 cis, 6 trans) reported that surgeons sometimes recommended they get other surgeries. Alternately, some respondents (5 cis, 3 trans) said they asked surgeons about doing other procedures. During interactions, surgeons helped code procedures in ways that aided insurance coverage (3 cis, 3 trans). Surgeons also provided aftercare (4 cis, 5 trans) and revisions (2 cis, 3 trans) for respondents.

He made me feel comfortable, I guess, from my pre-authorization and consultation the day before, he explained everything that was going to happen. I mean, everything happened the way he said, didn't nothing go differently.

—TJ, transman, chest reconstruction

I don't remember any of them putting any barriers or kibosh or anything like that in the process. They all seemed to be like, "Yeah, this is going to be straightforward, simple lipo fat suck. You'll be in and out. You'll have bruising for this long. It'll be like this, and these are the results you can expect. Here's some pictures from other clients and let's go."

—William, cisman, liposuction

Trans and cis respondents reported similar experiences regarding the ways their surgeons discussed procedures with them. Both groups reported that their surgeons explained how the procedures worked and how the surgery would affect their bodies. Both groups also reported similar rates of aftercare and revisions.

Surgeons with varied bedside manners. When describing their experiences with surgeons, respondents often relayed details about doctors' bedside manners. More respondents reported that their surgeons had positive bedside manners than negative demeanors. Nineteen respondents (8 cis, 11 trans) used positive language to describe the ways their surgeons interacted with them. They described surgeons as friendly, nice, and comforting.

[My surgeon asked], “How did the surgery center go? How did people treat you there? . . . Are you comfortable where you are? Do you need anything?” He would always ask me, so I felt, I just felt like he was checking everything. . . . And so he was just making sure that I felt comfortable in his world. . . . I felt like he really was thorough about making sure. . . . I felt completely comfortable from the time I came in. . . . It’s like he would sit and he’ll ask you, “Are you comfortable?” And he looks in your face and I feel like he really wants to know, *am* I comfortable.

–*Slice, transman, chest reconstruction*

[My surgeon’s] staff is very, very well trained. There was plenty of attention before you went in, the day of. . . . When you woke up there was two people with you. He came and checked on you several times. I mean, I know he had other things doing, but his staff was so attentive and caring. And like when I had the breast reduction, I happened to be the only one that was there that day for overnight. Those two nurses stayed with me the whole time, course I was higher than a kite on whatever I was on! And we watched television together and whatever, but it’s very clean. It’s very comforting. It’s very, you don’t feel like you’re an idiot doing it. Sometimes I think you can get into a medical situation and you’re just a number and whatever.

–*Lilly, ciswoman, breast reduction*

It was great, he was great and very comfortable. I had no problems asking any questions, you know, never felt uncomfortable standing in front of him. . . . When they do this whole here’s this and that, and just very, very professional.

–*Julie, ciswoman, breast augmentation*

Trans and cis respondents were both likely to note specific characteristics that contributed to good bedside manners, such as making respondents feel comfortable or having likable personalities. A surgeon’s positive bedside manner helped ease respondents’ comfort during interactions and the actual surgery.

Although more respondents described surgeons’ interpersonal skills using favorable terms, nine respondents (6 cis, 3 trans) described surgeons’ bedside manners using less than affirming language. These respondents described surgeons’ bedside manners in more negative terms, such as clinical, cold, business-like, and distant.

He wasn’t necessarily a warm and fuzzy man, he wasn’t. He was very realistic and very clinical and he didn’t give you any high hopes of what things were going to happen.

–*Re, ciswoman, blepharoplasty and facelift*

It was really business like. . . . He doesn't really have a good bedside manner. I mean, he was fake friendly, but it was very like in and out. He didn't seem too concerned with health or anything. . . . He would like pop in for my visits after and not really seem concerned when I was concerned about something. . . . Like when I had to go back for a brief visit, I would go and wait forever and then I would go in and then he would pop in real quick and would be like, poke his fingers on me and then be like, "Okay," and then leave.

–*Charlie, transman, chest reconstruction*

[My interactions with my surgeon were] relatively good, kind of cold and straightforward which I kind of didn't appreciate being so young and kind of uneasy about it. But as a whole, he knew what he was doing and I trusted him. So, I just took it for what it was.

–*Kris, cisman, rhinoplasty*

His bedside manner is not very good. You know, he's kind of a salesman. He does the operation and then it's kind of like, off to the next.

–*Alexis, transwoman, facial feminization*

Respondents trusted surgeons with the care of their bodies. So when surgeons exhibited unpleasant interpersonal skills, some respondents felt slighted.

Both cisgender and transgender respondents more often reported that their surgeons had good bedside manners than poor demeanors. Although cisgender respondents described surgeons as unpleasant more often than trans respondents, they attributed surgeons' distant demeanors to professionalism and did not mind the impersonal interactions. Cis respondents remained in the care of these surgeons despite their poor bedside manner. Trans respondents, however, tended to identify surgeons as insensitive or financially motivated. They sometimes chose to seek services elsewhere after unpleasant encounters. Trans respondents were also more likely to report that surgeons made flirtatious or sexual comments toward them or used overt gender stereotypes during their interactions. For example, Eva said that her surgeon asked her if her sexual partners knew she was transgender. Alexis reported getting a surgery consultation with a surgeon who hit on her and then became annoyed when Alexis rejected her advances. This difference in interactions with surgeons suggests that although trans people were like cisgender people in that

both generally attributed positive traits to their surgeons, trans people more often reported unusual and problematic scenarios with surgeons. These issues, coupled with the encounters described below, created a more hostile atmosphere for trans people seeking surgery.

Surgeons who questioned respondents. Although most respondents reported positive experiences with surgeons, some had their surgery decisions questioned. Nine respondents (5 cis, 4 trans) reported that surgeons questioned their specific surgery requests or their actual desires for surgery.

Among the nine respondents who reported that surgeons questioned them, four (1 cis, 3 trans) reported that surgeons questioned their desires for specific body sizes or shapes. These respondents felt like surgeons were initially resistant to their requests.

The surgeon and I were not exactly on the same page. I had to take him in photos of boobs and go, no, this is where I want to be. And he tried to like talk me out of it, “Oh, too small, too small, too small.” And it’s like, no. [laughs] . . . One funny thing he did ask me – this is the best – he said, “Is your boyfriend okay with this?” as far as the reduction. Like it would really play any point in whether I had it done or not! I thought that was kind of funny too, “Is he okay with it?” [I said], does it matter? You know? I mean *really*!

–*Sheri, ciswoman, breast reduction*

The first surgeon one trans woman saw for a surgery consultation questioned her request for large breasts:

So, alright doctor, well, how big can I go? “Well, on you I would probably go about 4 or maybe 500 cc’s.” Really? You know, I have 42 inch shoulders. If you’re going to make anything look proportionate on me, you’re going to have to go pretty big. “Well, yeah, 4-500 cc’s is pretty big.” 500 cc’s on me would be about a light C-cup. His idea of pretty big and mine are really different. So, I tried to express to him that what I really wanted was some 800 cc’s overfilled to about a thousand. “Oh no. No.” [laughs] – I remember this one – “No, you don’t want that.” Yeah, I kind of do. “No, you really don’t. You’d just look like a freak.”

She said that after he expressed his opinion, she left his office. Later, she had a consultation with the surgeon she eventually chose. This surgeon also questioned her size choice:

He questioned first, “Why do you want a boob job?” I said, because I am flat-chested. I am like an A-cup. . . . It’s very, very small. It did not make me happy. I wanted to change it. He said, “Okay.” And then his second one was, “Really, you want to go that big?” I said, yes, I want to go that big. . . . He said, “That’s pretty big.” I said, I’m a big girl. He said, “Well, yeah. But I mean, that’s really pretty big. That’s going to involve a lot of stretching. I don’t even know if it’s possible.” Well, what I would like from you doctor is the assurance that you will try. “I’ll try. I’ll do what I can. I’m not going to guarantee you that I am going to be able to get them to that size because your body might not be capable of holding it. We put stretchers in it and fill those up and see how they do. And if you can hold those, then we go ahead and put the implants in. And you may not be able to sustain.” Oh, okay. Well, that sounds reasonable.

—*Samantha, transwoman, breast augmentation*

Samantha appreciated that this doctor’s skepticism over her request was due to concern about whether the size was surgically possible. Incidentally, after Samantha’s surgery healed, she said her surgeon concurred that the large breasts looked proportionate to her body. Although the surgeon from her previous consultation may have had similar concerns about the feasibility of the procedure, she said he expressed them using judgmental language by suggesting she would “look like a freak.” Most of the cases where respondents reported having to convince surgeons to comply with their requests related to breast surgery. In the examples above, Samantha had to convince her surgeon that she wanted her breasts that large. Sheri had to convince her surgeon to make her breasts that small. It is possible that the resistance they encountered could be attributed to respondents’ concerns about the technical feasibility of the surgery. But the tones of these exchanges conveyed by the respondents suggest that these interactions were more influenced by norms about appropriately gendered bodies. This is especially evident in Sheri’s interaction, where she relayed how her surgeon imposed sexist ideas about men’s attractions to women’s bodies. Surgeons, then, sometimes acted as gatekeepers to ideal bodies for both trans and cis consumers.

Among the nine people who reported getting questioned by surgeons, seven (5 cis, 2 trans) reported that their surgeons questioned their actual decisions to have surgery. Respondents

experienced these situations in varying ways. Some believed surgeons were just checking in with them to ensure they were committed to the surgery, especially in terms of the recovery period and long-term effects on the body.

They asked me . . . before I had the breast reduction . . . and the tummy tuck, “Well, you’re not planning on having any more children, right?” And it’s like, no, no. I’m done.
–Sheri, ciswoman, breast reduction and abdominoplasty

The [ear-nose-throat doctor] sat down and he wanted to know why I was there for the surgery, what led me to that point, was I sure that I wanted to have surgery, because it was long recovery. . . . Once he realized that I was there for an aesthetic reason, I think, and then we talked more through it, I didn’t really know how long like the recovery time was, and what was involved and stuff like that. So he just kind of laid out for me what a commitment it was. Like you know, I’m going to be wrapped up in bandages for two weeks. For three weeks after that, two weeks, I had to wear an ACE bandage around my head 24 hours a day. And then for two months after that, I had to wear an ACE bandage to bed at night. So, he was like, “Are you sure that you can commit to doing all that and want to commit to it? Because it’s not just like you’re going to walk in here and have your ears pinned back and walk off the table and like it’s no big deal.” He made it very apparent to me what I was getting into, and then wanted to make sure if I was in it for that level of commitment. . . . That I really wanted the surgery and that it wasn’t like I was walking in like, oh I woke up today and thought it would be a good idea to have my ears pinned back. [laughs]
–Anthony, cisman, otoplasty

In these cases, respondents felt like surgeons just wanted to ensure they could commit to the surgery. Other respondents explained that when surgeons questioned their decisions, they seemed to want to assess their psychological mindsets. Two of these respondents, Re and Sophie, disclosed mental health issues to their surgeons. Re informed her surgeon that she was having a difficult time dealing with her divorce:

He wanted to make sure that I was having it for the right reason. That I also didn’t have exceedingly high expectations of what the surgery was going to give me, that I was realistic in what I thought was going to happen. . . . And also I think they wanted to make sure that psychologically you were also not thinking that that was going to be the answer to your life’s problems.
–Re, ciswoman, blepharoplasty and facelift

On Sophie's intake form, she disclosed that she had a history of anorexia:

I think vaguely for the leg surgery . . . , he wasn't really questioning me but it was sort of like, you know, "Do you think this is a good idea?" kind of question. Which I of course was like, oh yes, you know. It's really important for me blah, blah, blah. I don't know I came up with some spiel. But you know it was, it was kind of rhetorical. I think he was just doing it for appearance sake, like it wasn't serious.

–*Sophie, ciswoman, liposuction on legs*

Re and Sophie reported that their surgeon wanted to check in with them about their psychological readiness for surgery. They were honest about their mental health issues and said that their surgeon just wanted to ascertain whether they were comfortable with surgery. In another example, Aaron did not disclose any mental health problems to his surgeon. But during our interview, he said he believed his decision to have a surgery was influenced by having a distorted and unrealistic perception of his body. Aaron's narrative shows how his surgeon questioned his desire for surgery.

My doctor did say to me that it was probably an issue that I had more so than anybody else had. So, was I okay with and comfortable with that. . . . [With] the [surgery], to make sure that I realized that the before and after was not going to be this miraculous, completely different thing and it was going to be very subtle. And so, he just wanted to make sure that I was very comfortable with that. . . . He said, "This is probably more your own issue with this than the reality is."

–*Aaron, cisman, liposuction*

According to Aaron, his surgeon did not believe that surgery would significantly change the shape of his body. He suggested to Aaron that his impression of his body was not necessarily realistic. A disconnected sense of perception of one's own body is a characteristic of body dysmorphic disorder (Pertschuk et al. 1998). Still, Aaron's surgeon agreed to perform the procedures. Obviously, all respondents who said that surgeons questioned their decisions were still able to get surgery. This finding demonstrates how the presence of mental health issues did not preclude surgery for people in this study. Even after revealing they were in compromised psychological states or exhibited behavior characteristic of psychological disorders, respondents

were able to get surgery. Although reports of surgeons questioning respondents' decisions were not common, they occurred more often among cisgender respondents. And because cisgender respondents rarely reported hearing messages about getting questioned or evaluated by surgeons, they did not perceive these questions as indicative of a larger system that pathologized their desires. They did not feel judged. Instead, they typically attributed these questions to the surgeon being thorough and practicing more holistic healthcare. They did not feel like surgeons challenged their abilities to autonomously consent to surgery.

When transgender respondents reported that surgeons questioned their decisions for surgery, questions typically related to their decisions to transition from one gendered body to another. For example, Samantha relayed how consultations for breast augmentation contained questions about her decision to live as a woman:

I ended up making an appointment and having a conversation with [Doctor A]. And in doing so, he was *incredibly* condescending and actually confrontational about me transitioning. . . . In discussing with him, it rapidly devolved into, "Well, why do you want to do this?" Well, because I want bigger boobs. "No, I mean, why are you pursuing this? I mean, you're a man." Oh, well, I'm working on not being a man. I'm a man on the outside. I would like to make the outside match the inside. "Well, it seems kind of silly." Really? "Well yeah. I mean it's obvious that you're never going to look like a woman." Wow! Really? Now, I came to you because you are supposed to be experienced in dealing with trans patients. Is this how you deal with all of your trans patients? "Well, not *all* of them." And just confrontational, insulting, condescending and . . . I left. I was vastly upset after that.

The next surgeon Samantha saw also questioned her decision:

[Doctor B] insisted on having the letter [from a therapist]. And I said, well why is the letter important? And he said, "Well, legally I'm required to have it." And I said, well, actually it's kind of a recommendation from the Harry Benjamin Standards. And he said, "Well, I think I know best and legally I am required to have it. And if you don't have it, then obviously you're not very serious about this." Oh, if I don't have a letter from my mommy saying that it's okay for me to get a boob job then obviously I'm not serious about this? Okay.

—Samantha, transwoman, breast augmentation

Samantha's frustrating experiences illustrate how trans respondents' decisions for surgery could be subjected to increased scrutiny. In these instances, Samantha reported that her surgeons questioned her decision to live as a woman or to consent to surgery without an authorization letter from a therapist. She viewed surgeons as gatekeepers. Although rare, these cases highlight the different ways cisgender and transgender respondents must defend their decisions for surgery. Cisgender respondents endured questions about their decisions and specific surgery requests, but they remained under the care of those surgeons. When trans respondents encountered questioning surgeons, they were more likely to feel criticized for their choices and to seek services with another surgeon, which prolonged their surgery journeys. They viewed these questions as symptoms of a larger problem with psychomedical institutions that classified their desires as disordered.

Surgeons who denied surgery. Although cisgender respondents more often reported being questioned by surgeons, only trans respondents reported that surgeons overtly denied them services. Four transgender respondents were turned down for surgery. One trans woman was denied vaginoplasty and labiaplasty due to a congenital heart defect that required multiple surgeries over the course of her life. She was ultimately able to get the surgeries through a different provider. Another trans woman said she was turned away from a gender clinic in 1974 because she was married to a woman and expressed that she was sexually attracted to women. Gender clinics of that era tended to treat transsexuals only when they conformed to a narrow profile of a true transsexual. Clinicians typically believed "true transsexuals" would be heterosexual after transitioning (Meyerowitz 2002). However, Nikanj said he was denied surgery for a similar reason in 2007. He reported that a renowned surgeon who specialized in chest

reconstruction turned him down for surgery because he was legally married to a man and his sexual identity was that of a gay man:

As of 2007, [he] would not perform surgery if you identified as gay and were married. Okay, I was like eh, screw you. He didn't want to make a legal gay marriage, which I was sitting here going, aren't you in [a major urban city]? You know? Aren't there like gay people all around you? I was like yeah, whatever. . . . He said that I, that he was not comfortable basically doing a surgery on a, on basically somebody who is a straight woman and turn them into basically a gay man, "Because you are going to have a whole lot of problems and I don't want to contribute to that."

–Nikanj, *transman, chest reconstruction*

Nikanj's experience suggests that antiquated narratives about transsexuals may still be relevant to surgeons, especially given the erratic state of same-sex marriage in American politics. The last respondent who got denied for surgery believed that his surgeon did not want to work with him but blamed it on insurance issues. CJ's surgeon claimed that his top surgery would not qualify for insurance coverage, but he believed this surgeon was judging him because he was living as a masculine woman at the time:

I think part of it was that he didn't want me to be as small as I wanted to be. . . . I just didn't want any boobs. And I think for him that was not acceptable for a woman to not want any boobs and, or maybe he felt like he didn't have the expertise. I can't say for sure. . . . I think perhaps he was more inclined to want to do work with women that wanted to go down one size or you know, they still wanted to have breasts. And so I think that was more about my gender, maybe prejudice against women and their issues, why should a woman not want to have breasts, type thing. . . . He was friendly at first . . . but when he found out how small I wanted to go and, I don't know, it seemed like he cut it off at the end.

–CJ, *transman, chest reconstruction*

Data from respondents who were denied surgery show how surgeons acted as gatekeepers for trans respondents. No cisgender respondents reported getting turned away by surgeons for these reasons, including a cisgender woman who was able to get liposuction after disclosing her recent history of anorexia. Although these incidents were uncommon, they illustrate additional hurdles that trans respondents had to negotiate before finding surgeons willing to operate on their bodies.

Cisgender Thoroughness and Transgender Gatekeeping

The data presented in this chapter illustrate the processes of learning about surgery, choosing surgeons, and interacting with surgeons. When learning about surgery, both transgender and cisgender respondents heard about needing to meet basic health requirements. But trans respondents were much more likely to report hearing messages about having their surgery decisions questioned. When choosing surgeons, both groups shopped around for surgeons who had good reputations, great technical skills, and positive bedside manners. Trans respondents, however, were more concerned about choosing surgeons for practical reasons that related to the surgery's cost and the surgeon's location. Upon interacting with surgeons, most cis and trans respondents reported pleasant experiences working with skilled and likable surgeons. But trans respondents reported more specific problems during interactions with surgeons, including getting denied for surgery. Both groups reported getting questioned by surgeons about their requests and decisions for surgery. But when cisgender respondents' surgeries were questioned, they tended to credit surgeons as professionals who were being thorough. They typically were not annoyed with these questions. But due to discourses that pathologize transgender experiences, trans respondents tended to view getting questioned as gatekeeping. Whereas cisgender people stayed with surgeons who checked to ensure they were making good decisions, trans respondents were more likely to seek surgery elsewhere. Trans respondents' experiences with surgeons included more incidents that depicted a hostile atmosphere, which resulted from sociocultural norms that frame gender-crossing desires as troubled, immoral, and sick. When trans people were denied for surgery, they were sensitive to ways these decisions could have been informed by norms about appropriately gendered bodies.

The findings in this chapter reveal many similarities between transgender and cisgender respondents in their surgery experiences. It is refreshing that both cis and trans respondents reported having mostly positive experiences with surgeons. The findings also illuminate key differences between transgender and cisgender respondents where trans respondents had considerable disadvantages. Transgender respondents learned that they may need to defend their decisions for surgery. They expected that they might have to present their desires for cross-gender embodiment in a compelling manner. For some trans respondents, these expectations were realized during interactions with surgeons as surgeons questioned or denied their requests. The greater problems reported by trans respondents related to the ways that psychomedical communities pathologize cross-gender desires. As *transgender* people, these respondents pursued surgeries to change their gendered embodiment in ways that breached gender norms. When trans respondents contemplated surgery and then stepped into surgeons' offices, they entered into an institution informed by cultural norms that restrict cross-gender gender expression. As healthcare practitioners, surgeons reified the values of healthcare institutions. Based on respondents' experiences, surgeons managed the requests of trans respondents with a more heightened scrutiny than cisgender respondents. Their decisions worked in concert with mental health professionals whose disciplinary practices labeled cross-gender expressions as pathological. Due to classifications of gender-crossing as disordered, requests to change the body in gender nonconforming ways are inherently also disordered. But changing the body in gender conforming ways is not inherently wrong. Indeed, conforming to gender norms is expected. So when cisgender respondents presented with mental health issues and surgeons questioned their decisions, cisgender people did not experience this questioning as problematic. Their cisgender gender identities and gender-conforming desires for surgical body modification were not labeled

as disordered in and of themselves. Thus, cisgender respondents' surgeons could assess mental wellbeing and the ability to consent to surgery without a framework that pathologized all such requests.

Respondents' interactions with surgeons were only part of the psychomedical management of surgical body modification. Discourses that mark transgender surgeries as disordered and cisgender modifications as normative stem from psychiatric classifications that regulate gender. In the next chapter, I discuss the experiences of respondents in mental healthcare systems.

CHAPTER 7 – BECOMING CERTIFIABLY SICK: HOW TRANSGENDER PEOPLE GOT SURGERY AND HOW CISGENDER PEOPLE GOT SURGERY COVERED BY INSURANCE

In this chapter, I outline a major difference between transgender and cisgender consumers of surgical body modification by focusing on each group's ability to access surgery of their own volition. I focus on the process of getting authorized by therapists before surgery and show that while cisgender respondents could talk openly with therapists without worrying about authorization, transgender respondents negotiated counseling under scrutiny. In trying to gain approval for surgery, trans respondents encountered both permissive and restrictive therapists who would base their approvals on a variety of life factors. However, not all surgeons required letters, and those who did require letters did not process the letters further. In addition, three trans respondents reported being able to get surgery without therapy authorization. During therapy interactions, trans people negotiated a process wherein they became certifiably disordered. They submitted to pathologizing narratives to get surgery. The only comparable experience among cisgender respondents was their need to document a health problem in order to gain coverage for surgery by health insurance. In these instances, cisgender respondents became certifiably diseased. Becoming certifiably "sick" disadvantaged transgender respondents and benefited cisgender respondents. Trans respondents became certifiably disordered just so they could get surgery. Cisgender respondents, however, became certifiably diseased and were more likely to have the costs of surgery covered by insurance. Treating "sickness" with surgical body modification meant alleviating physical and psychological discomfort. But by supporting surgeries that aided the body more often than surgeries that aided the mind, healthcare

institutions privileged corporeal subjectivities and perpetuated false dichotomies of the mind and body.

Becoming Certifiably Disordered: Experiences in Therapy before Surgery

The most apparent difference between cisgender and transgender respondents related to the ability to access surgery upon demand. In this study, cisgender respondents were always able to get surgery without any kind of presurgical counseling requirement. Trans respondents, however, typically pursued psychotherapy because they anticipated needing a letter to change their bodies. The disparate regulation of surgeries among transgender and cisgender consumers has been theorized as inherently unfair (e.g., Spade 2006; Stryker 1997; Sullivan 2006; Wilchins 1997). Here I empirically demonstrate that although cisgender and transgender people pursue many of the same surgeries, they encounter different regulations in the process.

The respondents in this study were not averse to therapy. Indeed, both trans and cis people reported benefiting from rewarding relationships with therapists. Twenty respondents (3 cis, 17 trans) reported talking about their bodies and surgery with counselors. Both cis and trans respondents also used therapy for other reasons, such as to deal with depression or to discuss everyday life problems. But trans respondents were unique in that they reported seeking therapy because they expected that they would need to provide an authorization letter from their therapists to change their bodies. While 17 trans respondents reported that they went to therapy to get an authorizing letter for medical transition, no cisgender respondents reported going to therapy to get approval for surgery. Cisgender people did not have to formally validate their surgery desires. Instead, cisgender people who talked about surgery with therapists enjoyed supportive relationships with counselors.

My teacher, my shaman, teacher, guru, we had many talks about my body image issues. . . . We had many, many, many, many conversations about it. And in one I asked him . . . before I had [surgery], I said, so what do you think? I said, you know I don't want to be vain about this and . . . I don't want to circumvent something, I'm trying to make it better. . . . I wasn't foolish enough to believe that if I did this procedure, that the feelings or the emotions or the belief would just disappear, dissipate. So my point of working with him, at that point, was to deal with the root of the attachment from what was being said to me energetically or verbally to work through that process at the same time. . . . How can I make sure that I'm approaching this from a dynamic component, not one, like this will fix it, this surgery's gonna fix it, because I knew better.

–*Luke, cisman, liposuction on torso and neck*

It sounds crazy . . . but a couple weeks before the surgery, I woke up in the middle of the night and I thought, oh God, what if that's the only thing attractive about me? What if I go down to a C-cup and I never date again because that was the only thing that anybody was ever interested in? So, that's clearly a self-esteem issue that I had to kind of work through. . . . What [my therapist] and I talked about was more being able to handle what happened afterwards, and what had gotten me to that point, and trying to build my self-esteem based on something else, you know. Who I really was, as opposed to you know, boobs. . . . He was really very laid back and very much about letting me make my own decisions. So I guess he figured that the year that I had been in therapy with him before I decided to have [surgery], he worked me up to the point where he thought I was - it was like a decision coming from a healthy place.

–*Ruth, ciswoman, breast reduction*

While in counseling, cisgender people did not have to worry about passing as eligible or ready for surgery. They did not spend money for services unsure of whether or not therapists would support their decisions. They could talk openly about their concerns without worrying whether therapists would rescind authorization letters. In short, they did not view their therapists as gatekeepers.

Compared to cisgender respondents' experiences in therapy, trans respondents encountered a major hurdle to surgery. Before surgery, they had to first convince a mental healthcare professional that their desires to change their bodies were legitimate. Trans respondents' experiences in therapy varied. About half of the trans respondents reported seeing permissive therapists and the other half saw restrictive therapists.

Permissive therapists as acceptable gatekeepers. Transgender respondents in this study reported complex and varied relationships with therapists. Regarding their ability to access surgery, 11 trans respondents reported that their therapists did not impose rigid expectations on them before surgery. They described their therapists as lax in that they did not have strict requirements.

The excerpts below are from three trans respondents who saw the same renowned therapist who specialized in transgender issues. All three of these people believed their therapy experiences were generally positive in that they did not think the therapist acted as a gatekeeper to surgery.

I think I had a therapist that just sort of would take your money and give you a letter. So, I think I was able to go in and say, hey, I know what this narrative is. I don't buy into that narrative. . . . I'm choosing [surgery] for x, y and z reasons, and do we really have to pretend? And she was like, "Here's your letter. Yes, okay." So, I think she was just more like, "You get it? Okay fine." . . . I was not interested in therapy for its healing benefits. I was interested in getting a letter. . . . I emailed [my therapist] and said I would like to pursue chest surgery on this date, and could I meet with you [laughs] in reference to that. I mean, I think I was really specific. I was like, I would like to have chest surgery, you know, can I schedule an appointment with you? . . . And she was like, "Sure."

—Jasper, transman, chest reconstruction

After their initial email exchange, Jasper's therapist sent him 13 questions about his background and life experiences. He had to write his answers to these questions and bring them to their first meeting. He shared these questions with me after our interview. These questions inquired about Jasper's general wellbeing, such as mental health issues, substance use, involvement in legal proceedings, and physical description. They asked about the emergence of Jasper's gender variance and how this identity developed over time. They also asked Jasper to describe the medical, aesthetic, and psychosocial risks of surgery, how surgery might improve his life, reasons surgery might reduce any psychiatric problems, and any uncertainties he had about surgery. One question asked Jasper to contemplate nonsurgical options: "Gender expression can

be seen as a spectrum, rather than rigid, either/or, male/female categories. In the process of considering ways to deal with your gender variance, what other, perhaps less extreme, options have you explored as alternatives to chest surgery?" Another question asked Jasper to defend his decision:

Given the irreversible effects of this surgery, and how these might impact you in your professional and personal environment, what can you say that demonstrates sufficient reflection and full awareness of all that may come of this decision, and reasonable certainty that you can cope with the changes the surgery may produce in your body and in your life, and that proceeding with chest surgery is an informed and responsible choice for you at this time?

Jasper met with his therapist to review his answers during an in-person session. Despite questioning Jasper about his life, gender experiences, and decision for pursuing surgery, Jasper felt like his therapist was lax regarding requirements because she gave him a letter after they met one time even though he shared an atypical trans narrative.

I consistently was just like, you know, no, I don't think I was trans when I was two. But I think that's definitely what her questions were asking in a sort of leading way. . . . I said I was pretty butchtastic [as a child] but I don't think that was me being trans at like four. I don't think that's what it was. And she seemed like . . . she had met people that felt that way before, so.

—*Jasper, transman, chest reconstruction*

In seeing the same therapist, Nikanj also reported having to answer a set of questions. Whereas Jasper provided brief answers, Nikanj's responses took up eight, single-spaced pages. He reviewed those answers over five sessions with this therapist.

I said screw this, I don't need three months of psychotherapy or a year of psychotherapy because I know some people were saying, "Oh, they will take therapy in place of the RLE, whatever." But I said, look I already had, I have got this . . . five months, six months whatever plus the several years of part time, so I needed to dig up a therapist. . . . [When we met], it basically took most of the sessions to just read the questions because she would read the question and then read the answer [during the session]. . . . And she is like "Well, I guess I am not really worried about you on that one." [laughs] And she read the testosterone thing and she would read the answer out loud and she turns and said,

“You know what?” What? “I think you know more about the side effects of testosterone therapy than almost any client I have ever had.” [laughs]

–Nikanj, *transman, chest reconstruction*

Nikanj believed that because his therapist did not require a specific time in therapy or in a real-life experience, she was permissive in her willingness to write authorization letters. He explained that he discussed surgeons with his therapist, wherein she revealed her decision to give him an authorizing letter for surgery:

I said, well I was originally going to go to [A], but he didn’t want to do it because I identify as gay. I said, then I wanted to go to [B], and she said, “[B]? Why?” And I said, oh, because he doesn’t require a letter. And she looked at me and said, “Did you forget why you were here?” So I said yeah, yeah I guess I don’t have to worry about that, now do I? She was like, “You are going to get, you can get whatever letter you want.”

–Nikanj, *transman, chest reconstruction*

Nikanj felt that his therapy experience was “pretty decent,” but he was dissatisfied with the cost of her services. He said she charged \$135 for 45 minutes of counseling. Still, he viewed his therapist as lax because she did not require a set amount time in therapy or living in the desired gender. And when the subject of the letter came up, the therapist said he would get a letter without a problem.

Alexis saw the same therapist as Jasper and Nikanj. Although she had already been on hormones and had facial feminization surgery late in life, she wanted to talk through her decision to pursue SRS. She thought she would have surgery in Thailand where therapy letters were not required, but also did not want to rule out American surgeons. She sought therapy as a way to check in with herself about her upcoming procedure and ensure she could get a letter if she had surgery in the United States.

[My therapist] kind of like just gave me a, do not pass go. No, let’s see, get out of jail free card. I mean, I guess that’s it. That was really nice. I told her that I didn’t want somebody that was a gatekeeper. And she knew the words on that. I knew all the lingo when I went to see her. So, she knew that I wasn’t a fresh daisy. I knew most of this and I’d been studying it for years, self-evaluating myself to make sure everything, it was not a spur of

the minute thing, access to somebody that does, that really looks at things and then will go out of the normal bounds to either not be the gatekeeper and give you the green light to go or evaluate you and go, eh. . . . I was ready to go. And that's what she said.

–Alexis, transwoman, genital surgery

During their meetings, Alexis revealed that she lived her life as a woman all the time, except for the few times she spent around her brother and her adult children. The decision to stop living as a woman could have presented a problem. The WPATH Standards state that to be eligible for genital surgery, one must commit to living in one's desired gender full time for a year (Meyer et al. 2001). Alexis explained why her therapist seemed to waive this requirement:

I told [my therapist] that for the rest of my life I will be [Bob] to my brother. And I said, I will dress as [Bob] for my brother and I will dress as [Bob] for my kids and stuff because that's what they want. And it doesn't bother me. And [my therapist] was going, "You switch back and forth?" And I said, yeah. I said, I've been switching back and forth for years since I was three years old. . . . [She] wasn't particularly happy about that. She actually said, "You're so stable with stuff and you know exactly what you want. . . . Normally I would never say that would be okay," but she said, "really, just about anything you want to do is okay." Because I said, I wasn't doing it because I was trying to hide something. It was that I felt it was honoring them and trying to keep something that might be painful from them. And I said, for one week out of the year, I can be [Bob].

–Alexis, transwoman, genital surgery

According to Alexis, her therapist was willing to write a letter for Alexis's SRS even though Alexis violated an eligibility criterion for genital surgery. Alexis's therapist may have felt confident in her decision to pursue SRS because of her answers on the written questionnaire, which Alexis referred to as an "essay test":

She looked at it and said, "Wow, I could use this in my classes." . . . She said I had close to perfect answers on everything. . . . She said in 30 years she'd never seen anything that was just, I don't want to use the word perfect, but she said it was just you know, amazing. Everything was planned out and it was just like textbook stuff. . . . Most of it was because I was all ready to go and I'd been living the life for a lot longer than was required. So, I'd lived this my whole life since age three which she said was normally common. . . . And she said that it was amazing that most people that haven't done it before my age that are primary transsexuals have either killed themselves or they've done it when they were 20. . . . But I talked the talk and walked the walk for a long time and I just, I knew the answers for all the questions. . . . And she said that I had a real sense of humor in all my questions. And she said that so many transsexuals don't seem to be happy. And they're

not happy before and then they go out and get an operation and then they're not happy afterwards. . . . I said that I've been happy all my life . . . I've had the same stuff but I laugh it off. . . . And she was telling me that, considering everything, I was very stable. I'd had a very stable job my whole life. When I came out here [to Georgia], I came out here with money, bought a house, set everything up. I had no money problems. I had no mental problems. I was set and solid. I had an income, didn't have to worry about a job. I was ready to go. . . . The only mental thing that she said could have really screwed me up, but it didn't, was that my parents, between ages seven and 10, about every two or three months, they'd go in, search my closets and everything, pull stuff out and the whole family . . . walked out to the incinerator. They'd put all my clothes in there and then they'd, my dad would ask me questions, "Do you know what this is? . . . These are girl clothes." And then they'd set them on fire, in front of my siblings. She said, "Well, that could be very upsetting. . . . What did you think about that?" And I said, the whole time that was happening I was going, God, they're burning up all of my stuff. Now I'm going to have to go and get some more. And she said, "Oh, so you handled it really well." And I said, yeah, I knew it wasn't going to stop. There wasn't any almost power on earth that would stop this from happening. I just knew. I could just see the course of my life probably even at age six or seven. . . . I had done my time already. I told her I had done my time. She could've required me to do a one-year life test thing. But she waived that. But I went in with all the verifications . . . of my laser treatments, my FFS, all the other stuff that I'd had. My electrolysis, everything else. . . . I brought in paperwork. I brought in doctor's names with phone numbers, dates. . . . And so then she looked at all the stuff that I had, my answers to all the questions. She decided I was stable. [laughs] And that I had actually done basically all the requirements and could verify that.

–Alexis, transwoman, genital surgery

At that point, Alexis's therapist gave her a letter to continue her hormone treatments with a new doctor in Georgia. Two weeks after getting that letter, Alexis asked her therapist how long she needed to see her before getting the letter for SRS:

I went in and I said, okay between the questionnaire and our talking and stuff, we've pretty well covered where I am on this. I said, I would really like to get an idea of how long you think I'm going to need to be coming in. Then she said, "Lose the weight that you want to lose and go pick out your doctor." And then my jaw dropped. And I said, so you're saying that I'm ready to go? And she said, "Lose the weight until you're comfortable." I said, well, how much? And she said, "Until you get comfortable. And then pick your doctor. Those are my two requirements." But she had never [approved anyone that quickly] in 30 years.

–Alexis, transwoman, genital surgery

Alexis's surprise upon hearing her therapist's decision shows that she expected to stay in therapy longer to process her desires for genital surgery. The narratives of Jasper, Nikanj, and Alexis

show that trans people with different gender experiences can report that their experiences in therapy were not hindered by restrictive gatekeeping practices. Even though each of these respondents had different gendered journeys, they reported that they were able to get authorizing letters fairly easily. Other respondents who saw different permissive therapists reported similar ways of getting letters without problems.¹⁰

Respondents viewed therapists who quickly provided authorization letters as permissive. They generally described permissive therapy experiences as helpful in their pursuits of surgery. But these narratives also show that respondents still had to undergo questioning about their decisions. They appreciated that therapists did not impose additional hurdles or timelines in their surgery journeys. But having to justify surgery decisions and demonstrate psychosocial stability to therapists before surgery demonstrates how trans people submitted to a discourse that directs trans body modifications through the lens of psychomedical management. They believed that they needed professional counselors to authorize their surgery decisions. In this way, permissive therapists still acted as gatekeepers of surgery.

Restrictive therapists as formidable gatekeepers. Nine respondents reported more restrictive gatekeeping with therapists when they attempted to seek their services. These respondents explained that therapists questioned or doubted their decisions. Some were turned off by therapists who seemed financially motivated. Two respondents described therapists in extremely negative terms. Data from these respondents illustrate the ways therapists acted as formidable gatekeepers of surgery. They granted authorization requests only after respondents successfully demonstrated sincere desires for surgery. Or, after negative encounters, respondents chose to pursue surgery authorization through other means. Brian discussed how he encountered

¹⁰ One respondent was able to secure a letter quickly by revealing she had started hormones without medical supervision. Although the respondent in this case was seeking a letter for hormones, her experience suggests that some therapists may practice harm reduction in providing authorizing letters for medical transition.

barriers to care because he was 18 when he wanted to start medical transition through hormones and chest surgery:

I definitely got a lot of pressure from people, especially here [in Atlanta] about my age. And like doctors that I tried to see here to get letters for hormones definitely were like, “You are way too young. There is no way you can know that this is what you need. . . . You need to take a couple of years, I am not going to do this for you,” and plenty of other things to do. I’m like, awesome, that is great. [laughs] I do not know what to do, so that was really frustrating for me. . . . A lot of them I feel just had no experience with trans people whatsoever. They were just like, “Oh my God! Sex change, crazy! Jerry Springer shit going on here.” . . . I am not really sure why that was such a big deal for them. . . . [One LGBT-affiliated counseling clinic was] definitely going like by the book Harry Benjamin stuff. But it didn’t make any sense, because even that is like three months or something is what they require, and they went way beyond that, so. But they definitely referenced the Harry Benjamin stuff. And I think they definitely got freaked out that I hooked up with dudes. . . . They thought that like that made me less of a man, you know, like that made me somehow like a straight woman who was confused or something.
–Brian, transman, chest reconstruction

Brian’s experience reveals how he believed therapists questioned his decisions due to his age and sexual partnering. He saw many different counselors before he was able to find one who would grant him an authorizing letter. When Tyson needed a letter for surgery, he encountered a therapist who appeared financially motivated before he found someone he liked. Although Tyson appreciated the therapist he chose, his narrative illustrates how this therapist still questioned his decision:

I ended up calling around and I got a recommendation, actually, for Dr. [A]. And then, when I talked to him, he kind of told me he really, you know, he didn’t wanna do therapy just for a letter. You know? He was kind of like, “Honestly . . . , I really like to evaluate people.” And I really respected that. And you know, because other people like I talked to, they were really, I could tell more in it for the money. And they’re like, “Oh yeah, pay me \$500 and I’ll give you your letter.” You know? And I’m like, \$500? [laughs] Oh, my God. But with him . . . I just realized that he’s really there for the purpose of really helping people. It’s not just money or anything like that. And yeah, so it’s just like I felt more of a bond with him. And so when I met with him, that’s when I ended up getting my assessment done. And I mean we really went through my whole life, everything. And, I mean, it was like a healing process and so. I really came to a lot of things . . . it’s probably why I needed the Paxil because during that time, I felt a little kooky. I went through some kind of extreme anxiety and some stuff I had to deal with. There’s a lot of

things in my life I had to face during those months and it was really hard, plus trying to get everything ready for surgery. But he wrote my letter.

–Tyson, transman, chest reconstruction

Tyson was turned off by the first therapist he called because of the high cost for counseling. But he was happy with his chosen therapist even though he assessed him over three months of intensive therapy wherein Tyson needed psychotropic medication. Tyson perceived this experience as positive and rewarding and that it helped him live life more holistically. But Tyson's narrative also reveals how his therapist subjected his decision to pursue therapy to a rigorous evaluation. According to Tyson, his therapist was unwilling to write an authorizing letter without an extensive, months-long assessment of his comprehensive wellbeing.

Regarding restrictive gatekeeping practices, Jack's therapy experience provides an interesting contrast. Jack had therapy with the same transgender specialist seen by Jasper, Nikanj, and Alexis, whose permissive therapy experiences were reported earlier. Jack, however, viewed this same therapist as unhelpful. He wanted therapy not just for a letter, but also to have an experienced counselor to answer his questions about transition. Instead, he felt that she interrogated his decisions. Jack was not the only respondent in this study who reported feeling frustrated with this therapist. He explained his dislike for her:

She was supposed to be one of the best therapists in Georgia. She's a little hostile. . . . Like she gave me my letter. I only saw her a couple of times, but she's a little rough. . . . Everything you say . . . , you feel like you're being judged. . . . Like wow . . . , this is supposed to make me feel more comfortable and I'm not feeling more comfortable. I'm actually feeling worse. I felt better before I came in here than I do now. . . . I would just be talking about things like about childhood. She was like, "Well, if you're really this way, then you shouldn't be so happy." And I'm like, should I feel bad that I had a good childhood? I'm like, I don't understand. I'm like, I understand that people have bad childhoods, but I don't think necessarily that all of us have to have a bad childhood, to you know, I think that I can be who I am. I don't have to have an awful life to do it. And like she would say things like that that would just kind of throw me off. Why is it bad that I didn't have any problems? . . . But yeah, it was weird. . . . Why would you say that to me like that?

–Jack, transman, chest reconstruction

Although Jack reported that he was able to get a letter after a few sessions, he felt like his therapist questioned his decisions. He also felt like she questioned his gendered journey as well as his honesty:

I had been seeing her for like two or three months and she actually was like, “Well I’m going to write your letter. . . . Let me give you your letter. . . . This is how much for your letter, and I’m going to give it to you.” And so, I didn’t actually ask for it. She was like, “I think you’re ready for your letter.” . . . [Before the letter], she was always like trying to ask you questions to see if this is really what you want to do. I’m like, well you know, I’m 29 years old. This is definitely how I feel like I need to be. I’m super quiet. And I’m super shy. And I don’t really talk to anybody. . . . I want to hide over here in the corner ’cause I don’t think I look right. And I’ve done this and this and this, and I started doing [drag king performance] shows at [clubs] and that definitely helped me. . . . That kind of gives me a little outlet to get stuff like that. And then I talked to her about it and she’s like, [disapproving voice] “Oh.” So, it seemed like she had a big issue with trans people being drag kings at first or something. She was definitely like, “You don’t want to start in that kind of life, because then you just won’t ever finish.” And I was like, okay, I really think [doing drag] was just a good outlet for, this is kind of another form of therapy, but okay. I’m not trying to use this for anything else more than just fun. . . . “That’s just not going to make you transition in the right direction.” . . . Those kind of conversations were just kind of like irritating me to the point where I was just like, I’m done with you. I don’t know where this is going and I feel real uncomfortable around you and I’m like, no. . . . It was one of those things that is like, okay this is not the reason that I was coming to you. Yes, thank you for the letter. That’s awesome, but [laughs] it would’ve been nice to just have this conversation without all that. . . . It seemed like she was just really doubtful that you could be still in a somewhat good place and still want to [transition], which I thought was odd.

—Jack, transman, chest reconstruction

Although Jack sought therapy for its supportive benefits as well as the letter, the gatekeeping enacted by his therapist prevented him from talking openly about his experiences. He felt like he had to defend having a happy childhood yet still wanting to transition. He felt like she judged his participation in drag king shows. Overall, data from respondents who saw restrictive therapists for letters showed how therapists acted as gatekeepers to services. Therapists evaluated not only trans people’s decisions for surgery, but also their life choices. Although these respondents were

all able to have surgery, these experiences demonstrate the laborious processes they endured before reaching surgeons' offices.

Although rare, two respondents described their therapists as unprofessional and incapable of providing quality services. Samantha saw a therapist whom she described as "worthless." She explained:

She was very much trying to lead me in directions that I was resistant to. Because I was having familial difficulty with my little brother at the time, and I was trying to come to grips with him because it was causing me a lot of internal distress. And she kept trying to push her idea of why I was having those problems, which I disagreed with then, I disagree with to this day. So, first I had to spend a month trying to get an appointment because she wouldn't answer her damn email, and that's the only way you could deal with her. Then once I finally managed an appointment . . . , she kind of rushed us through it, then forced her own ideas on me. And when it was all over with, she never got back in touch with me to make payment arrangements or to schedule another appointment. So, with all of that in mind, I said, wow you are by far the most haphazard and disorganized human being who has purported themselves to be a professional that I have encountered in this particular phase of my existence. I do not believe that I will recommend anyone else to you because I think you're kind of a quack. . . . And then, when I went for a support group, I listened to the majority of the people who were there and for the most part all of them seemed to . . . have built a very delicate and complex fantasy structure for themselves. . . . She's very much an enabler of that. She encourages them to build that active fantasy life, while never giving them the encouragement or the tools to overcome the obstacles that are keeping them from it. . . . I don't respect that. . . . I do find her overall approach very irresponsible and very counter to being at all helpful to anyone in the community.

—*Samantha, transwoman*

Samantha perceived this therapist as unprofessional and irresponsible. She felt the therapy experience was useless and unhelpful. She believed her therapist was leading her (and others) into accepting the therapist's vision as her own. This experience turned her off to pursuing a counseling relationship.

The most negative therapy experience in this study related to a therapist who breached professional and ethical boundaries with his client. CJ had a history of mental health issues, but wanted to find a transgender specialist to discuss his feelings about gender. He was not simply

looking for a letter when he located a specialist for counseling. Early in the therapeutic relationship, CJ learned that this therapist was practicing without a license. He said the therapist told him he was allowed to practice therapy due to a legal loophole. CJ reported that his therapist made himself available at all times, gave CJ his personal telephone number, and had CJ come to his home for dinner. Although he felt uneasy about the relationship, CJ continued to see this therapist because he had been isolated and the therapist connected him to the trans community:

I needed to see a specialist. And [he] was willing to see me for less money than any of the others who were willing to see me for. And after the very first session, he was like my friend. I could call him anytime I wanted. There was no boundaries really. He invited me and my partner over for dinner, like a couple of weeks afterwards. I mean, so all of a sudden, I had all this support. He had an “in” in the trans community and my life was 100% going in another direction, like really fast. And so, I didn’t want anything to change that. . . . I typically interview therapists. I have been in therapy. I see it as you are hiring someone to go on a very important journey with you. . . . So I mean this was very much the anti-experience for me. I never would do this, you know. I know better than this. This was out of desperation. I had called these other people and I couldn’t, didn’t have access to this care.

–CJ, *transman, chest reconstruction*

Their relationship progressed. They attended events together. The therapist allowed CJ to recover from surgery in his house. Soon, CJ left his partner and moved into the home shared by the therapist and the therapist’s partner. Eventually, they all had sex. Instead of paying the therapist for counseling while also paying rent, CJ exchanged rent for therapy and started working as his therapist’s support staff. During one session, CJ’s therapist offered CJ testosterone to try. CJ declined the offer, but later sought a prescription from a doctor. When CJ’s therapist found out, he became angry that he had not first asked him for a letter.

He knew that what he was doing was wrong because he had told me specifically, “Don’t tell anybody.” . . . When he offered me testosterone, “Don’t tell anybody I offered you this. I would get in real trouble.” When we had sex, “Don’t tell them. You can’t tell anybody, I will never get a license.” He knew that what he was doing was illegal, was wrong. And he continued to do it.

–CJ, *transman, chest reconstruction*

CJ started having an affair with the therapist's partner. When the therapist found out, he physically assaulted CJ. Their relationship dissolved and, once again, CJ became alienated from the trans community. CJ's experience illustrates an incredible abuse of power with a therapist who was known as a transgender specialist. According to CJ, this therapist was willing to support CJ if he wanted to live as a man, but the therapist would not condone inhabiting any kind of non-binary gender identity. The therapist's philosophy prevented CJ from effectively exploring gender issues. In this way, the therapist acted as a restrictive gatekeeper because he only supported one type of transsexual identity. In addition, the horrible incidents that occurred after they started a therapeutic relationship caused CJ to retreat from exploring gender issues any further. Indirectly, this therapist led CJ away from medical transition.

According to some respondents, therapists were not always eager to write letters right away. For some, therapy included questioning, doubting, and denying services. It included upholding some trans narratives and identities over others. Two therapists were also extremely unprofessional during interactions. In these ways, therapists restricted access to surgery and questioned respondents outright, overtly imposing a pathologizing discourse where they had the power to confer or withhold treatment. Throughout the interactions with therapists, respondents relayed narratives they hoped would result in authorization letters. They anticipated that, by the end of therapy, they would leave with a letter that would validate their decision to seek surgery.

Although some trans respondents sought therapy for more holistic counseling, all of them expected to start relationships with providers whom they hoped would write them authorization letters for surgery. As such, all therapists were potential gatekeepers who could withhold, deny, or confer letters based on their own assessments of trans respondents' surgery desires and life experiences. The WPATH Standards exist to regulate cross-gender medical transitions. No

comparable standards exist to determine eligibility or readiness for cisgender surgical transitions. The WPATH Standards would not be needed if psychomedical institutions did not pathologize cross-gender experiences. Without the existence of gender identity disorder, cross-gender surgeries would not be subjected to increased scrutiny. This psychomedical discourse classifies the surgeries obtained by the trans respondents in this study as pathologized and in need of regulation. Thus, when trans respondents sought authorization letters with mental health professionals, they engaged in a process of becoming certifiably sick. Whether or not they received an actual diagnosis, the expectation that trans people need therapy authorization rests on the assumption that their desires to change their bodies are disordered. When trans people received therapy letters, then, they became certifiably disordered. They could present these letters to any surgeons who questioned their decisions, showing that a therapist had certified their desires as sick. This process occurred even as therapists and surgeons did not overtly frame surgical body modification as indicative of illness.

The great irony, of course, is that becoming certifiably disordered authorizes surgery. It would seem that a diagnosed mental illness would preclude invasive and irreversible surgical procedures. But gender-affirming surgery is considered suitable treatment for gender identity disorder (Meyer et al. 2001). This incongruity continues, then, when surgeons perform surgery and do not view it as treating a psychological illness but as a cosmetic procedure. In addition, becoming certifiably disordered does not matter when it comes to insurance coverage. Having a diagnosis of GID or gender dysphoria did not help any trans respondents pay for surgery.

Paper Tigers and Circumventing Therapy: Surgeons' Needs for Authorizing Therapy Letters

The data in the previous section revealed the processes through which trans respondents became certifiably disordered. Respondents interacted with permissive and restrictive therapists in pursuit of authorizing letters. To gain approval for surgery, they exposed themselves to psychotherapeutic probing. They relayed their life histories, their gender journeys, and their desires to change their bodies, all the while paying hundreds of dollars to do so. Instead of pursuing counseling as an elective option for support in one's decision, trans respondents felt compelled to submit to therapy to surgically modify their bodies. It is surprising, then, that among the 17 trans respondents who sought therapy in anticipation of needing letters, only eight respondents reported that surgeons actually required letters.

All eight respondents who reported that their surgeons required authorization letters had what might initially be considered "transgender-specific" surgery. Five of the eight respondents were trans men and needed letters for chest reconstruction surgery. Four of these trans men had surgery with the same surgeon, so this individual surgeon's practices appeared consistent. This surgeon was renowned for having an outstanding bedside manner and doing quality work. Three of the eight respondents whose surgeons needed letters were trans women. Each of them used a different surgeon, and all reported needing letters for genital surgery (orchiectomy, vaginoplasty, and labiaplasty). Only one other trans respondent had genital surgery, but she had it in Thailand with a surgeon who did not require a therapy letter. None of the trans women who had breast augmentation needed letters. Five people in the transmen group reported that they did not need letters for their chest or breast reduction surgery. Thus, there was no consistent pattern of what counted as "transgender-specific" surgery in this study. No surgeries required letters from therapists all of the time.

In addition, the lack of letters required for trans women's breast augmentation surgery challenges the need for letters among trans men who want chest reconstruction. Both surgeries significantly change the gendered appearance of the upper torso, as breasts are the most visible signifier of womanhood (Young 1998). While it is possible that breast augmentation was less regulated because the procedure is also popular among cisgender women, chest reconstruction for trans men is similar to cisgender male breast reduction surgery (Colić and Colić 2000). Perhaps chest reconstruction required authorization letters because this is the most common, and often only desired, surgical modification for trans men (Rubin 2003). Or, perhaps the act of a female-bodied person permanently removing a revered part of the female body deserved extra scrutiny within patriarchal medical systems. Whatever the reason, this disparity illustrates that trans women had an advantage over trans men. In this study, trans women could change the appearance of their upper torsos without providing authorization letters more often than trans men could.

Authorizing letters as paper tigers. Once respondents met with surgeons, letters typically became less important. Although the process of getting letters for surgery was highly involved, the act of submitting letters to surgeons was not. This was a paradox of the gatekeeping experience. The WPATH Standards – and the healthcare professionals who follow them – stress the importance and seriousness of permanently changing the body through surgery. But the surgeons who actually performed these irreversible procedures typically just collected letters and filed them away. According to respondents, surgeons never expressed concern about the content of the letters. Eleven trans respondents said that their surgeons were lax about therapy authorizations.

Turns out the doctors at [the surgery center I used] don't push or require any proof from a therapist of, you know, transgendered, GID. So, they haven't required any letters or anything from a therapist.

–Ann, transwoman, facial feminization, breast augmentation

He didn't need a letter because it was just cosmetic surgery. He wasn't really concerned about the gender. . . . I was just like, do you need a letter from a therapist or anything? And he was just, "No. It's cosmetic surgery." And his thing too is he's like, "I consider it cosmetic surgery. I'll never write you a letter if you want to change your gender marker or if you need something for your name change. . . . I don't do that. It's just a cosmetic surgery." . . . I think all I needed to get that surgery was the money, really. I don't think, nobody ever asked me like, "Are you sure you want to do this?" I mean it was just like, "Oh, you want this? You have money? Okay."

–Charlie, transman, chest reconstruction

When I got in touch with him – and hopefully this won't get him in trouble – he never asked me for a letter from my psychiatrist indicating that I had permission, which is one of the most galling things I find about this experience. Okay, [a cisgender woman] could go get a boob job, no problem, nobody cares. I on the other hand, have to go get a letter of permission from my psychiatrist or my therapist indicating that [mock baby voice] I am transgender and they say okay. I have to get that letter to start on hormones, I have to get that letter to get any body modification done. This galls me. He never asked. He assumed that I was an adult, that I was making a competent and capable decision of what I wanted done to my body, and he never questioned me. And for that, I will be eternally grateful. He's the only one that I have dealt with in this in this entire experience who gave me that benefit of the doubt, and actually treated me like a competent capable adult. . . . And this is sad that this is a raving recommendation. He just treats us like normal women. That's all. . . . He just treats us like normal women. The fact that we're trans doesn't ever come into the equation. The fact that we're girls with broad shoulders, yeah, that comes into the equation. The fact that our age, our level of health, all of that, that all comes into the equation. Trans never figures in. And that's all we really want. If you just treat us like regular adult women, that would be great. And he does.

–Samantha, transwoman, breast augmentation

These data illustrate that surgeons often did not care much about authorizing letters from therapists. And when surgeons required letters, they did not review them with respondents to verify their eligibility or readiness for surgery. For all the stress involved in securing letters, these authoritative letters seemed to become just another page in the patient file. Such experiences further deflate the power of imposing a separate standard of care for trans consumers

of surgery. For some respondents, surgeons appeared to make their own decisions, treating trans people in the same ways they treated cisgender consumers.

Authorizing letters as unnecessary. While only eight trans respondents needed letters for surgery, three trans respondents were able to completely bypass therapy requirements. Their experiences illustrate strategies for circumventing therapy requirements and pursuing surgery more autonomously. TJ's surgeon required an authorization letter, but TJ was able to use a letter written by a nurse at his hormone-prescribing clinic. Although TJ was not receiving counseling from this clinic, the WPATH Standards state that the mental health professional can be someone who has received formal clinical training in multiple disciplines, including nursing (Meyer et al. 2001). Eva started hormones at age 16 and "bought them off the black market." By starting medical transition on her own, she feminized at a young age and easily passed as a woman. She was also able to get breast augmentation with a surgeon who did not require therapy letters from her or from two other trans women who also used the same surgeon. Errol was able to get surgery without an authorizing letter because he chose a surgeon whom he knew did not require one. Another trans man in this study who used this same surgeon also reported that he was not required to present a letter. Errol also believed that he had an easy time accessing services because he was educated and studied trans issues. He explained how he presented himself to his healthcare providers:

I've presented myself to anybody that I've talked to like, I research trans issues. That's what I do. I educate on trans issues. I don't need to be told about the Harry Benjamin Standards. Chances are I've been out in a group of your peers telling them about the Harry Benjamin Standards. So, I think that they've taken that into account when deciding whether or not they want to help me out that, "Well, really what are we going to tell this guy? He already knows the options. He already knows the risks. He already knows what's involved. . . . Why do we really need this letter?" They've been really good that way, about not being über-gatekeepers.

—Errol, transman, chest reconstruction

These three different scenarios depict how trans people can minimize gatekeeping. Trans people can choose surgeons who do not require letters. This option seems the most similar to cisgender means of accessing surgery. Alternately, trans people can ask their medical health providers to write authorizing letters. This option requires that trans people have relationships with providers where they openly discuss their trans status. Not all trans people would have this option, such as a female-bodied trans person who does not want hormones, but wants chest surgery and does not have insurance for general healthcare. Another option is to present as competent and informed about trans healthcare, which is a privilege not everyone has or desires to achieve. Many respondents also reported strategically presenting as confident in their gender expression, even without easily “passing” as a man or woman. They believed this presentation would aid their ability to get surgery. One respondent reported writing her own authorization letters as a way to bypass gatekeeping in therapy. These different strategies suggest that there are ways around the pathologizing system that directs trans people to authenticate their identities and gendered decisions before surgery. Few trans respondents needed to present letters for gender-affirming surgery, which shows the impractical and inconsistent application of the WPATH Standards. These findings challenge the efficacy of the WPATH Standards, ultimately illustrating their futility in practice.

That 17 trans respondents pursued therapy for letters, however, demonstrates the power of the pathologizing discourse. Due to messages about surgery requirements and the eligibility criteria in the WPATH Standards, most trans people expected that they would have to produce external validation for surgery. The discourse promoted predominantly by the WPATH Standards and circulating through trans communities became a truth. External authorization for surgical body modification became normative. Many respondents thought they would need

letters, and sought therapy with that goal in mind. Some of these respondents reported pursuing therapy letters for hormones as well as surgery. But in theory, the WPATH Standards characterize top surgeries as on par with hormones and genital surgeries as in need of additional verification (Meyer et al. 2001). In practice, therapist authorizations for surgery should have been equally or more important as authorizations for hormones. Overall, trans respondents expected psychomedical surveillance. Although many had the ability to get surgery without an authorizing letter, they already put themselves through therapy. They submitted to the discourse because they believed it was necessary. Indeed, many respondents disagreed with the pathologizing discourse, but they felt it was the normative path to realize their ideal bodies.

Thus, much of the anxiety, distress, and costs trans people endured during counseling was unwarranted. They spent time in therapy portraying themselves as confident and secure in their decisions, hopeful that their therapists would not turn down their requests for letters, when most did not even need letters for surgery. Consequently, the pathologizing discourse also strained provider/patient relationships. By stifling potential doubts or fears regarding surgery, trans people could not reap the benefits of an open and affirming therapeutic experience. The pathologizing discourse then compromised quality healthcare for trans respondents even as it espoused quality healthcare.

Becoming Certifiably Diseased: Experiences with Insurance Coverage

A related, but markedly different experience reported by respondents involved becoming certifiably diseased. In these cases, respondents documented physical ailments with hopes of qualifying for insurance coverage. They justified surgeries by emphasizing anticipated medical benefits.

Documenting disease. In general, health insurance coverage for surgery among respondents in this study was relatively uncommon. Thirteen people (9 cis, 4 trans) said they wanted surgery to prevent or address a physical health problem, and twelve respondents (9 cis, 3 trans) were able to secure some insurance coverage for surgery. Three people (1 cis, 2 trans) were able to get some insurance coverage for their procedures even though they did not originally pursue surgery for its physical health benefits. In total, breast reductions (and one chest reconstruction coded as a reduction) and rhinoplasties were the most common procedures completely or mostly covered by insurance. For these procedures, respondents were able to document medical justifications for the surgeries. They demonstrated disease, or a compromised embodied state.

I guess my doctor's office wrote a great letter to [my insurance company] because they never questioned it. It was just really, really easy to get it approved. . . . It was actually really startling because I thought for sure that they would at least give us a little bit of trouble. But, as . . . my surgeon's assistant explained to me, it was the amount that [my surgeon] said she had to remove and the relationship of that amount to the frame of my body, because I'm only 5'4" and I was an F-cup. And she removed almost two and half pounds. So there was a formula that they had that if she removed a certain "cc" amount to get me down to what was considered a normal size, a relative size to my frame, that they approved it.

—*Ruth, ciswoman, breast reduction*

When I was young I dove into a pool and smashed my nose into the bottom of it. Getting older, it didn't grow together correctly, and I was having breathing problems. . . . There was a period leading up to [surgery] where they tried to put me on nasal sprays. . . . There's lots of glands and stuff inside your nose and they tried to shrink them basically so that I could breathe better. But that never worked. So once that stopped working, they decided that it would need surgery.

—*Anthony, cisman, rhinoplasty*

Based on data from respondents, breast reductions and rhinoplasties seemed easily justifiable to health insurance companies. Even when respondents reported only minor impairment in the function of their noses, such as excess mucous after swimming, they were able to secure coverage. In several cases, health insurance companies partially covered the cost of surgery

when respondents had other medical issues surgically corrected at the same time. For example, Sheri's insurance company covered part of her liposuction because her surgeon simultaneously repaired an inverted nipple that she suffered from a car accident. Overall, cisgender people were more likely to have insurance coverage for their surgeries. This disparity illuminates another economic disadvantage for trans people in accessing surgery.

But medical justifications were not always needed for insurance to cover procedures. Two cisgender respondents reported that insurance covered their surgeries without documented medical issues. One of these respondents was a cisgender man who had a hair transplant over 30 years ago. He believed he was able to get this surgery covered because it happened before insurance companies stopped covering elective surgical procedures.

At that time I was [able to pay through my health insurance for the surgery]. They soon abandoned that, wisely no doubt. But I guess I think it must have been a fairly new procedure and they hadn't quite realized that it was something quite elective, you know?
—Thomas, cisman, hair transplants

Although Thomas's procedure was covered by insurance decades ago, one respondent reported insurance coverage for surgery that lacked medical justifications in 2005. Anthony was able to cover the costs of his otoplasty through insurance even though he had no medical problems with his ears.

Surprisingly [the insurance company] accepted it really easily under the premise that it would improve my quality of life. Yeah, there was really never any questions asked. . . . When [my doctor] submitted the request, [the insurance company] came back pretty quickly and just said it was approved under the quality of life.
—Anthony, cisman, otoplasty

Anthony never had to submit any compromised "quality of life" documentation to aid coverage. Although he was 18 at the time of his surgery, research suggests that improved psychosocial functioning in children can be used to support health insurance coverage for otoplasty (Cooper-Hobson and Jaffe 2009). Another respondent who had otoplasty at 18 believed he was unable to

get his surgery covered because he was too old to qualify for it, which suggests that age limits for covering otoplasty are inconsistent. These rare incidents show that although insurance coverage typically occurred when people could demonstrate medical problems such as pain or breathing impairment, some people were able to get coverage for procedures with no medical basis. These cases show that disease could also relate to a compromised state of the psyche. Making a “quality of life” determination suggests that some health insurance companies will grant coverage for services that provide psychosocial benefits. The consequences of coverage for psychosocial benefits are enormous, especially given this study’s findings of improved psychological wellbeing after surgery. If this practice became commonplace, both trans and cis people could pursue coverage for surgeries after demonstrating postsurgical psychological benefits.

Assuming exclusion. Among respondents who paid outright for the costs of their surgeries, many did not seek coverage from their insurance companies. They assumed that insurance policies would exclude their procedures.

[The surgeon’s office] went through [insurance] vaguely and it was not covered, I believe. So, I don’t think they really pushed it hard and I never even thought nor considered to call, ’cause I just assumed that wasn’t covered.

–Michele, ciswoman, breast augmentation

I just assumed it wouldn’t be covered at all because there was no health risk for me to have to undergo that procedure.

–Matt, cisman, hair transplant

Respondents who did not seek insurance coverage for their surgeries typically expected that their companies would not consider elective and cosmetic procedures. These respondents were both transgender and cisgender. However, insurance coverage was less often an option for transgender respondents because this group was less likely to have health insurance. At the time of the interview, five trans respondents had no health insurance, compared to only one cisgender

person. Of the 15 transgender people who had coverage, 12 had been consistently covered throughout their adult lives, whereas 17 of the 19 cisgender respondents had been consistently covered. For transgender respondents, then, insurance coverage for surgery occurred less often due to lower and inconsistent amounts of coverage. In addition, the Centers for Medicare and Medicaid Services, formerly known as the Health Care Finance Administration, classify sex reassignment surgery as experimental (National Coalition for LGBT Health 2004; U.S. Department of Health and Human Services 2010). Consequently, many public and private health insurance companies typically do not cover costs associated with medical transition (Goodrum 1998; Hong 2002; Lombardi 2001). As of 2010, a few insurance companies have adopted more inclusive policies (U.S. Department of Health and Human Services 2010). But systematic discrimination continues, despite condemnation from the American Medical Association, the American Psychological Association, and the National Association of Social Workers (American Medical Association 2008; American Psychological Association 2008; U.S. Department of Health and Human Services 2010). These exclusions can be interpreted as examples of individuals asserting cissexual privilege in drafting cissexist policies, where cissexism represents “the tendency to hold transsexual genders to a different standard than cissexual ones” (Serano 2007:156).

Institutionalized cissexism disempowered trans people in this study. Some transgender respondents heard that insurance coverage for surgery might be possible, but decided that fighting for coverage was not worth the hassle.

I was trying to do a lot at one time and it might have, like a lot of my options probably just kind of fell through the cracks and I didn't pick up on it because I was so fixated on getting the surgery done.

—*Slice, transman, chest reconstruction*

I had the paper work, but we had tried to file it before we had the paper work and [the insurance company] said no. So we just didn't bother pushing it. It was just too much, you know, it was an uphill battle and we knew we were going to lose it. . . . The only way they would've covered it, is if I had breast cancer. And since I'd been biopsied and it wasn't cancer, then there wasn't any other way. There was no other code that they would cover the surgery under. . . . They considered it elective surgery, because it wasn't cancer so therefore it's elective.

—*Errol, transman, chest reconstruction*

Slice and Errol believed they could get insurance coverage because they qualified for medical breast reductions. They also knew that some surgeons were willing to code chest surgery as a reduction. For example, Nikanj and Errol used the same surgeon. Nikanj's chest reconstruction surgery was covered as a breast reduction because he provided ample documentation of health problems and his surgeon was willing to code the procedure accordingly. But the prospects of producing extensive documentation to verify health problems and negotiating with doctors and insurance companies discouraged some trans people from pursuing coverage. They believed that trying to secure coverage would be too much of a struggle. At the time of their interviews, other trans women were also disputing with insurance companies. One tried to get coverage for part of the fees for her abdominoplasty due to having a severe hernia repaired, but her company denied her claim. Although her surgeon photographed the hernia for evidence, she never followed up with the insurance company. She chose to let it go rather than continue arguing. One trans woman disputed the insurance company's refusal to cover her orchiectomy, but was ultimately denied. These data show that trans respondents more often expressed frustration over dealing with insurance companies that were resistant to cover surgeries. They knew insurance companies typically rejected transgender-related healthcare claims due to their cissexist policies.

The effects of cissexist insurance policies affected trans respondents in other serious ways. A few trans people did not seek coverage because they worried about how it might disrupt their legal documentation or risk their existing coverage for other healthcare expenses.

I didn't even try. Someone told me I shouldn't try . . . because it would, I run the risk of it being on records and it could actually affect my abilities to, it could somehow come up as a pre-existing condition and could affect my ability to have future coverage in the long-run for it. . . . Like it might open up issues like my hormones, which are covered by insurance which is very unusual. So, I just decided to not mess with that. . . . I didn't want to try to see what it would be like to file them, because I might, I would worry about the records issue.

–*Calliope, transwoman, genital surgery*

In this example, Calliope feared that requesting coverage could put her other healthcare at risk. She worried about the consequences of having a genital surgery on her legal health records. In addition to these concerns, one trans woman reported that her surgeon expressly forbade her to try for insurance coverage.

When you deal with [the surgeon's office and the hospital] where they're at, they refuse to deal with insurance companies and they don't want you coming back and asking them for information or bugging the hospital or any of that. Basically when you do this, you are signing off. That's one of their stipulations, is that you're not going to try to recover any of this through insurance. And the reason is that they don't cover it, first of all. I mean, my insurance company would not have covered this.

–*Caroline, transwoman, facial feminization*

In these ways, securing insurance coverage for trans respondents was more complicated by cissexist healthcare institutions. Cisgender people who did not pursue coverage simply assumed that companies would not cover their procedures. But transgender people encountered systematic institutional discrimination through insurance companies that explicitly excluded transgender-specific healthcare. They became emotionally fatigued over prospects of negotiating with insurance providers and worried about how coverage for one procedure might compromise coverage for another. These exclusions constituted another disadvantage for trans respondents.

Overall, negotiating insurance coverage for surgery was easier for cisgender respondents. Cisgender people were more likely to get their surgeries covered by insurance. For them, becoming certifiably sick had rewards beyond getting the surgery; they had surgery paid for by insurance. In addition, they were more likely to have health insurance coverage at the time of the

interview and were more likely to have consistent coverage throughout their adult lives. In contrast, transgender people encountered more problems with insurance companies. They were insured less often and less consistently. These health insurance disparities reflect an important difference between cisgender and transgender surgery experiences. For transgender respondents, being informed and confident consumers resulted in few gains in terms of coverage. Ultimately, these differences highlight the emotional labor performed by trans respondents in pursuing surgery. Transgender respondents worked hard to find alternative resources with little payoff. The transgender exclusions embedded in health insurance policies represented a foreboding institutional barrier. This finding also reflects the class difference between the transgender and cisgender samples, where cisgender respondents' superior access to health insurance mirrors their higher socioeconomic status. As a group, cisgender people maintained stable employment in more prestigious occupations. Transgender respondents were more likely to be underemployed in less prestigious markets or unemployed and looking for work. Thus, cisgender respondents were able to use their socioeconomic privilege by paying for surgery or getting their insurance companies to cover costs. As a whole, cisgender respondents had greater economic advantages in accessing surgery.

Certifiably Sick: Disparate Valuation of Disease and Disorder

In previous chapters, these groups reported many similar feelings toward their bodies before surgery which led to similar cosmetic and psychological motivations for surgery. In effect, surgery granted both groups similar cosmetic and psychological benefits as they affirmed their gender identities and expressions through changing their bodies. The last chapter discussed differences between cis and trans respondents in their interactions with surgeons and revealed

that trans people. Although both groups generally reported positive experiences, trans respondents encountered more disadvantages. Regarding the ability to access surgery autonomously, however, transgender and cisgender respondents differed greatly.

In this chapter, I outlined major differences between cisgender and transgender respondents' experiences with surgical body modification. I showed how cisgender respondents had more privilege in accessing surgery on their own volitions. They were able to consent to surgery autonomously and use counseling as a supportive tool. Trans respondents, in contrast, responded to pathologizing discourses that rendered their cross-gender identities disordered. Most of them anticipated that they would need authorizing letters for surgery and so sought therapy to obtain official verification. Fewer than half of them needed to present letters to surgeons, which meant that many endured therapy burdens in vain. They became certifiably disordered just so they could get surgery. Cisgender respondents, however, became certifiably diseased and were more likely to have the costs of surgery covered by insurance. This privilege exacerbated the disadvantages trans people encountered in obtaining authorization for surgery.

The findings in this chapter reveal how becoming certifiably “sick” (i.e., “disordered” for most trans respondents and “diseased” for some cis respondents) disadvantages transgender people and benefits cisgender people. Treating “sickness” with surgical body modification means alleviating physical and psychological discomfort. But by supporting surgeries that aid the body more often than surgeries that aid the mind, healthcare institutions privilege corporeal subjectivities and perpetuate false dichotomies of the mind and body. Ultimately, healthcare institutions value the surgical correction of disease over disorder. I explore the consequences of this division and its implications for surgery consumers in the conclusion.

CHAPTER 8 – CONCLUSIONS

It is thus impossible to discuss the nature of ‘disease’ even in theoretical medicine without locating the concept within a hierarchy of moral evaluations, which in turn have to be understood with reference to power in social groups. ‘Disease’ is not a unitary concept and not simply a factual statement about natural processes; it is a classification reflecting both material and ideal interests. The importance of such classificatory schemes is that they lead ultimately to questions about the ontological status of the body.
– Bryan S. Turner (2008:190-1)

In this research, I set out to compare two groups: cisgender and transgender consumers of surgical body modification. Theoretical arguments position the regulation of trans surgeries as unfair compared to the relative freedom that cisgender people enjoy while pursuing surgery. I wanted to empirically assess transgender and cisgender people’s surgery experiences to see if these groups truly were similar. What are the processes of surgical body modification? How do cisgender and transgender people use surgical body modification to enhance and confer their desired embodiment? How do consumers negotiate their desires with surgeons? How do healthcare authorities regulate surgical body modification? What strategies do consumers employ to facilitate access to services, and how are these influenced by normative gender expressions? How are surgical body modifications treated by insurance companies for consumers and for providers? The questions allowed for a systematic comparison of two groups that are often viewed as dissimilar.

I began the study with a content analysis of an online surgery community where cisgender users discussed issues often found in transgender communities. In the analysis of protocols for surgical body modification, I found a plethora of regulations for transgender people and a lack of guidelines for cisgender surgery consumers. I determined that the WPATH Standards represent the central framework for understanding surgery for transgender people. However, their inherent flexibility and failure to translate cross-culturally limit their power as

“universal” guidelines. These analyses provided me with a foundation for understanding surgery community norms as they exist in different media. They prepared me for interviewing actual consumers of surgical body modification.

The core of this research included data from interviews with 40 people who had surgical body modification. By comparing 20 cisgender people with 20 transgender people, I aimed to understand similarities and differences between two groups who appeared to encounter disparate regulation of surgery. I found that both groups reported similar feelings toward their bodies before surgery and similar motivations for surgery. Both groups reported feeling okay, self-conscious, and hatred toward their bodies before surgery, and both wanted surgery to look better and to feel better. Both groups also wanted to change their gendered embodiment. In effect, both groups reported similar cosmetic and psychological benefits after surgery. They both believed that surgery enhanced the inner self through improving the outer gendered body. Overall, both groups shared remarkably similar embodied experiences before and after surgery. For both transgender and cisgender people, surgical body modification represented an opportunity to change gendered embodiment. Despite these similar experiences, having a cisgender gender status determined respondents’ abilities to pursue surgery autonomously and with institutional support.

When respondents sought surgery, both cisgender and transgender people chose surgeons thoughtfully. They based decisions on similar factors, such as a surgeon’s reputation, skill, and bedside manner. During interactions with surgeons, both transgender and cisgender people had good experiences and appreciated the ways surgeons treated them. But trans respondents reported unique problems in these situations. Although more cis respondents reported that surgeons questioned their surgery requests, trans respondents encountered surgeons who

questioned their decisions to have gender-*crossing* surgery. Trans people also saw surgeons who denied their requests. Whereas the desire for surgical body modification among cisgender people is not classified as disorderly in and of itself, the desire for surgery among transgender people was inherently pathologized. Cisgender surgery consumers then benefited from institutionalized cissexism; their surgery desires were privileged as normative extensions of doing gender. The psychiatric label “gender identity disorder” directed transgender respondents’ presumed “cross-gender” surgery desires through the lens of psychotherapy surveillance.

A major difference between transgender and cisgender surgery consumers related to their abilities to pursue surgery autonomously. Cisgender respondents were always able to pursue surgery without having to first obtain a therapy evaluation or authorization before surgery. In contrast, transgender respondents responded to the pathologizing discourse that framed their surgery desires as indicative of disorder. They anticipated that surgeons would need authorizing letters from therapists and pursued counseling accordingly, even though most eventually chose surgeons that did not require letters. Although becoming certifiably disordered did not facilitate insurance coverage for trans respondents’ surgeries, cisgender respondents were more often able to get insurance to pay for their surgeries, even when their surgeries addressed minor or no physical health issues. Thus, trans people encountered more disadvantages than cisgender people in their surgery journeys.

Theoretical Implications of Surgical Body Modification

In this study, I establish that surgical body modifications bolster gendered embodiment through dialectical cosmetic and psychological benefits. Cisgender and transgender surgery consumers used surgery to achieve a more fulfilling gendered embodiment. As surgery enhanced

appearance, it facilitated comfort and confidence in themselves as gendered beings. This relationship was dialectical, or reciprocal, in that respondents believed surgery resulted in cosmetic improvements, which made respondents feel better psychologically. Consequently, this enhanced mental wellbeing enabled respondents to feel more comfortable showing off their bodies. As surgery enhanced gender expression, this change improved respondents' overall gendered embodiment. Of course, surgery choices typically reified normative standards of attractiveness. Both transgender and cisgender people said they look and feel better after surgery, but surgical body modifications typically perpetuate constrained parameters of ideal gendered embodiments. Surgeries to change the body contribute to the conformity of "attractive" gendered bodies which reify patriarchal and ageist standards (Morgan 1991). But surgery also provided psychological benefits for individual respondents who felt more confident, comfortable, and sexually free. Thus, my research supports feminist theory that conceives of surgery as both empowering and restricting (Gagné and McGaughey 2002; Gimlin 2000).

This dialectical effect of simultaneously produced agency (empowerment) and structural oppression (constraining ideals) illustrates central tenets of poststructural theory. According to Foucault's (1977) concept of power as productive, no one entity exists to subordinate people. People participate willingly in regimes of truth which exist to maintain the conditions that allow them to continue to live their everyday lives. Each regime of truth produces its own discourses, leaving no escape from the discursive world. This study extends these Foucauldian concepts. In analyzing people's embodied experiences with surgical body modifications, discourse about surgery motivations and effects reinscribes hegemonic gendered bodies. People articulate gendered subjectivities about looking and feeling better through surgery, and this discourse

fortifies restrictive narratives of gendered embodiment. This process is an empirical example of bio-power, and so develops poststructural theory.

In addition, the disparate regulation of cisgender and transgender surgery pursuits illustrates the psychomedical management of binary gender. The regulation of two-and-only-two genders persists, silencing the diversity in gender identity and expression adopted by many of the respondents in this study.¹¹ Foucault (1965) argued that medical and psychological discourses distinguish between “normal” and “abnormal” as a highly effective means of social control. These dividing practices function socially to maintain civility and social order. By positioning surgical body modification as healing, and acknowledging that aesthetic changes can produce psychological benefits, risky procedures become justifiable and even necessary interventions. Inevitably, these discursive techniques reify categorical distinctions between acceptable and unacceptable embodiments (Talley 2008). As healthcare institutions manage surgery choices, their discursive power interpellates consumers of surgery into psychomedical discourses about gender. The absence or presence of psychomedical regulations reflects pervasive gender norms. Gender conformity is rewarded, while gender nonconformity is pathologized. This regulatory system exemplifies Foucault’s (1965) interpretation of psychiatric authority where the “abnormal” is named and sorted out as a way to discipline the “normal.”

The pathologization of gender nonconformity normalizes cisgender gendered embodiment. Creating boundaries between normal and abnormal (and therefore pathological) is a subjective exercise. Even though no theoretical or empirical model exists to delineate what counts as healthy gender (Meyer-Bahlburg 2010), linear paths of gendered embodiment (e.g.,

¹¹ The appendix details respondents’ self-described gender identities and expressions. Many respondents, especially cisgender people, fit normative and binary gender standards. But others did not embrace conventional labels when describing their genders. These gendered experiences become invisible when psychomedical institutions perpetuate binary gender systems.

female/girl/woman/feminine and male/boy/man/masculine) remain unmarked and unquestioned. Of course a woman wants large breasts! Of course a man wants to look fit! Non-linear paths of gendered embodiment (e.g., male-assigned at birth/boy/man/masculine/woman/feminine or male-assigned at birth/boy/genderqueer) become disorderly and subjected to increased surveillance. Why on earth would a woman want to cut off her breasts? Why would a man ever want to lose his penis? Psychomedical gatekeeping of surgical body modification for trans people reflects widespread and structurally embedded cultural norms that maintain binary gender. Pathologizing gender nonconformity also conceals diverse gender expressions among cisgender people. It “imposes a model of coherent gendered life that demeans the complex ways . . . gendered lives are crafted and lived” (Butler 2004:5). Distinctions between transgender and cisgender surgery pursuits persist despite their similar embodied experiences before and after surgery. Regulating surgery for trans people is therefore not just about pathologizing transsexuality. This management maintains the binary gender order by validating cisgender experiences as normal, natural, superior, and required. Characterizing gender-crossing as “abnormal” and in need of expert evaluation regulates healthy gender for all.

Ultimately, the theoretical implication of this study reconciles two seemingly divergent arguments. Surgery is not simply an assertion of agency or a submission to oppression. The cosmetic and psychological benefits that respondents gained through surgery show how surgery provides individuals with an empowered sense of self. However, surgery also reifies ageist and sexist norms about attractiveness. The bigger issue, I argue, is that only cisgender individuals have the faculty to pursue surgical empowerment of their own volition. By subjecting cross-gender pursuits to psychomedical surveillance, only cisgender bodies have the means to freely change their bodies to realize desired ends, however problematic those means and ends are.

Sociological Contributions, Limitations, and Future Research

At its core, my research focuses on inequalities that result from identity and social status as they manifest within psychomedical institutions. I identified the psychosocial effects of surgical body modification, highlighting how surgeries change gendered embodiment for cisgender and transgender populations in similar ways. Although narratives about transsexual surgery often rely on cultural tropes about being tormented and “trapped in wrong bodies,” trans motivations for surgery were often considered by those pursuing them to be cosmetic improvements. And while cisgender people reported similar cosmetic motivations, they were also equally likely to report feeling tormented by their presurgical bodies. Respondents’ experiences also outline the ways surgeons and therapists manage the healthcare experiences of people with gender nonconforming identities and experiences. The disparate regulation of these two communities highlights the ways authoritative institutions regulate gendered embodiment. Ultimately, I reveal the individual and structural components of health disparities and gendered embodiment.

By describing similarities between transgender and cisgender respondents, I do not equate the two groups in every way. To be sure, my comparison of their similar motivations for and satisfaction with surgery should not suggest that the embodied experiences of cisgender and transgender people are identical. Indeed, transgender people often experience intense bodily distress for long periods of time when they are unable to express their desired gender. Transgender embodiment also carries social risks like discrimination and violence. Cisgender people’s experiences of having personal gender identities that are recognized through social interactions is a privilege that should not be minimized, even as they perceived their gendered embodiments as flawed.

A limitation of this study is that it does not include the perspectives of healthcare providers. To further explicate the central issues of this study, future research should include data from people who work with consumers of surgical body modification. Surgeons, primary care providers, and therapists likely have important insights on the issues addressed in this study. Interviewing them about their experiences working with people who seek surgery would illuminate the overall experience of surgical body modification. In addition, their views on psychomedical gatekeeping are important to incorporate when considering revisions in policy and clinical practice. I hope to gain access to these professional communities in future research.

A predictable critique of this research is that my ideologies against pathologizing gender nonconformity could have biased findings. Indeed, I started this research aware of theoretical assertions about the unfairness of disparate regulations of transgender and cisgender surgical body modifications. My past research on trans men's healthcare experiences concluded that psychomedical gatekeeping perpetuated trans discrimination and reflected oppressive gender regimes. But I purposely chose grounded theory methods as an analytical strategy that let the data emerge and drive the themes of this study. I designed the interview guides so that I would have equal bases for comparison. As the themes emerged through open coding, I did not count how many trans or cis respondents were represented in the themes. I waited until data collection was complete to systematically compare each theme in the data. In truth, much of the data in this study genuinely surprised me. I did not expect to find such extensive similarities between trans and cis people as they articulated their embodied experiences before and after surgery. Ultimately, the data support the conclusions discussed herein.

Overall, my research contributes to broader sociological issues. I expand on the sociology of the body by contextualizing the gendered body in healthcare institutions. I contribute to

medical sociology by illuminating power imbalances and psychosocial factors in provider/patient interactions. I highlight important social inequalities that result from gender identity and status, where one group is systematically privileged over another. Finally, this study has implications for public sociology regarding policies informed by the WPATH Standards and the dynamics of clinical practice.

Implications for Healthcare Policy and Practice

The findings in this study aim to affect healthcare policy and practice. They challenge the relevancy and necessity of imposing the WPATH Standards as a way to assess eligibility and readiness for transgender people seeking surgery. As I demonstrated, this policy manages surgical body modification for trans people under a climate of surveillance while privileging cisgender surgeries as normative. Although cisgender and transgender people report similar feelings toward their bodies before surgery, motivations for surgery, and surgery effects, the WPATH Standards seek to manage only cross-gender body modifications. The WPATH Standards promote gatekeeping and cissexism by requiring trans people to gain approval from therapists (Serano 2007). Their existence and enforcement creates an unfair double standard that disadvantages trans people while benefitting cisgender people and the providers who profit from psychomedical gatekeeping. Gatekeeping pushes trans people who cannot or will not conform to pathologizing models out of the system to places and providers where they can get services with fewer restrictions. Instead of gatekeeping access to care, healthcare providers with an ethos of care should embrace practices that facilitate safe access to trans-specific healthcare (Serano 2007).

The basis for the WPATH Standards depends on continued psychiatric classifications of cross-gender gender expressions as disordered. Both the WPATH Standards and the American Psychiatric Association's (APA) "gender identity disorder" categorization contribute to healthcare inequalities. Cisgender people can get surgery on demand, but transgender people must first endure psychological evaluations to receive authorization for surgery. Even with therapy prerequisites, a formal diagnosis of GID did not help any respondents in this study get insurance coverage for surgery. The disparity in treatment devalues transgender people's ability to make informed decisions about their own bodies. Thus, the WPATH Standards are not useful for trans people who are sure about their decisions to embody cross-gender or differently gendered features. They work against trans people's rights to self-determination by maintaining a system of surveillance. Instead, the WPATH Standards' eligibility and readiness criteria should only be used for people who report significant distress or impairment due to unresolved *gender* issues, or for people who are *unsure* about physically transitioning and want to be evaluated throughout the process. They should not be used for people whose distress is limited to negotiating a physical *embodiment* that does not affirm their inner senses of gender. Doctors who need guidance for treating trans people with surgeries or hormones can refer to publications that deal with the technical aspects of services provision (e.g., Colić and Colić 2000; Gorton et al. 2005).

In addition, the WPATH Standards and the APA's pathologization of gender diversity directly compromise the quality of healthcare transgender people receive. Trans people are less inclined to talk openly and honestly in therapy, lest they risk getting approval for services. They may withhold their fears, concerns, and doubts because they fear therapists will withhold authorizing letters. This tension compromises therapy interactions. For these reasons, requiring

counseling for both transgender and cisgender surgery consumers would be ineffective. If therapists vacated the gatekeeper role, trans people could instead pursue counseling as an elective choice. Therapy could become a more useful and supportive resource for people as they negotiate both momentous and mundane life decisions. Comprehensive healthcare for trans people, then, includes psychological services (Namaste 2000), as it ought for everyone. Depathologization would also encourage surgeons, hormone-prescribing doctors, and general practitioners to treat trans people as autonomous consumers with the same rights as everyone else, thereby improving relationships in broader healthcare contexts.

Depathologization as social justice. Depathologizing gender diversity is necessary to reduce stigmas against trans people. Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) pathologizes gender nonconforming behaviors and identities through the labels of transvestic fetishism¹² and gender identity disorder. Others have proposed additional pathologizing categories, such as autogynephilia¹³ (Blanchard 1989; Blanchard 2005). Removing these classifications from the DSM would mean that trans and gender nonconforming people would no longer be categorized as officially disordered. Depathologizing gender nonconforming behavior would advance an ideological model of gender that values diverse gender expressions. This move would promote freedom for people of all genders to express their identities in different ways.

Depathologization of gender nonconformity would especially afford boys and men more freedom of expression. Treatments to abolish gender nonconformity in children have most often targeted boys. These “corrective” therapies aim to prevent transsexuality in adulthood (Bryant

¹² The DSM reserves the diagnosis of transvestic fetishism for heterosexual males. The diagnosis is categorized as a paraphilia involving distressing or impairing sexual fantasies, urges, or behaviors associated with crossdressing.

¹³ Blanchard (1989; 2005) theorizes the autogynephilic male-to-female transsexual as motivated to change sex based on being sexually aroused by the idea of oneself as a woman.

2008). Pathologizing theories about autogynephilic transsexual women further demonstrate how people who were assigned male at birth encounter increased gender surveillance. The autogynephilic label pathologizes trans women for articulating gendered identity as interconnected with sexuality (Blanchard 2005, Bailey 2003). This policing of gender nonconformity in people who were assigned male at birth is a byproduct of sexism. The widespread hatred and devaluation of trans women is symptomatic of the devaluation of womanhood and femininity (Serano 2007). Cultural gender norms that reproduce gender stratification make gender nonconformity among girls and women more understandable because masculinity is associated with power, privilege, and prestige. In contrast, gender stratification makes gender nonconformity among boys worthy of scrutiny. It is perplexing – even unforgivable – when the privileged gender willfully explores and adopts culturally practices considered feminine. Thus, depathologizing gender nonconformity is an exercise in leveling the gender playing field.

Stigmas that accompany pathologization have also been used to undermine trans rights more broadly. One study with students in seven countries showed that the belief that trans women were mentally ill was the most powerful predictor of prejudice against trans people (Winter et al. 2009). Categorizing gender nonconformity as mental illness has disadvantaged trans people in a variety of social arenas. It has been used against trans people in gaining and retaining employment, military service and veterans benefits, marital legitimacy, access to healthcare services, child custody disputes, access to security clearances, and in civil rights-based protections (Jefferson 1999; Leff 2011; Meyer-Bahlburg 2010; Vance et al. 2010). It has been used to justify intense psychiatric interventions to suppress behaviors in gender nonconforming children (Hill et al. 2005). The pathologization of trans identities and experiences

“reinforce[es] the belief that certain behaviors are deviant, subnormal, or pathological, and therefore less deserving of genuinely equal rights” (Nichols 2008:476). Removing cross-gender expressions from psychiatric classifications would have far-reaching consequences, similar to how gays and lesbians enjoyed increased social acceptance and decriminalization after homosexuality was removed from the DSM in 1973. Although trans social movements have secured rights in the past decade while under the guise of disorder, “the DSM diagnoses may have played (and are still playing) an inhibitory role delaying the pace of change” (Drescher 2010:454). Despite the improbability that the APA will remove these classifications by the time the *DSM-V* is released in 2012, social justice for trans people depends on stepping outside of the pathologized ideological framework.

Practical limitations of depathologization. Due to widespread social inequalities for trans people, however, advocating for immediate depathologization is unwise. Despite the ways pathologization has harmed trans people, the medical model of transsexuality has also secured legal and political gains for trans people in a variety of institutions, such as prison, housing, and foster care (Spade 2003). In February 2010 the United States Tax Court ruled that treatments for GID count as deductible medical expenses. This ruling expands benefits for trans people by classifying medical and surgical treatments that aid comfort in social roles such as gender as tax deductible (Gay and Lesbian Advocates and Defenders 2010).

The study of transgressive gender enjoys an elaborate history, but the enactment of transgender rights has lagged far behind (Wilchins 2002). While the deregulation of gender is important, the marginalized statuses of the most vulnerable gender nonconforming people – people who are young, low-income, of color, immigrants, incarcerated, differently-abled – necessitate envisioning depathologization as a long-term goal until institutions can meet

marginalized groups' material needs (Spade 2003). Compromise is necessary for the near future, as legal expert and trans person Dean Spade (2003) asserts:

We must strike a balance between wanting to avoid over-reliance on medical evidence while contending with the fact that many trans people's lives are entangled with medical establishments, and for those people, it would be beneficial to prove that sex reassignment related treatments are "medically necessary" and should be covered by Medicaid and private health insurance. (P. 35)

Until we develop and implement a better model for recognizing a person's gender identification, the pathologizing medical model is most appropriate for the short term.

In addition to rights-based issues, depathologization also presents a logistical dilemma. How can medical transition become more accessible for trans people without a diagnostic justification? It is difficult to envision a system where gender diversity is completely depathologized while access to hormones and surgeries remains available (Drescher 2010). On an international level, most organizations advocating for trans people support removing the GID diagnosis from the *DSM-V*. But the main reason these organizations supported diagnostic labeling was due to concerns about insurance coverage for healthcare services (Vance et al. 2010). In response to concerns about loss of coverage for services, some scholars have proposed a model that reclassifies transsexuality as a non-psychiatric medical condition (e.g., Lev 2005). This model argues that the diagnosis should be medical because effective treatments change the physiology of the body. This medical model would reclassify transsexuality in the World Health Organization's *International Classification of Diseases* (ICD) as a physical condition. This medical model could work for covering certain procedures under insurance. But the problem of pathologization remains; transsexuality would still be considered an illness. Medical models also often erase transgender diversity by failing to meet the needs of gender nonconforming people

who do not identify as men or women – such as genderqueers and two-spirited people – or people who do not seek medical transition to realize their gender identities (Romeo 2004-2005).

Another proposed model of gender rests on the ideology of self-determination. While acknowledging that gender is informed and produced through social processes, Romeo's (2004-2005) self-determination model:

recognizes gender as a fundamental aspect of human life, which every person has the capacity and inherent right to control. If courts were to consider gender to be a healthy and legitimate expression of a person's identity, whether or not that expression conforms with the expected norms of their birth gender, the scope of claims available to transgender litigants would become much more expansive. (P. 738-9)

This legal model of gender proposes viewing gender, gender identity, and gendered embodiment as personal rights. It reasons that self-determined gender is analogous to reproductive choices. Pregnancy, for example, is a legally recognized and protected expression of healthy embodiment. In addition, unmarried fathers have gained legal rights to children by enacting fatherhood norms with their children (Romeo 2004-2005). Using similar legal logic, trans people may assert their gendered embodiment choices as healthy expressions, and may gain recognition in their desired genders by enacting that gender socially. Legal categorizations based on rights to privacy, however, have limitations in practice. Disadvantaged groups do not have equal access to exercising rights to privacy (Romeo 2004-2005). In addition, reproductive rights are hotly contested and tenuous, as the rhetoric of choice, privacy, rights, and freedoms is an ongoing and well-documented struggle (Simonds 1996; Smith 2010).

The Healthy Gendered Embodiment Model: A New Ideology of Gender Depathologization

As mentioned earlier, depathologization is an ideal long-term goal that is immediately impractical. Before depathologization can occur, a new model must be implemented that reduces

the stigma of gender nonconformity, offers legal protections for gender nonconforming people, and secures coverage for services to achieve ideal gendered embodiment. Based on the data in this research, I offer a new three-tiered framework – the healthy gendered embodiment model – that attempts to meet these central objectives. Naming this model “the healthy gendered embodiment model” expands on Romeo’s (2004-5) legal model of gender, where gender can be conceived as a “healthy” expression of the self. By referring to “gendered embodiment,” I foreground that gender is both an internal sense of self expressed through the body and a social reality where others interpret the body as imbued with gendered meanings.

Reducing stigma through depathologization. Ending gender oppression demands depathologization. Like sexuality, gender is complex, diverse, embodied, and can change over time. It is a part of human expression, informed by sociocultural meanings of identity and behavior. The healthy gendered embodiment model appreciates gendered embodiment as a continuum with no specific endpoints that rank the degree of expression. Thus, a cisgender man who shaves his face, wears cologne, injects steroids, and lifts weights to enlarge his muscles participates in body modification practices that are not any more or less morally superior, culturally acceptable, or legally viable than the transgender man who shaves his face, wears cologne, injects testosterone, and has chest reconstruction surgery. Both people assert their personal gender identities through their bodies. They affirm their social genders as they become culturally intelligible to each other as men. To reduce the stigma of gender nonconformity, transgressive gender practices and identities cannot constitute a diagnostic category in any psychomedical rulebook. This means that gender nonconformity should not be in the DSM, the ICD, or any other psychomedical classification system. This call for depathologization is not based on aversions to associations with mental illness, nor to a fear of being associated with

people who have psychological disorders, as suggested by Gorton (2006). Depathologizing gender diversity should not preclude working for social justice for people with mental illness. Instead, depathologization celebrates vast manifestations of gender. It rejects dualistic frameworks where diverse expressions of identity are immediately divided into normal and celebrated or abnormal and punished.

Offering legal protections through self-determination. Positioning cisgender and transgender gendered embodiment as similar requires recognizing all gender as a self-determined choice. Conceiving of gender as a choice is not meant to demean the “real” sense of gender that many people report. Both transgender and cisgender people may feel a strong and persistent inner sense of gender. A sense of innate gender may be intelligible in early childhood, or it may become clearer during adulthood. It may also shift over time. But everyone must choose to express that inner sense of gender in socially recognized ways. We all *choose* to gender our bodies, whether through mundane modifications (hair cuts, deodorant, clothing) or invasive modifications (orthodontic braces, hormones, surgery). Alternately, we purposefully choose to resist normative gender, such as by presenting androgynously or with mixed gender expressions. As this research showed, both cisgender and transgender consumers of surgical body modification used surgeries to affirm their inner personal gender identities. Pursuing surgery, then, was a form of self-determining gender for both cisgender and transgender consumers. To further depathologize gender nonconformity, courts could recognize self-proclaimed gender. To accommodate sex categories beyond male and female, they could instate a third legal category.¹⁴ Romeo’s (2004-2005) proposed model of self-determination is a good starting place for asserting self-determined gender identity while procuring legal protections. If courts adopted this model,

¹⁴ New Zealand implemented an example of a third legal sex category by allowing an “X” designation on passports (Veale 2008).

they would no longer base decisions about gender on details about gendered embodiment. This model would accommodate people who cannot afford or do not want medical transition to be legally recognized in their desired genders. This legal framework would facilitate protections for gender nonconforming people while advancing a basis for civil rights for people of all genders.

Securing coverage for medical body modification. This study showed that cis and trans people had similar feelings toward their bodies before surgery, similar motivations for surgery, and similar outcomes of surgery. Based on these data, trans and cis people are comparable surgery consumers. They did not, however, exercise similar freedom to pursue these surgeries, and they did not enjoy health insurance coverage for surgery equally. A defining feature of the healthy gendered embodiment model recognizes transgender and cisgender gendered embodiments as equally viable choices. Consequently, this model asserts parity in coverage for body modification services obtained by both transgender and cisgender people.

Access to comprehensive healthcare should be a civil right. Indeed, health care reform in the United States is underway. Although it may be idealistic, it is important to envision a comprehensive healthcare policy where insurance companies cover procedures that have physical and mental health benefits. Under a comprehensive healthcare plan, medically-assisted body modifications could be consistently covered. Such a model would facilitate coverage for surgeries or hormones. In this study, insurance companies sometimes covered surgeries that aimed to improve physical and mental health. These policies and practices need to become more consistent.

One way to ensure coverage for surgical body modification is to demonstrate a physical health benefit. In this study, several types of surgeries were covered by insurance companies, sometimes without any documented medical problems or with minimal ailments. People in this

study received coverage for surgery when they documented physical pain, cancer risk, and breathing impairment. Surgeries that have an obvious physical benefit are already easier to cover through insurance. Trans and cis people should be able to document these ailments without having their gender identities questioned.

Another way to cover surgery related to physical health is to cover surgeries based on medical authorities' determinations about "appropriate" male or female bodies. Medicine is ridden with proposed ideals and averages for different body parts or features, including height, body mass index, breast size, phallus length, and so on. In this study, women who had breast reduction relayed intricate formulas that their surgeons used to get the surgery covered by insurance. Coverage depended on determining the amount of grams taken out of the body in proportion to the respondent's bodily frame and height. Similar strategies can be used for other gendered body parts. For example, cisgender men often get male breast reduction surgery covered because their surgeons demonstrate that their breasts are "abnormally" sized for a man. Similarly, a transgender man – recognized as a man based on self-determination – could also receive a diagnosis of gynecomastia, where surgical removal of breast tissue to produce a "normal" male chest is a logical treatment. Coverage could also apply to hormones, where a transgender woman could have hormone therapy covered by insurance under the diagnosis of hypergonadism. In these examples, the surgery treats a diagnosis related to the gendered body part, not gender identity itself.

This means of coverage could be extended to help cisgender and transgender people get other surgeries covered by insurance. As doctors codify statistical averages for sizes of various body parts – breasts, penis, abdomen, skull, ears, nose, vagina – surgeons could file claims illustrating their patients' bodies' deviations from the statistical norm. For example, if a C-cup

breast size constituted the average breast size for American women, a woman with A-cup breasts who lived in the United States could argue for coverage based on being “abnormally” small. A person with an “abnormally” large nose could similarly file for coverage. Cisgender or transgender status would not matter in these cases. Admittedly, surgery for the sole purpose of approaching a statistically normative body size is fairly crass. But surgeons who calculate the ratio of breast size to body frame, for example, already use these measures to facilitate insurance coverage for breast reduction surgery. Documented pain or inhibited mobility was insufficient for insurers to cover the surgery.

A final way to secure coverage for services is to demonstrate psychological benefits. Such benefits would bolster the aforementioned arguments. Insurance companies are legally bound to comply with mental health parity laws and cover treatments that aid mental health as often as those that address physical wellbeing. The literature already shows that surgical body modifications typically result in improved wellbeing in transgender (e.g., Kraemer et al. 2008; Lawrence 2003; Pfäfflin and Junge 1998; Smith et al. 2005) and cisgender people (e.g., Bolton et al. 2003; Castle et al. 2002; Gimlin 2000; Hurd Clarke and Griffin 2007; Klassen et al. 1996; Rankin et al. 1998; Sarwer et al. 1998; Sarwer et al. 2005). My research shows that surgeries offer psychological benefits to both cisgender and transgender people in similar ways. Thus, insurance companies should recognize that surgical body modification for transgender and cisgender people can be psychologically healing and gender-affirming. To avoid the problems associated with psychomedical gatekeeping, surgeons should assess a patient’s likelihood of improved mental health. Surgeons should also have better training in mental healthcare sufficient to assess whether a prospective patient is capable of giving informed consent. They should discuss surgeries in depth with patients, ensuring that patients understand the physical and social

risks and benefits of surgery. As independent providers, surgeons may choose to refer patients to mental health professionals if they deem such care is warranted. And as independent consumers, cisgender and transgender people may choose to follow this advice. Alternately, rejected consumers – who become more informed about reasons why surgeons denied services – may then renegotiate their desires for surgery with a new provider.

Limitations of the healthy gendered embodiment model. Insurance companies need to adopt policies that provide coverage for procedures that aim to improve both physical and psychological wellbeing. Currently, the U.S. healthcare system does not promote comprehensive plans for covering services that improve quality of life. Thus, some of the recommendations in the healthy gendered embodiment model rely on idealistic conceptions of healthcare. It is my hope, however, that future configurations of healthcare adopt more holistic models of wellbeing.

Without doubt, surgical body modifications and rationales for covering them reify what constitutes normatively healthy and gendered bodies. Some people would view a woman who needs larger breasts to achieve a higher self-esteem as a sad or infuriating consequence of patriarchal beauty standards. However, the healthy gendered embodiment model asks critics to resist situating surgery on a hierarchy of body modifications. It is unfair to criticize surgically modified bodies more than nonsurgically modified bodies for conforming to the same beauty standards. Such critiques suggest an overly simplistic and technophobic logic (Talley 2008). If critics argue that surgeries reproduce narrow standards of beauty, then they need to critique *all* forms of gendered embodiment as oppressive. To avoid hypocrisy, critics should equally oppose other modifications and expressions that reify narrow standards of attractiveness, including (for women): shaving, deodorant, dieting, wearing make-up, permed hair, straightened hair, heels, or any other clothing, artifice, or alteration that presents the gendered body in normative gendered

ways. Many of these nonsurgical means to beauty are costly and risky. All of these bodies are altered bodies, crafted with social meanings, and bodies are always gendered.

Indeed, it is necessary to deconstruct the structural forces that compel and coerce people into some forms of embodiment over others. But the impulse to halt biomedical interventions in favor of social change is problematic, as the practical means to affecting change is often unclear, difficult, and long-term (Talley 2008). Critiques of surgical interventions also warrant critical analysis. In her work on interventions to transform facial “disfigurement,” Heather Laine Talley (2008) asserts:

The impetus to *not* intervene demands as much critical attention as the compulsion to intervene. Upon what grounds is intervention resisted? Who gets to say that a desired intervention should not be made available? Why isn’t suffering precisely the grounds upon which informed consent can be given? What might bioethics understand about face transplantation if it were read through suffering rather than outside of it? In a health care system characterized by a free market model of supply and demand, why does a patient’s desire for face transplantation preclude him or her from being an “ideal candidate”? In what cases are long and difficult solutions, namely social change, reasonable and ethical alternatives to biotechnological interventions? These are questions not posed often enough, but they are the questions that [need] to be asked of self-reflexive, feminist, and/or critical accounts of science and technology. If theory has fallen into a rut, dominated by predictable logics, then these questions are important for exposing the assumptions that undergird “critical” accounts. (P. 268-9)

Radical social change that works to end gender oppression is sorely needed. I began this project in the service of that ideal vision. But disparaging the surgery pursuits of individuals who seek healing and bodily comfort is misguided. It is especially troubling when people who have the privilege of inhabiting cisgender bodies and normative standards of attractiveness are the primary forces leveling these critiques. Arguably, the logic is comparable to blaming poor people for wanting nice things without critiquing the materialist, consumerist, and capitalist society in which we live and one’s own irresponsible financial management or money missteps.

Other critics might argue that comparisons between surgical body modifications and other body alternations like make-up and shaving are unfair because consumers pay for the latter by themselves. Because the healthy gendered embodiment model supports insurance coverage for surgical services based on anticipated mental health benefits, these critics might suggest that surgeries warrant special consideration. The problem with this critique is that it overlooks how insurance companies already cover certain “cosmetic” surgeries. Healthcare institutions often support these surgeries when they improve an individual’s quality of life. Assessing imagined quality of life is a subjective determination. As this research showed, people were able to secure coverage for a variety of surgeries, including ear surgery with no medical benefit, rhinoplasty with only minimal anticipated medical benefit and without postsurgical improvement, and breast reduction with medical benefits when the respondent focused only on favorable cosmetic outcomes. In addition, healthcare authorities use inconsistent measures to determine the ability of surgery to improve quality of life. These determinations systematically advantage cisgender consumers. Most insurance companies do not cover surgical body modification for transgender people despite the ample research supporting its positive effects on quality of life. Based on the data in this study and existing literature, even the psychiatric diagnosis of gender identity disorder typically does not aid coverage for surgery for trans people (Hong 2002; Lombardi 2001; National Coalition for LGBT Health 2004; U.S. Department of Health and Human Services 2010).

It is understandable, however, that some critics are uncomfortable with insurance support for surgical body modification. People may feel uneasy to have their tax dollars support procedures that they morally or ideologically oppose. But taxes often pay for a variety of

potentially objectionable and controversial expenses, such as abstinence-only until marriage education, space exploration, and war.

As a feminist, it is disheartening to imagine the hoards of women who would likely pursue surgery if it was covered by insurance. Although I have a greater appreciation for individuals who choose to modify their bodies, I worry that masses of surgically altered bodies would perpetuate hierarchies of beauty, further marginalizing people who “dare” to live in bodies that are “too” big, small, fat, flimsy, droopy, extended, bald, stretched, sunken, or wrinkled. But as mentioned above, a critique of surgery based on reifying beauty standards needs to critique all body alterations that aim for a more attractive or presentable appearance. A single surgery is not necessarily more severe or costly than decades of tanning or working out at the gym.

As a feminist, however, it is also admittedly easier for me to support trans surgeries. Even though my research has shown that trans and cis people feel similarly okay or traumatized about their bodies before surgery, and achieve similar embodied effects through surgery, I acknowledge the reality of cisgender privilege as it relates to social inequality. Most cisgender people experience tremendous privilege in that their social genders are taken for granted. Trans people often struggle to be taken seriously as their desired gender. Even after multiple surgical transformations, trans people can suffer workplace discrimination, housing discrimination, and violence due to their gender statuses. This is a major difference between typical transsexual and cissexual experiences, and one that I have not forgotten.

Although my proposed framework and prescriptive model on surgical body modification is somewhat unorthodox, I view this issue as a matter of healthcare inequality. My research has shown that cisgender and transgender people report similar feelings toward their bodies before surgery, similar motivations for surgery, and similar postsurgical effects. As my research

progressed and I learned how similar the two groups were, I was unsure how I could advocate for insurance coverage for transgender people's surgeries and not for cisgender people's surgeries. I also could not reconcile counseling requirements for both groups after learning about how psychomedical providers apply eligibility criteria inconsistently, and how they use more permissive guidelines for people who are already socially privileged (e.g., people who have occupational prestige, education, and gender-conforming appearances). Through this research I accepted that theoretically aligning the gendered embodiment of trans and cis groups requires equating them in practice as well. Early on, I understood that specific policy recommendations would have to apply to everyone or to no one, regardless of gender status. The healthy gendered embodiment model does not advantage cisgender people over transgender people, nor does it privilege medical health benefits over mental health benefits. Instead, it attempts to alleviate social inequalities that have impeded access to comprehensive healthcare.

To be sure, feminist critiques of gendered embodiment are warranted as long as gender inequality persists. Given that "third wave" feminists refute second-wave feminists who rejected contrived beauty, it seems unrealistic that all people – let alone those with feminist sensibilities – will eschew perpetuating normative standards of attractiveness anytime soon. While it might be even more liberating to envision a society where bodies are not subjected to scrutiny or do not cause internal despair, the reality is that bodies do matter. Gender matters, and gendered embodiment marks gender on the flesh. It is unlikely that humans will cease using gender to organize social life anytime soon. A more practical theory of gendered embodiment acknowledges that gendered embodiment is in a constant state of reinterpretation where people reconfigure meanings of the self through innovative body technologies.

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APPENDIX – THE SURGERY CONSUMERS

This appendix details the sample demographics to make the research more transparent. I designed the study to compare two gender groups: consumers of surgical body modification who were cisgender or transgender. To compare the gender groups, it is necessary to identify their inherent similarities and differences. Sample differences unrelated to gender status as transgender or cisgender may affect findings. For example, if one gender group was markedly older than the others, their experiences could have contributed to their motivations for surgery. Any differences between the two groups might then be better explained by age differences than gender group differences. Thus, this appendix reviews demographic factors that could have affected differences between the gender groups' experiences. The descriptions relayed in this section pertain to the most important demographic information (for additional details, see Tables 2.3 and 2.4).

Cisgender Consumers

Interviews with the 20 cisgender consumers occurred from February through November, 2010. Cisgender women were easier to recruit than cisgender men. I interviewed three cisgender men over the phone and met with the rest of the participants in person. Interviews with cisgender people lasted from 21 to 66 minutes, with a mean length of 42 minutes and a median length of 39 minutes. Among the cisgender respondents, 11 lived in Atlanta, three lived in Atlanta suburbs, three lived in North Carolina, and one respondent each lived in rural Georgia, San Diego, and Lawrence, Kansas at the time of the interviews. Ten respondents worked in professional occupations such as marketing and healthcare provision. Three respondents were full-time students, and each of these also worked outside of school in academia, real estate, and theater.

Two respondents retired from professional careers. Two others worked in artistic professions. One respondent did not work and was a stay-at-home mother. One person worked in sales, and another was as a self-employed business owner. Eighteen cisgender people identified as white and two identified as Hispanic. The cisgender respondents ranged in age from 18 to 85, with an average age of 41 and a median age of 40. Eleven of the cisgender respondents identified as heterosexual. Among them, five were legally married, three were divorced, two were single, and one was engaged. Nine cisgender respondents identified as gay, lesbian, or queer. Of these, four were single, four were partnered, and one was dating. Cisgender men were more likely to be gay than cisgender women. Twelve cisgender people had no children, two had one child, three had two children, and three had three children.

The research warranted several questions about respondents' gender identity and expression. Although I classify each group as transgender or cisgender, these gender labels represent different meanings for people. With that in mind, I asked respondents to state their gender identity and describe their gender expressions in terms of being feminine, masculine, androgynous, or something else. Eighteen cisgender respondents identified as female/woman or male/man. One respondent identified her gender as "queer femme" and another identified his as "male masculine." Among the cisgender people, seven described their gender expressions as conventionally masculine or feminine. Four cisgender women described their gender expressions using hyper-feminine terms such as "girlie girl" or "femme." Three cisgender men described their gender expressions as more or mostly masculine. Four respondents described their gender expressions as relative or "in the middle somewhere" on a scale of masculinity or femininity. One described her expression as womanly, but not feminine. Finally, one respondent said he leaned towards an effeminate gender expression.

In addition to asking respondents to describe their gender expressions, I also asked if they believed strangers would describe them as conventionally feminine or masculine based on looks alone. Thirteen cisgender respondents believed that they passed as conventionally feminine or masculine in their movements through the world. The rest provided more complicated interpretations of others' perceptions. One cisgender man hoped that others viewed him as conventionally masculine but thought they only possibly did. Another cisgender man felt others probably viewed him as conventionally masculine. One cisgender woman believed she was not perceived as conventional because she was not very "girlie," nor was she conventional in other ways. Another said she passed as feminine, but that her tattooed body and queerness skewed others' perceptions of her as conventional. Similarly, one cis man said others' impressions of his gender expression depended on the context. Finally, one cis man said he thought others did not view him as conventionally masculine due to the way he spoke and carried himself.

Cisgender respondents' surgeries varied. Ten respondents had only one body part surgically modified in one session. In other words, these respondents had only one surgery. Two respondents addressed more than one body part during a single surgical session, such as getting breast augmentation, blepharoplasty (eyelid surgery), and liposuction on the thighs in one sitting. Seven respondents had two surgery sessions and only one addressed multiple body parts during surgery. Only one had three surgeries over the course of her life. In total, the 20 cisgender surgery consumers surgically modified 34 body parts over 29 surgery sessions. The most common surgery type among the cis women was breast reduction (four respondents), followed by blepharoplasty (three), breast augmentation (three), liposuction of the neck area (three) and of the limbs (two), facelift (two), and abdominoplasty, also known as a "tummy tuck" (one). Among the men, rhinoplasty was most common (four respondents), followed by liposuction on

the torso (three) and neck (one) areas, hair transplant (two), otoplasty, or ear surgery (two), abdominoplasty (one), chest skin removal (one), and thigh lift (one). The age at first surgery ranged from 16 to 55 years old, and averaged 31. The oldest age at the time of surgery was 60. Only two respondents were interviewed within a year of their most recent surgeries. The longest lapse between surgery age and age at the time of the interview was 30 years.

Cisgender respondents' surgery choices and costs also varied. Eighteen of the cisgender respondents sought surgery with men surgeons. Their surgeons operated out of Georgia, North Carolina, California, and Kansas. Three cis women who were related to each other used the same surgeon. In addition, two cis men who were partnered shared a surgeon. Cisgender respondents' estimated out-of-pocket costs of individual surgeries ranged from \$0 to \$16,000. Some respondents were unsure about the costs of their surgeries, and others offered rough estimates because they did not pay for the surgery themselves. Due to this factor, calculating an accurate mean cost of surgery is impossible. Eleven respondents paid in full for their procedures because insurance did not cover the costs of the surgery. Six respondents reported that insurance covered most or all of their surgeries. Two respondents who had two procedures each reported that they paid for one surgery out of pocket while their insurance companies paid for the other. One respondent who had three surgeries reported that insurance paid for the total cost of one procedure and partially covered the others. Surgeries covered in full by insurance included breast reduction, rhinoplasty, otoplasty, and hair transplant. Fourteen cisgender respondents had no future plans for more surgery at the time of the interview, and six believed that future surgery was possible.

Transgender Consumers

Interviews with the 20 transgender consumers occurred from May through September, 2010. Trans women were easier to recruit than trans men. Interviews lasted between 43 minutes to over four hours. The longest interview lasted just under three hours and required a follow-up interview that lasted just over an hour and a half. The average length of interviews with transgender respondents was 94 minutes, with a median length of 77 minutes. Among the transgender respondents, nine lived in Atlanta or Decatur, five lived in Georgia suburbs, four lived in rural or small towns, and one lived in urban Alabama. One respondent lived in San Francisco but recovered from surgery in the Atlanta area. Five respondents worked in professional occupations such as financial management. Three respondents worked in service industries, and one worked as a laborer in an assembly line. Three respondents were technically retired, but one of these was changing careers and another was still looking for work. Eight respondents lacked steady employment. Among them, two worked in temporary jobs, one worked as a consultant and researcher, and another did gig work as an artist. One respondent was a student and another was planning to return to school full-time. One person had recently become unemployed, and one was on disability. In terms of race, sixteen respondents were white. Two of these respondents, however, did not agree with race categories and so resisted identifying as white; both acknowledged they were perceived as white. Each of the remaining respondents identified as white and American Indian, Mexican, multiracial, and African American. They ranged in age from 22 to 63, with an average age of 38 and a median age of 33.5.

The gender identities and expressions described by transgender respondents varied. Eighteen of the transgender respondents lived fulltime within the gender they identified. One trans woman respondent lived fulltime as a woman except for the few days she spent with her

brother and adult children. Another trans woman respondent lived as a man most of the time because she feared that coming out as trans would threaten her ability to qualify for full retirement after working for the federal government. When asked to describe their gender identities, seven of the transgender respondents described themselves as female/woman or male/man. Nine respondents included their trans status in their gender identities, such as “transgender woman” and “queer but more male-oriented.” Two respondents were specifically trans-identified and described their gender identities as genderqueer and transgender and trans. One respondent described her gender as “funny” and “interesting,” but also “female.” Another respondent who had a female-to-male-to-female transgender experience described his gender identity as “confusing.” This respondent had de-transitioned and was trying to live as a woman at the time of the interview, but has since reported the decision to restart testosterone. In terms of gender expression, seven transgender respondents described their gender expressions as conventionally feminine or masculine. Three trans women used hyper-feminine terms such as “ultimate girlie girl” and “femme.” One described her gender expression as “dominant female” and another said she was unsure how to describe her gender expression. Two trans men described themselves as masculine but not in the standard way. For example, one of these respondents described himself as metrosexual and the other said he “turn[ed] [his] masculine dial on 60 or 65 percent.” Three respondents described their gender expressions with references to gay masculinities. For example, one of these respondents said he was comfortable being “a little faggish.” One respondent’s gender expression was androgynous, another respondent said he was pretty feminine, and a third described himself as more masculine but also sometimes genderqueer, depending on the context. Eight respondents believed that others perceived them as conventionally feminine women or conventionally masculine men. Three trans women

respondents reported that they had trouble passing as women and so believed that others did not read them as conventionally feminine women. One felt that others' perceptions of her depended on the context. Eight trans men did not think people perceived them as conventionally masculine. Instead, most of these respondents thought that others viewed them as gay men. Trans women were more likely to adopt conventional gender identities and expressions than trans men.¹⁶

These diverse gender identities also impacted how transgender respondents described their sexual identities. Five trans women respondents reported having sexual identities that were mostly bisexual or pansexual. Of these five, one identified as pansexual/bisexual, one as poly/omni, one as "slightly bi" with a slightly greater attraction to men, one as bisexual but leaning toward partnering with men, and one simply as bisexual. One respondent said she was attracted to women but felt "almost asexual." One respondent believed her sexual identity was changing in that she formerly partnered with women but now found men attractive. One respondent said she was mostly lesbian. Only two respondents described their sexual identities using singular terms. One of these respondents identified as heterosexual and another identified as lesbian. Among the trans men, none identified as simply straight, but three reported primary attractions to women. Only one reported primary attractions to men and identified as mostly gay. Six respondents described having queer or pansexual sexual identities. Among the transgender respondents, eight were not partnered. Of these eight respondents, four were trans women who were divorced from cisgender women. Among the five partnered trans women respondents, two had trans women for partners, one was dating a cis man, one was in an open relationship with a trans man, and one was romantically (not sexually) partnering with a newly transitioning trans

¹⁶ In this research, I sometimes refer to the gender subgroups as ciswomen, cismen, transwomen, and transmen, but I am aware that these terms do not sufficiently reflect the varied and diverse gender identities claimed by each respondent. I use these terms for brevity only, but encourage readers to consider respondents' nuanced gender identities when reviewing findings. Where appropriate, I account for these differences in the findings.

woman. Of the partnered trans women respondents, two had been divorced from women. Three trans men respondents were in open relationships. Four trans men had partners and of these four, two partnered with cis men and two partnered with cis women. Concerning parentage, twelve of the trans respondents had no children. Two trans respondents had one child, three respondents had two children, two had four children, and one had five children.

Trans women's surgeries varied. Thirteen respondents had only one surgical body modification procedure in one session. One respondent had two procedures in one surgical session. Three respondents had two surgeries over two sessions, while two respondents had three surgeries over two sessions. One respondent had five surgeries over four sessions. In total, the transgender respondents surgically modified 32 body parts over 28 surgery sessions. The most common surgery types among trans women addressed the face or neck (nine surgeries among six respondents). Of these six respondents, four opted for a comprehensive surgery known as facial feminization surgery (FFS). The catch-all FFS may include multiple surgeries to address different parts of the face, including the brow, nose, lips, chin, jaw, and cheeks. Five respondents had breast augmentation. Four respondents had genital surgeries. One respondent had abdominoplasty. All of the trans men respondents had some kind of top surgery. Nine of them had chest reconstruction surgery and one had a breast reduction. One trans man also had full body liposuction and rhinoplasty. The youngest age at first surgery ranged from 21 to 62, and 62 was also the oldest age at the time of surgery. The average age at first surgery was 36. Fourteen respondents were interviewed within a year of their most recent surgeries. The longest lapse between surgery and interview was 10 years. Seventeen respondents saw only men surgeons, two had surgery with women surgeons, and one had surgery with both women and men surgeons. Ten transgender respondents obtained surgery from providers in Georgia, five had surgery in

other states, and two had surgery in other countries, Iran and Thailand. Six surgeons were seen by multiple respondents. Respondents' estimated out-of-pocket costs of individual surgical procedures ranged from \$0 to \$40,000. Seventeen transgender respondents paid for their surgeries without any insurance coverage. Two trans men respondents were able to get most or all of their surgery costs covered by insurance by qualifying for breast reductions, and one trans woman secured insurance coverage for a small portion of the surgery's total cost. Eight respondents planned to have future surgery, six respondents did not, and six felt unsure or that future surgery might be possible.

Key Similarities and Differences among the Gender Groups

Based on the above demographic information for the two gender groups, some key similarities and differences exist between them. The cisgender and transgender sample groups were similar in important ways related to identity, social status, and surgery experiences. They lived in similar areas, represented similar racial and ethnic groups, and had similar family structures. Transgender and cisgender respondents also reported similar numbers of surgeries, age at first surgery, and characteristics of surgeons.

Transgender and cisgender groups had several identity and social status characteristics in common. The first similarity was in residence. Seventeen cisgender respondents and 15 transgender respondents lived in urban or suburban areas in the southeast United States. Although a few more trans respondents were likely to live in less populated areas, this difference in residence did not particularly impact their surgery experiences. Next, in terms of race, 18 cisgender and 16 transgender respondents were white. Although a few more trans respondents were members of racial minorities, this difference did not appear to greatly impact their surgery

experiences. In general, race is an important factor to consider when describing gendered embodiment. The effects of race on gendered embodiment and surgery decisions are discussed in the findings. Finally, transgender and cisgender respondents also had similar family structures. Partnering and parenting patterns were similar across the gender groups. Ten cisgender respondents were in serious relationships, one was dating, three were divorced and single, and six were single. Eleven transgender respondents were in serious relationships, one was dating, four were divorced and single, and four were single. Cisgender and transgender respondents were equally likely to have children. Although more transgender respondents reported being in an open relationship than cisgender respondents, this minor difference did not appear to affect substantive findings.

Cisgender and transgender respondents were also similar in terms of total number, range, and frequency of surgical body modifications. Cisgender respondents had 34 total surgical body modifications over 29 surgery sessions and transgender respondents had 32 total surgical body modifications over 28 surgery sessions. Per individual, the number of cisgender surgeries ranged from one to three and ranged from one to five for transgender respondents. Eleven cisgender respondents and 13 transgender respondents had only one surgery over one surgical session. These similarities are important because higher numbers of one group in any given conceptual category or theme cannot be attributed to unequal numbers of surgery experiences.

The age at the time of first surgery was somewhat similar between transgender and cisgender respondents. For cisgender respondents, the age at first surgery ranged from 16 to 55 years old, and averaged 31. For transgender respondents, the age range at the time of first surgery ranged from 21 to 62, and averaged 36. These ages are similar and suggest that both groups had surgery at different points throughout the lifetime.

In terms of surgeons' gender and location, cisgender and transgender respondents were both more likely to have surgery with men surgeons in the United States. Two surgeons performed surgery on multiple cisgender respondents, while six surgeons performed surgery on multiple transgender respondents. The higher overlap of surgeons among transgender respondents is likely due to the greater sense of shared community among transgender people. Although higher overlaps of surgeons enable another way to compare respondents, substantive differences were unremarkable.

Transgender and cisgender sample groups were also different in important ways related to interview length, identity and social status, and surgery experiences. Although the sample groups had a few more differences than similarities within the variables deemed important to data analysis, the quality of the differences did not impact findings in ways that detracted from the key comparative factor: gender status.

Interviews with transgender respondents were markedly longer than interviews with cisgender respondents. Part of the length disparity can be explained by the extra questions posed to transgender respondents. In addition, the differences in length likely related to the timing of the interviews, or how soon after surgery respondents were interviewed. Two cisgender respondents were interviewed within a year of their most recent surgeries compared to 14 transgender respondents. The longest lapse between surgery age and age at the time of the interview for cisgender respondents was 30 years, whereas it was 10 years for transgender respondents. Thus, transgender respondents had surgery more recently than cisgender respondents and were likely able to recall more details. Based on analyses, most of the length differences related to transgender-specific experiences in surgical body modification. For example, transgender respondents typically had much more experiences in therapy before

surgery. Narratives related to therapy prerequisites, experiences with therapists, and the process of securing an authorizing letter for surgery contributed to lengthier interviews. This difference between transgender and cisgender groups reflects a core difference between the two, but does not affect the comparability of the groups. Although transgender respondents relayed more detailed experiences related to surgery, this finding is attributable to their different gender statuses. It does not make the two groups' surgery experiences any less comparable.

Although trans women were typically older than trans men, cisgender respondents as a whole were slightly older than the transgender respondents. The ages of cisgender respondents ranged from 18 to 85 with a mean/median age of 41/40. The ages of transgender respondents ranged from 22 to 63 with a mean/median age of 38/33.5. The differences in age mean and median are small, but the wider range of ages among cisgender respondents – coupled with longer intervals between interviews and cisgender respondents' most recent surgery – suggest that cisgender people's surgery experiences could differ from the more recent surgeries reported by trans respondents. Differences in age and timing between interview and most recent surgery are important to keep in mind when considering findings.

Occupational status was a key difference between cisgender and transgender respondents. Cisgender respondents enjoyed more gainful employment in more prestigious occupations while transgender respondents were more likely to be underemployed or unemployed. Among the cisgender consumers, 14 were employed full-time and three attended school full-time. All 14 of the cisgender respondents who worked full-time worked in professional or white collar occupations. Three cisgender respondents did not work due to being comfortably retired or choosing to be a stay-at-home parent. In contrast, nine of the transgender consumers were employed full-time and one attended school full-time. Of the nine full-time workers, five worked

in professional or white collar occupations. Six transgender respondents were underemployed or unemployed and looking for work. Three transgender respondents were retired, but two of them were looking for work. One transgender respondent was on disability. Occupation can be used as an indicator of socioeconomic status, especially as it relates to health (Fujishiro, Xu, and Gong 2010). As such, there was a major class difference between the respondents. When transgender respondents had full-time work, they were less likely to work in high-paying and prestigious occupational sectors. This class difference is an important factor that affected findings, and reflects other research that reports economic disadvantages among transgender people (Grant et al. 2011).

Compared to the transgender respondents' more diverse genders, most of the cisgender respondents used simple, singular terms to describe their gender identities and expressions. Most cisgender respondents also believed that others perceived their gender expressions as conventionally feminine or masculine. In summary, 18 cisgender respondents used simple, singular terms to describe their gender identities, seven described their gender expressions as conventional, and 13 believed others would describe them as conventionally gendered. In contrast, seven transgender respondents identified simply as female/woman or male/man, seven described having conventional gender expressions, and eight believed others would perceive them as conventionally gendered. These differing gender characteristics reveal several important factors. Cisgender respondents more often identified on the gender binary and believed others perceived them as having conventional gender expressions. But both groups described their own gender expressions similarly. These gender differences likely arise due to cisgender privilege. Cisgender respondents typically take their gender identities for granted and do not often reflect on their gender identities. In contrast, transgender people often spend much of their lives

questioning their gendered selves. Although these differences are important to note, they stem from basic differences in each group's gender status. These differences informed the research design and so are inherently relevant to substantive findings.

The generally straightforward gender experiences of cisgender respondents and the complicated gender experiences of transgender respondents related to differences in sexual identity between the groups. Eleven cisgender respondents were heterosexual, eight were lesbian or gay, and one was queer. In contrast, four transgender respondents were heterosexual or primarily heterosexual, three were bisexual, three were lesbian or gay or mostly lesbian or gay, eight were queer, pansexual, or poly, one was asexual but attracted to women, and one's sexual identity was changing. Although the complex genders and sexualities of transgender respondents were not surprising and are supported in other literature (e.g., Devor 1997; Dozier 2005), these differences are important to keep in mind when interpreting findings because gendered embodiment is often informed by sexuality.

Cisgender and transgender respondents differed in terms of types of surgeries. Transgender respondents had more varied surgery types. Unlike cisgender respondents, transgender people had genital surgeries, major facial surgeries, dental surgery, and tracheal surgery. On the other hand, cisgender people had surgeries transgender people did not have, including otoplasty, hair transplant, chest skin removal, and thigh lift. These varied surgery types represent an important difference between transgender and cisgender respondents. Although the two groups reported similar motivations for and satisfaction with surgery, they modified different parts of their bodies.

Cisgender and transgender respondents differed in terms of cost of surgery and ability to pay for surgery with health insurance. Although the maximum estimated out-of-pocket cost of

surgery for cisgender consumers was \$16,000, it was \$40,000 for the transgender sample. In addition, nine cisgender respondents successfully had their surgeries covered by insurance in part or whole, but only three transgender respondents did. These economic disparities are important to note and relate to the class differences discussed earlier. Based on occupation, surgery cost, and insurance coverage, cisgender people have a considerable economic advantage over transgender consumers of surgical body modification. This difference affected their experiences with surgical body modification, as discussed in the findings.

In terms of future surgery, transgender respondents were more likely to seriously consider additional modifications. Based on this trend, it is plausible to infer that more transgender respondents had not yet realized their ideal bodies through surgery in comparison to cisgender respondents. This difference is important to keep in mind when comparing the effects of surgery and overall satisfaction.

Discussion of Comparisons

Overall, the transgender and cisgender groups were remarkably similar. They shared many demographics and surgery characteristics. However, they also differed in ways that had the potential to affect interpretations of findings. Each of the chapters that relay interview data findings considered how inherent sample differences might have affected interpretations of findings. Ultimately, the similarities rendered the two groups sufficiently comparable.