TO THINE OWN SELF BE TRUE: SELF NARRATIVES, GENDERQUEER IDENTITY, AND CLINIC ACCESS

“Other actors, human and unhuman, regularly resist reductionisms. The powers of domination do fail sometimes in their projects to pin other actors down; people can work to enhance the relevant failure rates. Social nature is the nexus I have called artifactual nature. The human "defenders of the forest" do not and have not lived in a garden; it is from a knot in the always historical and heterogeneous nexus of social nature that they articulate their claims. Or perhaps, it is within such a nexus that I and people like me narrate a possible politics of articulation rather than representation. –Donna Haraway, The Promises of Monsters: A Regenerative Politics for Inappropriate/d Others.

Gender has been theorized to be one of the primary frames from which understandings of self and other arise, and corresponding behavior and social relations.¹ Gender can be defined as distinct from sex, which refers to biological and physiological categorization, while gender has been posited as ongoing “process in which individuals accept, reject, or modify the cultural gender norms in which they are socialized.” ² Building on this notion, Candace West and Don Zimmerman propose a theory of “doing gender,” in which gender is conceived of as an practice that is not only happens within the self, but is necessarily interactionally achieved through interactions with others.³ Soon after, Judith Butler developed her theory of gender performativity – or the production of "true gender", a put-on narrative sustained by "the tacit collective agreement to perform,
produce, and sustain discrete and polar genders as cultural fictions is obscured by the credibility of those productions – and the punishments that attend not agreeing to believe in them. For those of us who have questioned our genders and explored multiple presentations of an outward expression that aligns with our internal experience – manipulating characteristics and aesthetics assigned to a sex not our own, we’ve lived this performativity. But, according to this idea, not before we had access to a subjective self-knowledge, mediated by our observations of other bodies, sexes, and genders.

A sex-gender system is formed when sexed bodies are assigned to a set of gendered behaviors. The umbrella term transgender (or trans) is used to indicate the experience of self, identity, and expression as different from the sex and gender assigned at birth, where gender identity refers to one’s innate sense of the gender belonging to the self, and gender expression refers to how the gendered self is perceived by others. Trans people who transition from one sex-gender system to the other - from female/feminine to male/masculine (FTM) and vice versa (MTF), fall under a larger umbrella of trans umbrella, where others have embraced the identity marker “genderqueer” and the term gender-non-conforming (GNC) when one’s sense of self doesn’t fit with binary categories of cisgender man or cisgender woman, or transman (FTM) and transwoman (MTF). I use cisgender to denote those for whom gender identity is aligned with sex at birth. I use the terms genderqueer and GNC interchangeably throughout this piece to refer to individuals whose sense of self and corresponding gender expression constitutes a performance outside a dichotomous system.
Genderqueer identity is not a singular or fixed category, and individuals who understand themselves to be genderqueer or GNC reject the notion that there are only two sexes and genders and transgress gendered norms. They may see themselves as simultaneously both male and female, neither male nor female - existing completely outside the sex-gender binary, or falling somewhere between male and female ends of a “gender spectrum” where male and female are on opposite ends.

Further destabilizing this categorical overview, to varying degrees, gender identities are not fixed and lasting, as cultural constructs are defined by the potential for a multiplicity of possibilities with no real or fixed meanings. Both clinical accounts and prevailing theories of gender have made evident that the way one experiences and performs one’s gender is fluid and shifts over time – and further that even gender fluidity itself isn’t a constant. Gender identity can be fixed at one time and context and become more fluid in others. For many genderqueer individuals, one of the queerer aspects of their gender is that it can be experienced as changing or shifting in different contexts or relationships over time.

Gender identities, whether trans or not, binary or not, more or less fluid, are predicated on the concept of a “true self” that one has access to knowing, prior to the process of socially or medically transitioning from one gender to any another. Thus one’s access to one’s true self is implied for all subjects, irrespective of whether one’s internal sense of
gender matches with the sex they were assigned at birth or not. Signifying a major shift in conceptions of socially and/or medically transitioning from one gender to another, over the last decade, leading psychologists, physicians, and trans activists have argued that in order to live happy, healthy lives, individuals must have both the agency and access to live in congruence with one’s knowledge of one’s “true self.” The concept that there are a plethora of genders to choose from is one that has gained salience relatively recently in queer communities, but one that has taken longer to root in the medical and psychological institutions who function as gatekeepers of whom has access to medical transition care such as hormone replacement therapy (HRT) or sex-reassignment surgeries (SRS).

In this paper, I aim to explore the ways that the modern western discourse of the “true self” has fostered the conditions under which formations of non-binary gender identities have proliferated and become legitimized, both socially and medically. Further, by deploying the theory that the self can be understood as a biographical narrative, the self-narratives surrounding gendered experiences have led to the development of the collective notions of "true self" used to understand, create, and establish identities attempting to exist outside of gender binarism. More salient than any medical or psychological research to pinpoint root causes of Gender Identity Disorder (GID) or gender dysphoria, linguistic narratives rooted in the concept of the “true self” have created the space for non-binary identity formation. This modified the pathways to accessing care from mental and medical health providers and fundamentally
transformed the types of care available for those whose feelings and understandings of their "true selves" do not fit with social and/or biological understandings of what it means to be male or female – and changed the World Professional Association for Transgender Health (WPATH)'s Standards of Care (SOC), and facilitated much speedier access to non-binary transition care in the two largest community health clinics dedicated to LGBTQ care in the country, Lyon Martin in San Francisco, and Callen Lorde in New York City.

Western notions of self-determinism are rooted in a long-standing tradition of individualistic thought, free will, and autonomy rooted in liberal philosophical principles. Liberal philosophy guides our social, political, economic and cultural systems, and the autonomy of the self, even if interrelationally created, is of paramount centrality to our understanding of self. Thus, while the ability to self-determine one’s gender has gone against older cultural views of sex as a fixed biological trait, self-determination of one’s gender also fits in neatly with culturally engrained conceptions of the importance of being able to exercise one’s free will to self-determine one’s course in life. The words “know thyself” are inscribed on the Temple of Apollo, and later, existential philosophers proposed that authenticity was key to living a fulfilling life. Such ideas are popularly enshrined in texts as central the US Declaration of Independence to Oprah Winfrey’s self-actualization empire. Of course, in order to be able to self-determine one’s gender identity, especially externally, one must first have access to the information about one’s true self. Then, one’s true self is an immaterial knowledge about the material
knowledge of one’s body that carries implications for which kinds of embodiments, metaphysicalities, and acts are possible or desired.

Shakespeare famously said “To thine own self be true.” The notion of a true self holds high resonance in contemporary popular culture. Career advice blogs, coffee dates with friends about romantic relationships, and the massive proliferation of the genre of self-help books on “finding yourself” are chock full with a “you do you” brand of popular wisdom that dictates that a happy, healthy, well-adjusted person is one who has access to understanding their true self or “nature,” and thus makes choices and takes actions in concordance with that self. Popular cultural fixtures such as Sesame Street, *What Color is Your Parachute*, and *Eat Pray Love*, are rife with this concept. We are told be true to ourselves, not to change for anyone else. Americans from Emerson to Lady Gaga, Dr. Seuss to Jim Morrison, Maya Angelou to Marilyn Monroe, have offered wisdom on the paramount importance of living in accordance with the self. This call is particularly pervasive within queer communities, as evidenced by Kate Bornstein’s *My Gender Workbook: How to Become a Real Man, a Real Woman, the Real You, or Something Else Entirely*. Rita Mae Brown, Allen Ginsburg, Oscar Wilde have echoed the call. Parents, Families and Friends of Lesbians and Gays (PFLAG) publish pamphlets on “being yourself,” while the primary concept behind annual gay pride parades and celebrations are that one should be proud of who one truly is. Yet the ability to clearly articulate what the true self exactly is, remains elusive.
The subjective experience of one’s self is certainly subject to philosophical, psychoanalytic, psychological, neurological, literary and spiritual inquiry, but the particular notion of true self I refer to retains its salience and primacy through popular wisdom. Culturally, we’re no longer reliant on scientific studies to prove that “being yourself” is the most desirable option. This concept can be traced back early Greek philosophers such as Aristotle, who believed that the highest form of excellence is achieved when one’s life is in alignment with one’s true self. And, as gender theorist Riki Ann Wilchins says, don’t we all just seem to be walking through our “entire waking lives carrying on a continuous nonverbal dialogue with the world, saying, ‘This is who I am, this is how I feel about myself, this is how I want you to see me.’”? ix

Due to the widespread popular wisdom about the notion of true self, empirical evidence for the “true self” has proven to be exceedingly difficult for neuroscientists and psychologists find, and multiple propositions abound. Developmental psychologists generally agree that self and language emerge interdependently, emerging when children learn how to speak and make demands in the first person – understanding themselves as a separate distinct self. Yet leading neuroscientists such as Antonio Damasio have hypothesized that self must pre-exist language, because he sees the self as a neurological construct that gives access to feeling, a “knowing of what happens.” In his explanations of consciousness, which he defines as the private, first person process we call mind. He distinguishes between a core consciousness – the sense of self at any present moment, on which extended consciousness is built; an elaborate sense of
identity that evolves over one’s lifetime. For Damasio, the two types of consciousness relate to two types of self, core self and autobiographical self. Core self is consistently recreated for each moment of core consciousness, and extended consciousness provides the framework for the autobiographical self, the self linked to identity and a non-transient collection of notions reliant upon memory. This autobiographical self is the portion which correlates to the to the experiences of knowing one’s gender, as his description of the conscious self is one manifested through feeling. Although Damasio describes this ongoing conscious process of self as non-transient, the fluidity of gender is still expressed by this self, as a fixed aspect of gender can be that it is fluid, and non-stable.

Turning to the humanities and social scientists at the other end of the academic spectrum, such as Paul John Eakin, Dan McAdams, and János László argue that self-narratives are essential to the formation of identity. As psychologists and physicians became the mediators between trans and GNC subjects’ feelings of true selves and their access to treatment in the first gender clinics, self-narratives were not only exceedingly important to the creation of one’s own identity, but to securing any medical care. Aside from visual cues that were easily misinterpreted by physicians, we shall see how self-narratives were the vehicle in which patients seeking hormonal or surgical gender confirming procedures used to obtain care.
John Paul Eakin leverages Damasio to explain how we translate the non-verbal bodily experience of self into language. Since our core selves are only born as the story is told, it exists embodied within the narrative itself, and it can’t be extricated from the story. Therefore, compatible with Damasio’s theory the linguistic narrative process is a bodily process. Eakin writes: “Narrative identity then, the notion that what we are could be a story of some kind, is not merely the product of social convention; it is rooted in our lives in and as bodies.”

For both Eakin and Damasio, the “adaptive purpose of self-narrative, whether biological or literary, would be the maintenance of stability in the human individual through the creation of a sense of identity; as self-narration maps and monitors the succession of body or identity states, it engenders the ‘notion of a bounded, single individual that changes ever so gently across time but, somehow, seems to stay the same.’” We get the distinct phenomenological experience of telling ourselves who we are, forming the reality of our selfhood. This access to knowing from the feeling of watching ourselves is the process in which truth claims about gender arise. He hypothesizes that it is through this process that one can access knowledge about oneself, and tell ourselves into being. But how do we access the specific information about our own sex and gender?

Since gender is socially realized by and performed in cultural contexts, we must account for the construction of gender in order to discern how we can tell ourselves the story about this external concept. In this sense, gender is a disembodied, immaterial concept
– a social construction dealing with bodies, but not ontologically tied to materiality. Gender happens to bodies as it’s performed, and through viewing others, we perceive the attachment of gender to sexed bodies, and only relationally, do we draw conclusions about our identification with a gender or genders. In Out of Our Heads, UC Berkeley Philosopher Alva Noë writes that consciousness cannot simply “live in our brains, or in our bodies, but is the ongoing experience of relating to and being changed by our environments and other organisms.” The brain cannot know gender on its own, but requires the operation of our brains, bodies, and world, so consciousness is an “achievement of the whole animal in its environmental context.”

As processes of visual cognition in relation to others occur, we read gender’s visual, behavioral, social cues, and thus form self-narratives in a necessarily relational process. Self only becomes known in relation to other, so where gender is concerned, the embodied integration of this immaterial construct becomes a part of the true self through one’s interaction with other gendered bodies in particular cultural locations and times. As we shall see, Noë’s ideas hold much in common with leading queer theorist’s concepts of the way gender is produced and experienced.

Self-determination theory (SDT) has emerged in the psychological field as evaluative frame to explore the ways in which the concept of true self is related to well-being. Psychologists researching the role of self-concept in self-esteem, meaning, and identity formation loosely define true self-concept as private thoughts and cognitions, and authenticity as the execution of that concept, or the “unimpeded functioning of one’s
true self in daily life." SDT is based on the principle that self-determination is essential to the mental health, happiness, and overall well-being of individuals. As such, it evaluates the importance of the evolution of one’s inner resources, or intrinsic motivations, based on our needs for competence, relatedness, and autonomy. The fulfillment of these three needs, as they relate to the determination of one’s true self, are conceived of as essential to optimal social development and personal well-being. xiv The incorporation of living in congruence with one’s internal true self as essential to mental well-being into generally agreed-upon conventions of psychology has been key to changing the type of care GNC patients can receive. Self determination implies that each of us have autonomous, separate, and individually unique true selves, and since these attributes are internal, it not longer becomes the role of the clinical practitioner to deny one’s access to such an internal experience. In 2005, the American Psychological Association (APA) appointed a Task Force on Gender Identity and Gender Variance and issued a resolution in 2008, which called for “legal and social recognition of transgender individuals consistent with their gender identity and expression, adequate and medically necessary treatment for transgender and gender-variant people, the recognition of the benefit and necessity of gender transition treatments for appropriately evaluated individuals, and call on public and private insurers to cover these treatments.” SDT theory is the premise on which this resolution is based, where the ability to externalize one’s inner self is desirable and “healthy”:

WHEREAS gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that
appropriately evaluated individuals benefit from gender transition treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom, et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005);\textsuperscript{xvi}

It is noteworthy that this language used by APA’s task force explicitly includes gender variance. A pamphlet released in 2011 by the same task force accounts for the distinction between trans and gender variant, implying their acknowledgement of genderqueer experience: “While transgender is generally a good term to use, not everyone whose appearance or behavior is gender non-conforming will identify as a transgender person.”\textsuperscript{xvii} However, ability to determine ones’ self via medical transition remains mediated by psychological and medical institutions. Does the term “appropriately evaluated” allude to the need for healthcare providers to be equipped with trans and GNC-inclusive knowledge, or is it an implied vestige from the gender clinic era, when doctors endowed themselves with the responsibility of determining others’ gender identities – turning away thousands of patients for HRT and SRS for not being “trans enough”? Some, but not all genderqueer people desire medical interventions – some choose to socially transition via changing one’s name, one’s sex on identifying documents, or pronouns – sometimes opting for a gender-neutral option such as they/their. However, social transitions also require acknowledgement of one’s true self from others, and some require state sanctification.

The notion that we have a clear knowledge about our innermost natures seems to have only strengthened in the last decades. Therefore, our autobiographical narratives have
been essential in shifting the types of care available to trans people, but also for GNC individuals who not identify their gender to be female or male. The first gender clinics that opened in the United States were predicated on the notion of sexual difference, anchored in biological and psychological differences between sexes and their corresponding genders. Sexual difference has been leveraged to call for access to care as a right for trans people under the framework that gender variant people are born in the wrong body so their gender doesn’t match their sex. Yet sexual difference has also been used to pathologize the presence and desire for a gender different that the sex one was born.

The first clinics that opened in US chose the latter, but used that very pathology as a justification for care. The Stanford Gender Dysphoria Clinic, opened in 1969 by surgeon Dr. Donald Laub and psychiatrist Dr. Norman Fisk on an experimental basis, and soon after, similar clinics opened at a handful of other universities, including Johns Hopkins led by Dr. Benjamin Money. By the end of the 1970s, over one thousand people had received SRS in the United States, yet codified diagnostic criteria did not yet exist. When attempts to make the mind match the body through a variety of psychiatric and psychotherapeutic interventions eventually was understood to be a failed project in the medical community, Dr. Benjamin Money’s model of making the body fit the mind through hormone replacement therapy and sex reassignment surgeries. Thus the internal true-self is preserved as paramount, and well-being for individuals starts to become defined by a primary allegiance to the internal story of who we really are.
Psychologists and surgeons maintained the Cartesian split between body/sex and mind/gender, and doctors argued that for transgender patients, the internal feeling of being a man or woman was separate from anatomically determined sex – and consensus in the medical community posed transsexuality as a rare but legitimate mental illness for which one needed “rehabilitation” to correct the “repugnant concept” of changing one’s “God-given anatomical sex.”ix When attempts to make the mind match the body through a variety of psychiatric and psychotherapeutic interventions eventually was understood to be a failed project in the medical community, Dr. Benjamin Money’s model of making the body fit the mind through hormone replacement therapy and sex reassignment surgeries. This shift signaled that internal gender identity, or the feeling of knowing your true self, now trumped the biological determinism previously attributed to the physical body. The true self reigned over the untrue body, despite the dehumanizing morality judgments expressed by the gatekeepers of medical care. Also significantly, this model reentrenched the “naturalness” of the female/male binary, not only for cisgender people, but for trans people as well.

With physicians as intermediaries between one’s experience of true self, patients were required to share their self-narratives in order to secure care. In her overview of trans narratives in the 1950s – 1970s in The Empire Strikes Back: A Posttransexual Manifesto, Sandy Stone demonstrates that the most critical moment of narrative self deliverance
was the intake interview at the gender dysphoria clinic, where the all cismale staff mediated bodily access to one’s internal “true self.” Doctors determined eligibility for SRS and HRT, and thereby positioning themselves in business of constructing the criteria for gender itself. The determinations for eligibility were made by staff on the basis of an individual sense of the “appropriateness of the individual to their gender of choice.” Fisk says “I now admit very candidly that...in the early phases we were avowedly seeking candidates who would have the best chance for success,” which meant that patients were evaluated on the basis of outward performance of their internal gender identity. True self took the back seat, while outward expression drove. Thus these technologies, along with attempts to devise tests for GID or gender dysphoria syndrome, produced gender.\textsuperscript{x} By defining who was truly trans, and who is not, these practices defined and created what it meant to be male or female. As we shall see later, queer theorists take up this notion of gender as produced, which questions the ability of any subject to represent a “true self.”

The mediation of access to care that aligns one’s knowledge of gender identity with their bodies meant that trans patients not only needed access to their narrative selves, but to the narratives required by gender clinics. Whether or not patients identified as trans or GNC or genderqueer, if they wanted access to treatment, they were required to learn and apply their knowledge of acceptable narratives required by medical institutions, over expressing narratives of their “true selves.” Thus trans patients, upon desiring access to care, read the sole textbook on transssexuality, Harry Benjamin’s 1966
The Transsexual Phenomenon, in which the sense of the true self as being in the “wrong” body became the only narrative seen as warranting treatment for a pathological condition. Citing proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome at Stanford in 1973, Stone writes that “It took a surprisingly long time – several years – for the researchers to realize the reason the candidates’ behavioral profiles matched Benjamin’s so well was that the candidates, too, had read Benjamin’s book, which was passed from hand to hand within the transsexual communities, whose members were only too happy to provide the behavior that led to the acceptance for surgery. The advent of the diagnostic category “Gender Identity Disorder in the third edition of the American Psychiatric Associations’ Diagnostic and Statistical Manual of Mental Disorders in 1980, left the “born in the wrong body” concept intact. The institutionalization of trans care solidified further that year with the establishment of what is now the World Professional Association for Transgender Health (WPATH), the body that codified the Standards of Care (SOC) for transgender patients across the country. Not only did diagnostic categories, clinics, and standards police which patients got treatment, but what gender possibilities existed in the first place. Trans patients who didn’t conform to cultural markers of masculinity and femininity were turned away. Patients reported being rejected from clinics – a trans man described as “having a slight build and delicate features” disclosed that he didn’t make it past his first intake session at Stanford because his doctor said he could too easily imagine him to be an attractive feminine woman. Between 1969 and 1973, the Stanford clinic rejected 398 of 796 potential clients – over half – on the basis of being
“non-transexuals,” only 74 of the 371 accepted were recommended for surgery. xxiv Thus it can be argued that medical providers at the first gender clinics were not operating on the basis that patients had access to their inner true selves.

While access to care for those with the correct narrative, expanded possibilities from just cismale and cisfemale, to transmen and transwomen, the gender binary was left intact across cultural contexts. Not only were the experiences of GNC and genderqueer people disregarded, but the fluidity and variation in internal or external gender experience among both cisgender and MTF and FTM individuals was denied by psychiatric and medical institutions. Stone lamented that the “emergent polyvocalities of lived experience, never represented in the discourse but present at least in potential; disappear; the berdache and the stripper, the tweedy housewife and the mujerado, the mah’u and the rock star, are still the same story after all, if we only try hard enough.” xxv Trans experience, while disrupting the gender binary, also demonstrated a reification and reinvestment into a male/female system.

At the same time that care for transgender patients was expanding due to psychiatrists’ understandings of the need for one’s true self to align with one’s “wrong” body, queer and feminist theorists were beginning this ongoing project of deconstructing a binary gender system, and both theorists and biologists like Anne Fausto-Sterling were demonstrating that sex is also much more complex and varied than previously thought. Feminist theorists had already been arguing that individuals’ internally experienced
traits and external behaviors do not line up easily within a system of rigid gender roles that are prescribed to certain sexed bodies – Such as ascribing assertive, dominant, rational, independent, powerful traits to men, and submissive, emotional, empathetic, irrational, and dependent ones to women. Since multiple combinations of traits and bodies are possible, the way one experiences one’s gender may be easily questioned.

When gender is understood as embodied, experienced, and performed in multiple ways due to its ever-shifting cultural and symbolic constitution, gender, and the discipline thereof that informs our experiences, the concept of an internal fixed and true gender identity dissolves. Michel Foucault’s notion of disciplinary power as productive shows that the governance of gender, justified by medical, psychiatric knowledge, constrains the “structure of the possible field of actions of others.” xxvi Thus, requirements for diagnosis and treatment build gender, rather than one’s “true self” dictating one’s gender. Because each subject’s experience of their gender is affected by the cultural myths that construct what gender actually is, there can be no true, natural, or “healthy” gender for trans, GNC, or cisgender people. Further, any gender identification, even a genderqueer one, perpetuates the binary paradigm. That they are defined in opposition to it implies the existence of male/female genders.

Ironically, the theoretical projects that have problematized gender identity so deeply, have also helped create the space for a multiplicity of trans identities beyond FTM and MTF, allowing individuals to understand our gender as queer, since there are no such
things as “true” males and females, when gender is a construct. Rather than narratives fitting neatly into one “true” trans experience, an insistence on localized, specific experiences recentered the primacy of Eakin and Damasio’s autobiographical narrative to account for the multiple complicated ways gender expresses itself, and the kinds of treatment we may desire. Even if GNC patients no longer have to lie for HRT if they have access to queer community health clinics such as Lyon Martin or Callen Lorde, we are still experiencing our genders through the dominant cultural ideology of what male and female mean. Our personal narratives cannot be divorced from the systems that develop them.

Thus, the culturally powerful concept of true self, carried via the vehicle of narrative, remains responsible for the shift in access to care for genderqueer-identified people – even as the concept of the subjective knowledge of true self is flawed. We all experience what it is like to have a gendered body in this world, and by virtue of that experience, we must be able to determine livable lives for ourselves. Trans historian Susan Stryker makes sense of this seemingly contradictory push between queer theory’s decentralization of gender identity and disavowal of “true self”, and the simultaneous demand for access to care for those who question the ways in which their bodies and cultures dictate that experience. She writes that we must continue to consider self narratives and:

...the embodied experience of the speaking subject, who claims constantive knowledge of the referent topic, to be a proper – indeed essential – component
of analysis of gender phenomena; experiential knowledge is as legitimate as the other, supposedly more ‘objective’ forms of knowledge, and is in fact necessary for understanding the political dynamics of the situation.

It was not a huge stretch for queer community health clinics to embrace multiplicities in identity, as such a concept is very much in line with a culture already primed in the doctrine of “to thine own self be true,” one that values individuality and uniqueness. True self narratives of multiple identities helped loosen each of the subsequent revisions to the WPATH SOC and the DSM, in which the word “disorder” was removed this yearxxvii (Note: Homosexuality was removed from the DSM as a disorder in 1973). Language used in the 7th edition of the SOC, released in 2011, demonstrates a marked shift away from rigid and binary gender identity concepts used by physicians in the 1970s, and includes a section distinguishing gender non-conformity from gender dysphoria:

The SOC are not intended to limit efforts to provide the best available care to all individuals...These principles Include...respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression)...Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications...Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary...
understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). xxviii

The primacy of individuality, of self-narratives that describe the gender they feel, of an identity that matches a “true self” have shifted these standards of care. Access to one’s autobiographical self has shifted care towards an understanding of the ways gender binaries do not reflect all experiences, and away from requiring patients’ narratives to fit within narrowly constricting boundaries across the board.

Currently, the process for seeking HRT at Callen Lorde and Lyon Martin is based on the principle of “informed consent,” where patients make an appointment with a trans care patient navigator to explain the treatment they are seeking, and undergo a blood test determine safety of hormone therapy for that patient. On the second visit, patients sign informed consent paperwork with delineated risks as well as permanent and reversible effects involved in HRT, and agree to have their liver function periodically checked. Then, HRT is administered. The language on Lyon Martin’s informed consent form is GNC inclusive and resists binaries: “This form refers to the use of estrogen who wish to become more feminized...” and patients initial by statements such as “I identify as a having a female/feminine and/or a gender non-conforming gender identity and therefore wish to be treated with estrogen.” xxix

Legal scholar and activist Dean Spade has noted that despite some the presence of such clinics in large cities, access to mental and surgical care – especially low-cost care is still
not easily accessible. Trans and GNC people still experience very high levels of
discrimination and lack of access to both medical and mental health care. A proponent
of Self Determination Theory, Spade demands access to care based on lived experience,
yet resists the primacy of identity and the notion of true self.

This paper has traced the formation of a genderqueer or gender non-conforming
identity to be predicated on the assumption that one has a "true self" that one has
access to knowing – and thus can claim the right to care. Despite the ways in which
queer theorists have problematized this concept, this popularly accepted concept of the
true self has informed the WPATH Standards of Care, modifying the establishments as
well as conditions and narratives for which gender non-conforming individuals can
receive access to mental, social, and physical transition care, as well as the range of care
available. There remains much work to be done to ensure the experiences of queers
result in the ability to live livable lives. While such categories have proven useful, they
still construct and constrict the ways in which gender operates and is possible.
Therefore the project of queer theory to imagine all the ways in which we can construct
gender, rather than be limited by its constraints, remains necessary even as it
decentralizes categories of gender identity and “true self” that have propelled
necessary, but limited change. Dean Spade offers the following suggestion for the
conditions in which we might access a queerer future outside of the gender norms that
limit us all:
An alternative starting point for a critique of the invention and regulation of transsexualism is a desire for a deregulation of gender expression and the promotion of self-determination of gender and sexual expression, including the elimination of institutional incentives to perform normative gender and sexual identities and behaviors. This understanding suggests that the problem with the invention of transsexualism is the limits it places on body alteration, not its participation in the performance of body alteration.


v ibid, Corwin, 2.


xi Eakin, Living Autobiographically, Pg 74-76

xii Ibid, Eakin pg 76, Ibid, Damasio pg 134.


xvi APA Resolution on transgender and gender identity and gender expression non-discrimination, 2008: http://www.apa.org/about/policy/chapter-12b.aspx#transgender


xxi Ibid, Stone Pg 161.


xxiv Ibid, Laub & Fisk.

xxv Ibid, Stone, Pg.163.

xxvi Michel Foucault, The Subject and Power, in MICHEL FOUCALUT: BEYOND STRUCTURALISM AND HERMENEUTICS 208, 221 (Herbert Dreyfus & Paul Rabinow eds. 1982).


Informed consent for Estrogen Therapy for Male-to-Female Transition, Lyon Martin Health Services. 