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A defining moment in our history *Examining disease models of gender identity*

Interest in feminization, historically revered or feared, has benefited from advances in science that expand possibilities for its physical expression. These advances led to scientific models of gender variance, which were positioned as objective alternatives to the judgmental “sin” models promoted by some religions. Unfortunately, some allegedly scientific models being used merely replace metaphors of sin with metaphors of disease and impairment, rather than using objective scientific language. The time has come to examine these judgmental models: the assumptions behind their definitions, how they masquerade as science, their roots in eugenics, their impact on our access to health services, and their political implications.

The most insidious disease model appears at first glance to be progressive, even liberal, but on closer examination, it views gender variant behavior in children and adults as a psychosexual pathology (a fancy way of saying it’s a sex-fueled mental illness). Though the idea has been around since the 19th century, new language for this “disorder” was proposed by

Ray Blanchard (1989) and restated by Anne Lawrence (1997) and J. Michael Bailey (2003). Though the Bailey-Blanchard-Lawrence (BBL) model claims to be non-judgmental in a moral sense, it is undeniably judgmental in suggesting gender variance is a disease.

These old school sexologists still use terminology based on century-old ideas about gender-variant behavior as a sex-fueled disease. Their definitions tangle up several distinct threads about sex and sexuality in our community. Inflammatory language about transwomen like “man who would be queen,”¹ “man without a penis,”² or “men trapped in men’s bodies”³ has led to responses in kind about BBL and their apologists, but thankfully, such polemics are now limited to shrill but secluded fringes of discussions about untangling the mess they’ve made.

Definitions and thresholds

Scientific language evolves with understanding, and scientific discussions require that words be used with scientific precision. In short, definitions matter. A definition simultaneously includes and excludes. It affects how people view our community, especially those who expose problems with existing definitions. BBL and their apologists mock the evolution of definitions and ideas as “politically correct,”^{4, 5, 6, 7} a term used by guardians of convention that signals a lack of intellect and contempt for scientific progress. For instance, Lawrence’s opening salvo brags of being one of the “troublesome people who are inclined to doubt the *conventional* wisdom” about transgender eroticism, then just ten sentences later defends Blanchard’s use of the inaccurate and offensive term “homosexual transsexual” because it is “*conventional* usage in the psychiatric literature.”⁸ [*emphasis mine*]

Specialized definitions for many words in this debate evolved within separate institutional realms. Though used differently, a term as defined in one field influences another field, especially as we see attempts to merge

biology, psychology, law, and medicine into biopolitics.⁹ Within the current medico-judicial system, clinical thresholds affect legal thresholds and vice versa.

Imprecise and idiosyncratic definitions plague this debate. The BBL model declares transsexual women are men with one of two sexual desires: “homosexual” (males aroused by males) and “autogynephilic” (males aroused by the thought or image of themselves as women). Both categories efface our identities as women, but “autogynephilia” is more problematic in many ways. One major problem is the tendency for some who embrace the term to look at the etymology and think it denotes an innocent and happy form of feminist self-esteem: “I love myself as a woman!” they’ll say. I do too, but that’s not what this word denotes. When I say, “‘Autogynephilia’ is defined by its creator as a type of paraphilia,” some say, “Well, that’s not how *I* use it.” That’s like saying someone is a pedophile because she loves children, or that someone is a zoophile because he loves his pets. Those terms are clinical and legal descriptors. Yes, “pedophile” literally means “love of children” in Greek, and “autogynephile” means “love of self as woman,” but both terms are inexorably linked to their clinical origins as psychosexual pathologies.

Calling oneself or others “autogynephilic” is participating in one’s own pathologization, and it legitimizes this fake disease when people claim they *don’t* have it. BBL are engaging in scientific McCarthyism, where they claim a hallmark of “autogynephilia” is that those afflicted will deny it. Any refutation becomes proof they are right, a no-win situation like asking “when did you stop beating your wife?”

When we say “autogynephilia” is a made-up disease, some mistakenly think we are claiming erotic interest in feminization is made-up, too. Obviously, this exists. Many women in our community have been very open and honest about their erotic interest,¹⁰ yet still take issue with labeling it a disease.¹¹

Sex and sexuality

My response to “sexology” is similar to how a person of color might respond to “raceology.” I question anyone who seeks to draw bright lines between nuanced possibilities of sex and sexuality, especially when they claim their attempt is science instead of something arbitrary and subjective. Trying to map a scientific schema onto complex traits and behaviors is like turning an impressionist painting into a paint-by-numbers. Those who fear miscegenation of the sexes or sexualities are just like those racists who use “science” to reinforce socially constructed categories of ethnicity. As Anne Fausto-Sterling notes, “Labeling someone a man or a woman is a social decision. We may use scientific knowledge to help us make the decision, but only our beliefs about gender—not science—can define our sex. Furthermore, our beliefs about gender affect what kinds of knowledge scientists produce about sex in the first place.”¹²

What kinds of knowledge about sex are BBL producing? They claim variously that homosexuality appears to be an evolutionary mistake¹³ and a “developmental error,”¹⁴ and gender variance is a “defect in a man’s sexual learning,”¹⁵ and a “sexual problem.”¹⁶ It makes sense that a doctor would choose a disease metaphor and psychologists would use a mental disorder model to describe their observations and impressions. If we have a disorder, then what is the “order” to which they adhere? They imply the “purpose” and “function” of sex and sex organs is procreation. Why, it’s so obviously true that the belief shouldn’t even be examined, right? According to people who believe this overly simplified idea, males have evolved (or were designed) to be attracted to females, and vice versa. In their worldviews, anything that deviates from that is, well, deviant.

Well, to borrow a phrase, a few troublesome people are inclined to doubt this conventional wisdom.¹⁷ Many of us question Lawrence’s claim that sexual desire is “that which moves us most.”¹⁸ We point to our experiences and feel our identities are what drive us; Wyndzen shows psychology supports our recognition of how powerful a force “identity” can

be.¹⁹ We even question some passages of Darwin and the Bible (at the same time, no less!). BBL get very upset when highly respected evolutionary biologists like Roughgarden²⁰ or Gould²¹ question their most deeply-held beliefs about sexual selection and human behavior.

Eugenics, genetics, degenerates, gender

The words “eugenics,” “genetics,” “degenerates,” and “gender” all derive from the same Greek root meaning “to produce or bring forth life.” Some sciences and some religions seek to explain our genesis and control our reproduction of subsequent generations. New reproductive technologies are ushering in a host of bioethical issues and raising the specter of a new wave of eugenics, where the genocide (another related word) will happen before or shortly after conception, after genetic material is screened for “undesirable” traits. Should people with Down Syndrome or dwarfism be eliminated from the gene pool? How about intersexed people? If Bailey’s colleagues find the “gay gene,”²² should we wipe out sexual minorities, too? What about gender minorities? Will we see a “transgenocide”? Who decides what’s a disease or a degeneracy?

As evidenced by BBL’s metaphors of disorder and disease, people can only express ideas in the language they have available. Their models of sex and sexuality originated with doctors and criminologists in the late 19th century eugenics movement, and BBL’s ideas haven’t evolved much from the influential works that shape their thinking. After Darwin’s *Origin of the Species* (1859) came Francis Galton’s *Hereditary Genius* (1869). Following ideas in that book, Galton coined the term “eugenics” in 1883, which melded with the emerging fields of criminology and sexology. Though the term “eugenics” is now rightfully associated with Nazism, a few modern adherents hope to usher in an “Age of Galton.” Bailey and Blanchard are charter members of a conservative-run eugenics discussion group devoted to this pursuit.²³

Three physicians who were Galton contemporaries are central to the BBL worldview: Richard Freiherr von Krafft-Ebing, who wrote *Psychopathia Sexualis* (1886); Havelock Ellis, who wrote *The Criminal* (1889) and *Sexual Inversion* (1897); and Magnus Hirschfeld (coiner of both “transvestite” and “transsexual”), who in 1897 founded Germany’s Scientific Humanitarian Committee, whose motto was “justice through science.” Like BBL, these doctors genuinely believed that social ostracism of sexual minorities would be eliminated through science, but we all know what happened next in Germany. These doctors’ “scientific” models were imbued with eugenic paternalism (they believed homosexuals had a pathology and were unfit for procreation), and they claimed those who engaged in non-procreative sex were biologically different. By mid-century, Hirschfeld’s institute had been destroyed, and persecuted minorities had been rounded up and murdered based on “scientific” models that claimed groups like Jews, gays, and other persecuted minorities were “degenerate,” biologically distinct, and a threat to “social hygiene.”

Lest we think this is an isolated phenomenon that only happened in Nazi Germany, in America, disability and race took center stage in the eugenics movement,²⁴ which focused on sterilization and birth control for the “unfit.”²⁵ In Canada during the same period, the focus was immigrants, and the method of control was psychiatry. A physician named Charles Kirk Clarke oversaw the two largest Canadian asylums before accepting Canada’s top mental-health post. Clarke advocated eugenic policies to limit the immigration and marriage of the “defective.” He also used psychiatric diagnoses to incarcerate new citizens. Foreign-born patients were 50% of his institutionalized population, including political activists, homosexuals, and other “defectives.”²⁶

Clarke’s sociobiological leanings are still alive and well at the institution named after him, The Clarke Institute in Toronto, where Ray Blanchard works.²⁷ There, Kurt Freund and Blanchard used Freund’s controversial plethysmograph to delineate deviance.²⁸ Though the quack device is just a lie detector for the penis (open to manipulation and interpretation by both

subject and observer), they used it extensively to separate homosexual from “non-homosexual,” and later to do sex experiments on “male gender dysphorics, paedophiles, and fetishists,” which they lumped together, yet divided into homosexual and “non-homosexual.”²⁹

In historic diagnoses for sex problems, homosexuality and masturbation were “diseases” that could strike either sex, but other problems were gendered degeneracy: women who had “too much” interest in straight sex had the now-discredited disease “nymphomania,” while men who had “too little” interest in it were inverts or perverts, a still legitimate disease category called “paraphilia.”

Dysphoria, disease, disorder, disability, defect

According to my medical records, I am mentally ill. The psychiatry industry’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) alleges that I am afflicted with “gender identity disorder” (GID). Before that, I had “childhood gender nonconformity,” from their special “kids’ menu” of mental disorders. Others with an interest in feminization get diagnosed with the “disorder” of “transvestic fetishism.”³⁰ For many years, some in our community have relied on mental illness models as a form of validation. I ascribe to the view that “psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others. ‘Mental illness’ is not something a person has, but is something [a person] does or is.”³¹

I suppose I had a “dis-ease,” an uneasiness, a dysphoria about the sorts of social and sexual expression I was allowed in the gender roles assigned to me at birth. I did not conform until it became clear in 7th grade that the other option was ever-increasing ostracism and violence, but since when is non-conformity a disease? Imagine a mental illness diagnosis for “racial nonconformity” or “religious identity disorder.”

Disease models affect the kinds of knowledge produced by those who use them. Bem called sex researchers’ preoccupation with the causes of homosexuality “scientifically misconceived and politically suspect” because embedded in their preoccupation with causality is the idea that something went wrong that needs to be diagnosed and fixed.³² The situation is no different when we look at how sex researchers study transgendered persons. BBL are what Ordover calls “biological apologists” who look to the body for absolute truths. A major medicalization of homosexuality occurred in the 1990s, in response to AIDS (a disease which led to renewed interest in a “gay gene” and later a “gay germ” disease model of homosexuality).³³ While Bailey was drawing federal funds to isolate homosexuality the way others looked for HIV, nobody was looking for the “straight gene” or “straight germ.” Like a good eugenicist who believes biology is destiny and genetics dictate human behavior, Bailey started linking gender roles to genetic discussions: “childhood gender nonconformity does not appear to be an indicator of genetic loading for homosexuality.”³⁴ Is gender genetic?

Despite these problems, many in our community embrace a disease metaphor. Lawrence intones about “symptoms” of transsexualism, its “clinical course,” the benefits of “palliative treatment.”³⁵ Lawrence then magnanimously claims that “everyone has a right to self-define,” yet asserts that those who disagree with Lawrence’s diagnosis aren’t being very honest with themselves or others. A “palliative treatment” helps symptoms while leaving the disease uncured, and the uncured disease can be a personal and political identity. In her important series of scientific criticisms of Blanchard, Wyndzen cites studies on self-verification where people “assimilated their illnesses into their identities.”³⁶ Almost everyone who is attracted to the concept of “autogynphilia” identifies through metaphors of impairment. Many participants in the main “‘autogynphilia’ support” newsgroup are on public assistance, which seems related to their fears about removal of gender variance from the DSM. They fear subsidized medical services will be denied if there is no mental illness classification. But what do they think will happen if there is differential diagnosis that claims their subgroup does all

this to indulge an autoerotic interest? Should insurance companies give out high heels as “palliative treatment” for shoe fetishists?

As Lawrence notes, “There are many human behaviors that look like the same thing, but really aren't.”³⁷ Previous medical attempts to catalogue behavior like Lawrence’s were not only pathologizing, but insulting: People like Lawrence were “transvestitic applicants for sex reassignment”³⁸ who are “aging”³⁹ and “distressed,”⁴⁰ suffering from “pseudotranssexualism”⁴¹ a “non-transsexual” variant of “gender identity disorder” (GIDAANT),⁴² and “iatrogenic artifact.”⁴³ Many notable “borderline” cases are doctors: Renee Richards, Anne Lawrence, Gregory/Gloria Hemingway. They may epitomize these published observations. They all self-treated, vacillated, and “detransitioned” to varying degrees, and all three challenge existing diagnostic categories.⁴⁴ If interest in feminization is an iatrogenic artifact (a disease made up by doctors), wouldn’t doctors be the best evidence of that? Further, why would Dr. Marci Bowers transition without incident in the same hospital group that forced Anne Lawrence to resign? Do they really have the same “disease”? I have never heard Dr. Bowers have to assert she’s a “real” transsexual, as Dr. Lawrence has.

I do not defer to people just because they are clinicians. My work fighting quacks and consumer fraud has put me in touch with countless “experts” who have no business in science or medicine. Some “expert” will probably diagnose my questioning “experts” as “authority nonconformity” or some other made-up disease to undermine my credibility. After all, my questioning the legitimacy of “autogynephilia” is evidence I’m afflicted with it. To refute that kind of argument, we need to contextualize the term.

“Paraphilia” and “autogynephilia”

The term “paraphilia” first appeared in 1923, in a book prepared for doctors and criminologists by physician Wilhelm Stekel.⁴⁵ Over eighty years later, BBL collaborator Simon LeVay still calls paraphilias “illnesses that

need treatment.”⁴⁶ “Paraphilia” is the psychiatric term for problematic sexual desire or behavior. The current name for this alleged mental disorder first appeared in the DSM in 1980.⁴⁷ It describes “paraphilia” as “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving

- (1) nonhuman objects
- (2) the suffering or humiliation of oneself or one's partner, or
- (3) children or other non-consenting persons....

The behavior, sexual urges or fantasies cause clinically significant distress in social, occupational, or other important areas of functioning”⁴⁸

Some people who identify with the diagnosis of “autogynephilia” chime in at this point and say, “Well, then *I* don’t have a paraphilia, because *I* don’t think I have a problem.” The most recent version of DSM was revised just for them—it says this illness can be diagnosed even if the person does not experience any subjective distress or impaired functioning.⁴⁹ LeVay notes: “This is quite a significant shift; it emphasizes that psychiatrists may go beyond responding to clients' complaints and may use their expertise for other purposes, such as protecting society from sex crimes.”⁵⁰

“Autogynephilia” is not a behavioral model, it describes a sex-fueled mental illness that lumps gender variance in with sex crimes. BBL believe that paraphilias cluster, meaning that they believe that “autogynephiles” are more likely to be aroused by children, corpses, excrement and other illegal and socially unacceptable things. This diagnosis was widely ignored after Blanchard first suggested it in the *Journal of Nervous and Mental Disease* in 1989.⁵¹ By the end of his series of papers, Blanchard was shoehorning other behaviors into his model with crackpot variants like “partial autogynephilia.”⁵² However, Blanchard and his colleagues had enough influence in this rarely-studied subspecialty to get “autogynephilia” mentioned in the DSM.⁵³ The work would have remained an obscure intradisciplinary skirmish until Lawrence found Blanchard’s articles in 1997, during a time of great need. A year earlier, Lawrence’s erotic interest in ritualized genital modification led to indulging that interest.⁵⁴ Lawrence

had taken “physician, heal thyself” to heart previously, and after yet another failed “cure” in the form of vaginoplasty, Lawrence’s fascination did not wane. In 1997, a lack of social acceptance at work (described in one account as “bizarre behavior”) ⁵⁵ and an incident where Lawrence examined an unconscious patient for signs of ritualized genital modification ended a respected career. ⁵⁶ Discovering Blanchard was clearly revelatory for Lawrence, who now had a diagnosis to explain what happened. Suddenly, this forgotten diagnosis had a vocal and influential champion. I dismantle the pseudoscience behind “autogynephilia” in a longer essay elsewhere. ⁵⁷

A scientific or reasonable discussion of “autogynephilia” is like a scientific discussion of horoscopes: there’s no science to discuss, only pseudoscience. Yes, both concepts exist, but that does not mean either are legitimate science. Some people have a need to create an identity based on a worldview where people are predictable based on vague, unproven categories that arbitrarily assign traits to everyone, imposing order onto an unpredictable and incomprehensibly complex world.

“Transsexual” defined

BBL have proposed several definitions for “transsexual” that include people not previously considered within that definition. Their definitions view gender variance through the lens of disordered sexual desire. Bailey defines “transsexual” as anyone who has “the desire to become a member of the opposite sex.” ⁵⁸ They do not have to act on this desire—“only serious thoughts” are enough to qualify. ⁵⁹ This model reflects Bailey’s definitions of sexual orientation: someone is a homosexual whether they act on their desire or not. Lawrence believes transsexuality is “fundamentally about changing one’s anatomy, or sex; and that sometimes it may have little to do with gender identity, or with gender role.” ⁶⁰ Some do this “not primarily because they have a gender problem, but because they have a sex problem, and indeed a sexual problem... the expression of a paraphilia” ⁶¹ Blanchard

says he’s reluctant to label children as “transsexual,” ⁶² which is reminiscent of the “pre-homosexual” language used by his homophobic counterparts in “gay cure” groups like NARTH. ⁶³ Blanchard’s colleague Ken Zucker is a vocal advocate of reparative therapy for gender-variant children, and he considers transsexuality “a bad outcome.” ⁶⁴ In fact, Bailey has noted that unchecked, this disease could spread: a world tolerant of gender-variant children “might well come with the cost of more transsexual adults.” ⁶⁵

Echoing Lawrence’s strict anatomical construction of “transsexual,” a quaint aphorism claims, “If you aren’t a transsexual before surgery, you are after.” Really? What about David Reimer or others surgically altered as children who do not identify as transsexual? ⁶⁶ Conflicting definitions occur within any demographic grouping. Extremist separatists from both sides of any constructed binary often create unlikely alliances: for instance, “people of color” and “African-American” are terms debated by both ethnic separatists and conservatives. ⁶⁷ In our community, pluralist concepts like “queer” or “transgender” are debated in circles where distinctions between gay men and transwomen, or between crossdressing and transsexualism, are very important.

Lawrence insists the few who embrace this diagnosis “do not declare ourselves sick.” ⁶⁸ Not morally sick, anyway, but physically sick. Lawrence’s self-descriptions have remarkable parallels with descriptions of binge-and-purge cycles among crossdressers who hate their behavior, or those “afflicted” with “unwanted homosexuality”: “The loneliness and disconnection from others that typically accompany autogynephilia [*sic*] are a large part of what makes this condition feel like genuine paraphilia (i.e., a “disorder”) to many of us who experience it (and I’m including myself here) and not merely a “benign variant” form of human sexuality.” ⁶⁹ Swap “autogynephilia” with the word “homosexuality,” and Lawrence’s comment would feel right at home in a NARTH publication. Lawrence’s “problem” is not self-love, but self-hate.

For those of us who view “gender” and “sex” as socially constructed, transsexualism can’t be separated from its social component. Phenotype can

trump genotype; gender expression can trump anatomy. Those who need to use anatomy as evidence of their identity have failed in gaining acceptance within a social or institutional framework. Everyone has a right to self-identify, but if others don't accept that proclaimed identity, we must either accept their lack of acceptance, or work to change their minds. People can legislate rights, but not acceptance. That has to be earned.

Audre Lorde said "Your silence will not protect you."⁷⁰ I say your anatomy will not protect you, either. Legal and medical models based on anatomical benchmarks for "male" and "female" will inevitably conflict and fail. Sexists who wish to efface the identities of women like me can always find a physiological or behavioral reason to say I am "'really' a man," and some of the worst offenders are "helping professionals" and people in our community. They echo the racists who came up with "scientific" schemes to determine who was "'really' black," or heterosexists like BBL who create ways to determine who is "'really' gay."

Gatekeeping versus services on demand

Much of my early activism was informed by sex-positive, pro-choice feminism. We passed out condoms and "Just Say Yes" sex-ed books at Chicago Public Schools, and we defended clinics from Operation Rescue. One of our major initiatives was family planning services (including abortion) that were "safe, free and on demand." I have always seen parallels between family planning and transition-related medical services, both of which were once only available through back alley clinics and black market sources. Women in our community died from this, and still die from illegal and unregulated products and procedures because of our legal status. I believe controlling our bodies is a fundamental human right. If someone wishes to undergo a vasectomy, vaginal rejuvenation, abortion, facial tattoo, piercings, tongue splittings, facial feminization, breast implants, mastectomy etc., I believe these procedures should be available to anyone who is willing

to sign a release. I find it quite telling that our surgical procedures and abortion both face similar challenges, since both involve altering one's capacity to reproduce.

Psychiatric gatekeeping only works for those who are unwilling or unable to find easier and faster ways. Before the internet, most young people got what they needed through extralegal networks (many poor people still do), and anyone who had the means would skip gatekeeping altogether and jet off to an exotic locale, as it had been done for many years before the gender clinics began imposing controls. At the apex of the gender clinic system, only those willing to endure a process akin to criminals at a parole hearing took that route—people who would say whatever the gatekeeper wanted to hear in order to get what they desired.⁷¹ Ironically, many who tried to get around gatekeeping during their own involvement now insist it remain in place.⁷² Lawrence, who is fond of quoting Audre Lorde,⁷³ must have missed "The master's tools will never dismantle the master's house."⁷⁴ Gatekeeping also appeals to those who don't get much validation except from gatekeepers. The acceptance letter becomes about the only acceptance they get. Not only is getting a vagina a status symbol and evidence of identity for this tiny group, but "beating the system" is a status symbol, too (which might also explain the correlation between online "'autogynephilia' support" and welfare support).

I should note that I had a great therapist who helped me immensely. I probably would have gone even without being required. Therapy and support should be encouraged, but voluntary, and without the stigma of disease, in the way that someone questioning their spiritual beliefs might find therapy helpful without needing their spiritual journey labeled as a "religious identity disorder." With gatekeeping, we end up with people like BBL controlling access to services in exchange for money or sex. "Sexology" is an unregulated activity in most states, meaning anyone could set up shop as a sexologist or sex therapist. Bailey, Lawrence, and others have all used their "sexologist" credentials to gain easier access to sex partners. Some dismiss this as OK because they sign our little permission slips so we can get

medical services. Call me old-fashioned, but I don't feel it's ethical or scientific for gatekeepers and sex researchers to have sex with clients and research subjects. I also don't want my tax dollars federally subsidizing the sex life of a self-hating tranny-chaser like Bailey, so he can meet women like me and later claim we "have the brains of men but the genitals of women"⁷⁵ or are prone to criminal activity and sexual promiscuity.

Here's my question: why not cut out these middlemen and simply request and receive services? If people go to their physician and say they are depressed or anxious, the doctor believes their self-report and suggests options. Why can't it be that simple for us?

Replacing GID as the principal diagnostic means for obtaining medical service is considered a top health priority in our community. Citing a progressive San Francisco program, the National Coalition for LGBT Health states: "There is a great need for more such programs that avoid GID as a requirement for access... this [requirement] results in many transgender people avoiding the psychiatric diagnosis process altogether, and not accessing medically regulated Trans Health Services."⁷⁶ The interest itself isn't the problem, it's the anxiety and depression caused by depriving its expression.⁷⁷ If in some cases hormones and surgery help relieve anxiety and depression, they should be available as an effective, time-tested option.

Roughgarden notes: "Their bogus categories and made-up diseases are intended to subordinate, not to describe."⁷⁸ Until we get away from this childlike dependence and deference to so-called "experts" simply because they take our money or don't kick us out of their offices, our accommodation in healthcare and law will not be fully realized.

Beyond BBL

People like BBL rarely admit they are wrong, because they are very concerned about their academic legacy (which mirrors their beliefs about

offspring). They will spend the rest of their lives fighting tooth and nail to defend their words and actions, but in the end BBL will be regarded as an interesting curiosity from the waning years when our community was considered disordered and diseased because of our interest in feminization, in whatever form that interest might take. Luckily, we don't have to convince them they are wrong; we just have to convince everyone else.

We need to embrace judgment-free models to describe these phenomena. I hereby suggest the phrase that leads off this article: *interest in feminization* (IF) and the subset *erotic interest in feminization* (EIF) as umbrella terms without the stigma of disease. It encompasses not only our community, but anyone regardless of motivation, affectional orientation, or gender assigned at birth. Change "F" to "M" in the acronym for the F to M folks. I can think of a laundry list of problems with this proposed terminology, but this article is part of an ongoing evolution of ideas. I'll leave the definitive statements to those who fancy themselves "experts" who claim they know "the truth." My thoughts here won't be the end of old ways of thinking, but with luck, it will spark some new ones, where we describe ourselves and our identities without the stigma of sin and disease.

From the day in April 2003 when Professor Lynn Conway began an investigation into Bailey's book,⁷⁹ it was clear that this was a defining moment for our community. We mobilized all around the world as never before.⁸⁰ We made sure this book did not become another *Transsexual Empire*.⁸¹ BBL underestimated everything about us, from our numbers,⁸² to our intelligence,⁸³ to our ever-strengthening network, to the direct contact we have with our youngest and most vulnerable, to our influential positions in every career and profession, to our ability to effect positive change.⁸⁴ This isn't just evolution, it's revolution. We're replacing sin and disease with pride and strength, and this is only the beginning.

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References and notes

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Full texts of many references below are available online via:

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