Exhibit 5

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Discursive stickiness: Affective institutional texts and activist resistance

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Abstract

Pushing the bounds of public relations theory and research, we explore how institutional texts have produced and reified stigmas around gender transgression and how these texts are bound up in moments of activism and resistance. We considered how different discursive and material functions get "stuck" together by way of texts and how this sticking depends on a history of association and institutionalization. Activism presents opportunities to challenge institutional and structural stickiness, and we argue that public relations can challenge the affective assemblages that comprise and perpetuate these systems, unsettling the historical discourses that have governed institutions by establishing new communicative possibilities.

Keywords

Activism, agency, resistance, stickiness, transgender

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Pushing the bounds of public relations theory and research, we explore how institutional texts have produced and reified stigmas around gender transgression and how these texts are bound up in moments of activism and resistance. We focus on the Diagnostic and Statistical Manual of Mental Disorders (DSM)—a handbook used by behavioral health-care professionals in the United States and much of the world—linking lived experiences of transgender people to the history of the epistemological violence perpetrated in the DSM that reifies hegemonic norms of gender, sex, and sexuality. Importantly, the DSM is not a benign text; journalist Reese (2013) critiques the DSM, drawing attention to the bureaucracy implicated in the text:

> The American Psychiatric Association owns the DSM. They aren't only responsible for it: they own it, sell it, and license it. The DSM is created by a group of committees. It's a bureaucratic process. In place of scientific findings, the DSM uses expert consensus to determine what mental disorders exist and how you can recognize them. Disorders come into the book the same way a law becomes part of the book of statutes. People suggest it, discuss it, and vote on it. Homosexuality was deleted from the DSM by a referendum. A straight up vote: yes or no. It's not always that explicit, and the votes are not public. In the case of the DSM-5, committee members were forbidden to talk about it, so we'll never really know what the deliberations were. They all signed non-disclosure agreements. (para 15).

In this article, we contend that the DSM creates the web of language from which we come to understand and communicate about gender variance in the United States, and this language is rooted in institutional discourse and extends to the practices of public relations and activism. We then turn to the connections between discourse, activism, and power-plays among and between key stakeholders. We orient this argument in queer theorist Sarah Ahmed's (2004) concept of stickiness, demonstrating how the affect of disgust gets attached to transgender subjectivity within an institutional text and is carried out performatively within material landscapes. The purpose of this paper is threefold: (1) we argue that institutional texts, because of their prominence as world-defining documents, are important public relations discourses; (2) by historicizing this text, we can see how these documents leave behind a trail of the past, remnants of power, and hegemony; and (3) we demonstrate how activism resists the stickiness of these texts.

A note about terminology and context: "Transgender" is a contemporary term that emerged in recent years to indicate a wide variety of people whose gender identity or expression transgresses the rules of binary gender. We use the term "transgender" to refer to what Susan Stryker, a leading voice in the field of transgender studies and longtime advocate for transgender visibility and rights, refers to as individuals who "move away from the gender they were assigned at birth, people who cross over (trans-) the boundaries constructed by their culture to define and contain gender" (Stryker, 2008: 1). Transgender, according to sociologist Monro (2005: 3) "explodes the notion that male and female are discrete categories." This conceptualization, as other gender scholars have noted, undergirds a historical discussion that allows for a "history sensitive to a wide range of identities and experiences" (Tebbutt, 2012: 506). We also use the phrase "gender transgressive," which transgender activist and legal scholar Spade (2003) argues encapsulates myriad identities and experiences and is not limited to narrow understandings of sex and gender. As historian and transgender activist Beemyn (2013) explains:

"Any attempt to write 'transgender history' is complicated by the contemporary nature of the term 'transgender'" (p. 113). We recognize that applying terms and concepts of gender variance from the early-20th century is problematic (Boag, 2005), for these categories, as historian Cleves (2014) notes are indebted to "a very modern regime of knowledge and power," (p. 461) particularly the role of medicine in defining the category. Spade (2003) draws our attention to the contentious and oppressive relationship between gender transgressive people and medical establishments. Additionally, because culture is a major variable in attitudes toward gender transgression, it is important to note this essay comes from a U.S. perspective using U.S. examples.

In this article, we attend to both discursivity and materiality of the DSM as an institutional text, first in our examination of medical texts and then in our analysis of a moment of resistance. We bring to light the normative linkages brought into power through medicine and legitimized and leveraged through promotion. We make visible these linkages and provide an anecdote that highlights the disruptive power of activism. We start by presenting Ahmed's concept of stickiness and then pivot to the literature on activism and public relations as a space where affect theory can inform an intervention. We are interested in how the DSM, as a discursive object, generates affect and how it travels through institutional texts via affective transfer, as well as how activists challenge this affect. Our analysis is inspired by Ahmed's (2010, 2014) work on affect as sticky, presenting a framework to attend to the production and transference of emotions through institutional texts. We draw on Ahmed's notion that affect is performative, and we point to the ways in which affect is contagious and has the ability to stick. Regarding the stickiness of affect, Ahmed (2014: 91) writes:

> Stickiness involves a form of relationality, or a 'withness,' in which the elements that are 'with' get bound together. One can stick by a friend. One can get stuck in traffic. Some forms of stickiness are about holding things together. Some are about blockages or stopping things moving. When a sign or object becomes sticky it can function to 'block' the movement (of other things or signs) and it can function to bind (other things or signs) together. . .Stickiness then is about what objects do to other objects – it involves the transference of affect – but it is a relation of 'doing.'

Stickiness, according to Ahmed, involves the transference of affect, and for Ahmed, objects become sticky, or logged with affect, and pickup traces of where they have been. We argue that institutional discourses and frameworks, like those of pathology put forth in the DSM, sustain a particular kind of affective relation, that of pathology, to social norms and texts that govern bodies and material realities. We conclude with an anecdote in which transgender activists employ public relations to block the binding of pathology to transgender subjectivity. We wish to highlight that the vanguard of this activism was transgender women of color. The intersection of race and gender is vital to understanding the manifestation of this activism, as the resistance mounted was multi-pronged in regards to which vectors of power the activism unmasked. Given the history of the DSM as a white-centric text (Thomas, 2014) where non-white identies have been othered (Cermele et al., 2001), paired with the high incidence of physical and institutional violence against transgender women of color, the anecdote demonstrates displays of agency in response to multifaceted hegemonic vectors of silence.

Tracing gender variance in institutional discourses

For nearly the last 70 years, the DSM has been used to identify, classify, and categorize mental illness, diagnoses that are social and contextual. It is a text that holds much power, as it is used by clinicians, researchers, regulatory agencies, health insurance companies, pharmaceutical companies, and policy makers. According to the American Psychiatric Association, the DSM is significant because it provides a common language for "clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders" (DSM–5: Frequently Asked Questions, 2019, para 1). To understand the bearing of the DSM in shaping the stigmatization of transgender individuals and the subsequent impact on material conditions for these persons, we must first ground our understanding of how health care functions in the United States. The dominant model of health care in the western world is the single-disease model of health, also known as the biomedical model (Wade and Halligan, 2004). The biomedical model of health is a reductionist framework that creates a myopic and non-reflexive orientation toward health that may create malady where arguably none exists. The medical establishment has the power to construct and shape identity, classifying what is considered normal and abnormal (Foucault, 1965), a classification that can have long-term societal impacts that range from positive (e.g. vaccinations against smallpox) to negative (e.g. stigmatization of sexualities). The diagnosis and treatment of behaviors is predicated on medical and psychiatric classification (Foucault, 1965). In short, medicine is socially constructed, and, therefore, the history of a gender variance is a journey that reveals mechanisms of hegemonic power, structures in which public relations plays a role. Importantly, in a cultural and political context in which medical care remains inaccessible to many and particularly low-income transgender people of color, medical care associated with gender confirmation is administered through gender-regulating processes—often guided by the DSM—that reinforce oppressive gender binaries. Thus, in acknowledgement of these contexts, we proceed with caution when approaching the historically interwoven systems and structures of medical and communicative realms that continue to shape the lives and experiences of transgender people.

This history of the clinicalization of gender transgression in the United States illuminates some of the parallels between medical and psychiatric institutions and how these texts are linked to very public and promotional moments in history. Importantly, we do not intend to group any past figures or classifications with modern identity categories; rather, we understand them as historical and contextual, serving as a framework for contemporary transgeder activism. By way of publicity and promotion, in the early 1950s, American Christine Jorgensen was the first person widely known for having sex reassignment surgery, and she became the face of transsexuality. Jorgensen's story was the subject of a front-page story of the *New York Daily News* and appeared in mainstream magazines like *Time* and *Newsweek*, and she became a celebrity using her platform to advocate for transsexuals. Importantly, as historian Skidmore (2011) chronicles, Jorgensen distanced herself from "deviant" groups, providing the press with a narrative of white respectability that was distinct from stories of homosexuality or cross-dressing. Within the backdrop of Jorgensen's publicity, in the 1960s, clinicians in the United States began to develop criteria for gender identity programs, most notably with the publication

of endocrinologist Harry Benjamin's *The Transsexual Phenomenon* and the opening of the first gender identity clinic at Johns Hopkins University in 1966. Prior to this time, clinicians provided individuals surgical interventions on the basis of correcting what they considered anomalies (Stone, 1991), often grounding diagnoses in the DSM.

To date, there are eight iterations of the DSM: DSM-I (1952), DSM-II (1968), DSM-II sixth printing (1973), DSM-III (1980), DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-V (2013). We argue the DSM is an institutional text that catalogs and codifies gender transgression; it is a reification of authoritative knowledge production that, through its various iterations, produces remnants of stigma that travel through time. These texts demonstrate how institutional discourses have shaped and continue to shape contemporary gendered subjectivities. Since the publication of its first edition in 1952, the DSM has created pathways through diagnostic classifications that link gender variance to other pathological categories. For example, the pathology of gender variance can be traced to the first iteration of the DSM where transgenderism was listed in the "Sexual Deviation" section (000-x63), a list derived from "cases formally classed as 'psychopathic personality with pathologic sexuality'" (1952: 39). Specifically transvestism, or what at the time was understood as cross-dressing, listed alongside homosexuality, pedophilia, fetishism, and sexual sadism—which includes rape, assault, and mutilation. A formal diagnosis of transsexualism as a psychiatric disorder did not appear in the DSM until the third iteration published in 1980, identifed as "Gender Identity Disorder," categorized as an Axis I mental illness—disorders most commonly found in the public. In 2008, as part of the revision and update of the DSM, the American Psychiatric Association appointed a Work Group on Sexual and Gender Identity Disorders resulting in concern among the lesbian, gay, bisexual, and transgender (LGBT) community, largely focused on the status of the diagnostic categories of Gender Identity Disorder. As with homosexuality in the 1970s[1], activists maintained that it is wrong to label expressions of gender variance as symptoms of a mental disorder. While some activists contend the perpetuation of Gender Identity Disorder (GID) diagnoses in the DSM would further stigmatize and cause harm to transgender individuals, other advocates in the transgender community expressed concern that removing GID could lead to the denial of medical and surgical care for transgender individuals (see Drescher, 2010). In the latest iteration of DSM V, the introduction to the section on Gender Dysphoria reads: "The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines." This quote encapsulates the historical and contextual nature of discourses surrounding gender variance and the contested nature of representing gender variance.

Inclusion of gender variance in the DSM is complex and arguably a double-edged sword. On one hand, classifying gender variance as a disorder "open[ed] many door[s]" (Arune, 2004: 115), providing access to hormone therapy and gender affirmation surgeries in countries with state health programs. Conversely, through the anchoring of gender variance in the DSM, it could be argued that gender transgressive individuals have had the "misfortune to become objects of medical concern" (Brown and Tucker, 2010: 230), embodying the stigma of a mental disorder (Arune, 2004). Furthermore, the history of the DSM as a normative text includes embedded understandings of hegemonic race, which can serve as a framework for systemic racism, as has been documented

by scholars (Alarcón et al., 2009; Cermele et al., 2001; Loring and Powell, 1988). This misfortune, when coupled with other vectors of hegemonic power, can serve to further erase and stigmatize groups such as transgender women of color.

Although the DSM was developed within an American context, it is applied in a range of countries across the globe. Edited by the American Psychiatric Association (APA), the DSM has positioned itself as "the most authoritative text on mental health in the Western culture" (Crowe, 2000: 69) with influence in health domains and on social practices including legal fields and insurance (see Harper, 2013; Lafrance and Mckenzie-Mohr, 2013). The DSM is a powerful tool within a hegemonic block, and we argue that its temporal nature creates a stickiness through the editions of the text that allows it to have such a prominent place. These texts and the institutional practices they are implicated in are social forms, and it is through repetition, as queer theorist Butler (1993) reminds us, that norms materialize. Within the context of materialization, Ahmed is interested in how different figures of speech get stuck together and how this sticking relies upon histories of association. We argue the DSM functions as a vector of hegemonic power that sets the guidelines for transgressive behavior, defining gender norms as those that are linked to normative or dominant understandings of sex. We argue that through circulation and repetition of the DSM, the pathology of gender transgression generates stickiness, and activists challenge this stickiness through public relations.

Activism in public relations

While promotional and persuasive communication has long been part of the work of activism and social movements (see Coombs and Holladay, 2007; Heath and Waymer, 2009), public relations research has experienced a swell in activism scholarship over the past decade (see Adi, 2019). Heath and Waymer remind us that that "obtaining the democratic exchange long championed by public relations" required "seeing how and when activists engage in the dialogue that occurs on various issues" (2009: 195). Activism requires the development of oppositional consciousness, contesting dominant ideologies, and providing "symbolic blueprints" for collective action and social change (Morris and Braine, 2001: 26). Activists use a variety of public relations strategies and tactics, including boycotts, demonstrations, and symbolic events, to galvanize attention and influence public opinion and policy. Historically, scholars have studied activists to understand their communication practices, their strategies, their ideological motivations, and the power differences between them and the organizations they are resisting (Manheim and Holt, 2015). From a tactical perspective, scholars note how activists mobilize resources and power to influence decision-making, employing techniques such as persuasion, negotiation, pressure, and/or force (Kim and Sriramesh, 2009). Public relations literature on activism has tended to focus on organizational perspectives and management of activist groups (Brown, 2010; Smith and Ferguson, 2010), with a recent shift to looking at how practitioners function as activists (Holtzhausen, 2007, 2012) and how activists engage in public relations practice (Ciszek, 2015, 2017).

While traditionally public relations research has positioned activists as "an antagonistic force" (Coombs and Holladay, 2012: 82), aside from a handful of contemporary projects (e.g. De Moya and Bravo, 2016; Stokes and Atkins-Sayre, 2018; Toledano, 2016),

until fairly recently few studies have looked at how activists use public relations to achieve their objectives. Activists play an important role and often function as pressure groups that influence and shape society. Coombs and Holladay contend:

> Activists seek to change organizations in some fashion and that requires them to utilize power and persuasion. Typically, activists are marginalized by and have much less power than organizations. Through public relations, activists can attempt to build power and to persuade organizations to alter their behaviors and policies (2012, 882).

Reconceptualizing the activist role, Holtzhausen (2007, 2012) carves out a space in public relations theory for exploring resistance and dissent to normative power structures. Holzthausen (2012) conceptualized public relations activism as public relations which resists power structures, employs dissent, and incorporates subaltern voices to challenge normative practices. In this article, we come at activist public relations by way of Ahmed's notion of stickiness to articulate and explicate the ways activists utilize public relations to unstick the structural and discursive connections between ideas, values, and objects surrounding transgender subjectivity. We look at the instutionalization of gender transgression, turning to a moment of activist resistance, and contributing a non-corporate context for the discussion of how activists use public relations. We attend to the webs of power and institutional logics that transgender individuals are located within, illustrating through one example how activists utilize materiality as a form of resistance.

Activism, agency, and resistance

In 2017, one author attended the United States regional conference of the Professional Association for Transgender Health (USPATH) in Los Angeles in the presence of clinicians, researchers, and TGD advocates.[2] At this conference, Drs. Kenneth Zucker, Heino Meyer-Bahlburg, Dan Karasic, and Vilanayur Ramachanfran, a group of controversial psychologists of sexual orientation and gender identity, presented a session entitled "Development of Gender Variations: Features and Factors," in which they discussed myriad cases. The purpose of the session was to lay out potential clinical implications for working with transgender clients. However, the tenor of the session was one of caution and liability, with panelists (particularly Zucker) questioning the increase in prevalence of transgender identifying persons. Zucker, the lead of the DSM-V Sub-Work Group on Sexual and Gender Identity Disorders, has had a long career working with gender-diverse clients, but he is viewed by transgender activists as harmful for his ties to conversion techniques (see Serano, 2016). Zucker is famous for his contested corrective reparative therapy for gender-variant children, where as part of his research he forced children assigned female at birth not to play with trucks and soldiers and children assigned male at birth not to play with dolls (Ashley, 2020). In 2015, Zucker's practice of gender conversion psychotherapies on transgender children was famously shut down (Hayes, 2018), shrouding Zucker and his supporters in a veil of stigma. Social work and gender studies scholar Jake Pyne and other transgender advocates and scholars contend that at the heart of Zucker's approach is an understanding of gender diverse children as disordered, casting a specter of shame over their behaviors (and over parents' tolerance of it) and seeking

"redemption, success, and normality for the gender problematic child" (Pyne, 2014: 88). Despite these critiques, Zucker maintains a private clinical psychology practice focused on gender dysphoria, and holds the position of Professor in the Department of Psychiatry at the University of Toronto.

At the 2017 conference, Zucker presented his hypothesis on the increased prevalence of transgender persons, pointing to desistance (a false claim by Zucker that 80% of adolescents who transition desist; see Winters, 2016) and regrets of clients (psychological faults of clients, including sexual fixations). Zucker's presentation embodies a performative iteration of the stickiness of pathology. Despite his controversial practices, his research passed the peer review process that governs WPATH conferences, and he was given authority and power to hold a forum which was buttressed by his position as the lead of the Sexual and Gender Identity Disorders working group. Importantly, no space was made for transgender persons on this panel, reifying the othering of gender transgressive people. Furthermore, this lack of inclusion echoes the institutional documents that govern the *treatment* of gender transgressive bodies, as the authors and users of these documents are almost exclusively cisgender, individuals whose gender is the same as their birth-assigned sex (Aultman, 2014). The term cisgender emerged in the 1990s from trans activist discourses that critiqued the hegemony surrounding sex and gender and gained popularity among activists and scholars.

The fragility and vulnerability of this space was demonstrated by the cisgender heteronormativity governing it. As Butler (2004) notes, "the regulation of gender has always been part of the work of heterosexist normativity" (p. 186), and this wielding of control continued the hegemonic formations of power. However, what resulted next demonstrates the ways in which activism can exploit fissures of logic within hegemonic webs of power. During the panel, Lina Riparia, a transgender woman of color, led a walkout where protesters used their voices to drown out Zucker's presentation. Importantly, this protest led to hegemonic rebukes; specifically, hotel security removed the protesters from the premises. As a result, activists employed public relations: issuing press releases, hosting community forums, and engaging in performative strategies that challenged the stickiness of pathology. Activists demanded Zucker's symposium be cancelled and for the WPATH Executive Board to provide an explanation and apology for his presence at this conference and the 2016 WPATH conference in Amsterdam. In a statement, transgender people of color asked for a formal apology both in person and on the USPATH/WPATH website from the USPATH/WPATH board for calling security on transgender conference attendees for exercising their right to protest. Additionally, activists demanded that WPATH hire transgender people as paid consultants, give local transgender communities input into planned conferences and promise that gender transgressive persons will be given seats on WPATH committees, including the scientific committees that decide which academic papers are accepted for conferences. This example embodies what transgender scholar Keegan (2020) calls a moment of resistance "gendered self-fashioning" (p. 61) by gender transgressive people who have existed both within and against the systems that have classified them. Importantly, this was not a forum for dialog; it was a space cultivated by and for transgender women of color to vocalize their demands to the USPATH executive board. Transgender women of color demanded to be listened to and for conference organizers to acknowledge the institutional erasure and

violence against gender transgressive persons, and they called into focus the historical dissymmetry and marginalization that governs a conference focused on transgender people.

The protesters' presence was, in and of itself, an exposure of the fissures in logic in Zucker's presentation and the institutions that supported him, as it demonstrated how those with lived experiences as transgender did not conform to the constitution of normative gender that Zucker reified in his presentation. As a member of the DSM board, Zucker functions as a hegemonic vector of power. Zucker, the flagbearer of the DSM's power over transgender subjectivities, was withdrawn from the program and was institutionally rebuked through this removal. Transgender women of color used their material and embodied experiences to challenge medical and institutional hegemony. The protest was enough for several transgender women of color to gain the attention of conference organizers. During a meeting with USPATH organizers held the next morning, these women were given the floor to air their grievances with Zucker's presence at the conference. Transgender women of color refused to concede power to white and cisgender individuals, noting as one activist, Danielle Castro, emphasized during the meeting:

> Trans women of color are being pushed out to the sidelines even though we are tokenized and asked to participate in ways that exploit us to your benefit. That's not going to happen anymore. We are taking back our power and taking back our voice. . . . It's time to include us in meaningful paid and respected ways. We're not here for a dog and pony show. We've gone to school. We're working in professional settings. And it's high time our voices are respected as such.

The transgender women of color shared their list of requirements and reinforced the need for each of their demands to be immediately addressed by USPATH organizers. These demands included a formal apology posted on USPATH's social media pages and website and shared publicly at the conference, the dismissal of the individuals who called security to stop the protesters, and removal of Zucker from the conference, specifically cancelling his upcoming session. Additioally, activists called for the organization to employ transgender women of color as paid consultants throughout all levels of the USPATH and WPATH working on transgender health and conference organization. This meeting embodied the creation of "third space feminism," or what Golombisky (2015) called womanist tactics, to "get things done" (p. 407), but importantly did not include "harmonizing and coordinating" or "dialog," as it was not designed as a dialogic space between activists and organizers, rather it functioned as space for agency and dissent. This is embodied by the comments of Bamby Salcedeo, the president and CEO of the TransLatin@Coalition:

> Even though we are here in a peaceful manner, I think it's important that we understand that these are serious demands that we are presenting to all of you. We're actually expecting direct results that will change the landscape of the current violence that we're continuing to face institutionally, and within our society.

This uprising resulted in the cancelation of Zucker's panels, the issuing of a public apology to these women and to TGD conference attendees, and the instatement of a new

panel of and by transgender women of color. In this panel discussion, transgender women of color articulated their lived experiences to a standing-room-only audience, working to challenge, and unstick the pathology from its roots in institutional erasure and marginalization. They demanded accountability, respect, and safety. In this way, activist public relations that utilizes materiality functions as a way to disrupt stickiness across temporal planes. Therefore, activism is a resistance to institutional power, and this example embodies the discursive struggle that underpins the work of cultural intermediation that is anchored in the acquisition of power (Thompson, 2016).

In opposition to the hegemonically sanctioned discourses, activists were able to reclaim space and, through public relations techniques, dispel fallacies through narratives of their own lived realities. During the public apology issued by USPATH and the conference organizers, transgender women of color led the presentation by inviting those who stand in solidarity with trans women of color and the protesters to join the presenters onstage. The majority of the audience stood up and moved to the stage, demonstrating solidarity, and support for transgender women of color. Conference organizers and board members publicly apologized for Zucker's presence at the conference and their part in perpetuating the mistreatment of and violence against transgender women of color in particular, and they promised to incorporate transgender women of color into each level of WPATH's organization. Although this public apology was generally well-received, the leading activists Danielle Castro and Bamby Salecedo reiterated the importance of practicable action and material change throughout the organization, instead of limiting the apology to a single moment of solidarity. Slecedo reiterated this need for tangible change, asserting:

> I want for us to acknowledge and remember this time. Right? This is a show of solidarity. This is what solidarity looks like [. . .] We can change the landscape of our community if we really are intentional.

Surrounded on stage by transgender protesters, supporters, and allies, the transgender women of color controlled the direction and tenor of the public apology and discussion of institutional change. Centering their voices and lived experiences, the activists directly confronted the pathologization of and violence against transgender women of color and concluded with a chant of "Trans Power!" This embodied performance of agency and solidarity serves to "unstick" the association of pathology and trangender subjectivity, especially for transgender women of color. This USPATH case demonstrates how activists utilized public relations to bring key stakeholders together to pressure decision-makers to challenge the hegemonic iterations of pathology and bring about institutional change. The protest of Zucker's panel, the public apology at the conference, and the resulting panel by transgender women highlight the fissures of logic within the hegemonic orderings perpetuated by the DSM. Furthermore, these actions lay bare the racialized patholigization of institutional bodies and documents, as the organizers of these actions deliberately centered their racial identities and both the epistimioloical and physical violence perpetuated against them in their efforts. Specifically, they called attention to the inordinate levels of violence perpetuated against transgender women of color, the lack of transgender representation in positions of power in governing health institutions,

and the tokenization of their bodies for these organizations. In short, these efforts exposed a vertable cross-section of fissures of logic, setting the stage for measurable action and progress, and through activist public relations, transgender women of color took power back both materially and discursively.

This anecdote necessitates that we do not reduce transgender persons to historical victims; rather, we need to understand them as complex individuals that challenge our expectations and continuously resist the historic erasure and pathologization placed upon them by dominant health discourses. Their communication became affectively sticky to the extent that it gave rise to new capacities for thinking, doing, and being. In this instance, through their physical presence and opposition, transgender women of color "intervene[d] in and reconfigure[d] contexts. . .informing and mediating ways of knowing and acting" (Trimble, 2010: 300). This is a moment that illuminates the performance of institutional legitimacy that was challenged and apended. These activists center their lived reality, signaling a shift away from the textual to the material. Therefore, activist public relations that utilizes materiality functions as a way to disrupt stickiness across temporal planes.

We conclude with this example of the dance between hegemony and resistance, highlighting a moment of opposition. Opposition is active, not passive, and according to philosopher McWhorter (1999), is the way to enact change and to untie us from the systems of normalization:

> Opposition. . . involves a great deal more than resistance. Resistance is merely negative, a no to domination. Opposition involves something positive, a departure from dominating networks. It involves the production of a different sort of self and a different sort of community—selves and communities not bound by the dictates of sexual identification. . .Opposition, then, is not just a matter of re-creating ourselves or of creating counterculture; opposition will involve changing the dominant culture as well. And, therefore, opposition entails exercising power over other people to force them to allow us to do our self-transformative work. (p. 191).

McWhorter furthers our understanding of how to build new systems, demonstrating that in order to displace systems, we must use the systems of power already in place. In other words, the tools of the system must be inverted to reflect the fissures of the system. In this example, the USPATH conference functioned as a tool of hegemonic power, through tacit support (e.g. providing individuals like Zucker a platform) and explicit support (e.g. by upholding the WPATH standards of care). In this example, Zucker's panel represents a fissure in the logic of transgender intelligibility, as transgender women of color lay bare the illogic of this panel.

The conference served as a stage for hegemonic reification of transgender intelligibility and resistance, and the perspectives of transgender women of color provide a critical counter voice to the white cisnormativity that has produced and upheld structural and institutional violence and exclusion of trans people of color.

We argue that affect theory provides a framework to understand how discursive texts like the DSM are used performatively and have material consequences that perpetuate and reify existing pathology, and affect theory also allows us to understand how social actors, like the transgender women of color at the 2017 WPATH conference, challenge these discourses to reclaim agency, and ownership of their identities. Ahmed (2014) reminds us of "the way in

which a signifier, rather than simply naming something that already exists, works to generate that which it apparently names" (p. 92). Therefore, this moment of activism is a successful performative utterance, as it is grounded in norms already in existence, but it opens up the future, challenging the temporality of the hegemonic vectors of power like Zucker and the DSM. Importantly, a successful performative utterance relies on the citation of norms and conventions already in existence; it opens up the future by repeating past conventions.

Activists, like the transgender women of color in the aforementioned anecdote, may be well-positioned to do public relations work, facilitating change through strategic communications. Like our analysis above demonstrates, to assist in this move, activists must exploit the fissures of logic within these discourses. Turning back to McWhorter, in protest, transgender women of color first leveraged their own material existence to expose this fallacy and then utilized the conference platform, the very tools of hegemonic power, to tell their stories in contrast to the dominant discourses bull-horned by USPATH. Ahmed asks us to consider why social transformation is so difficult to achieve and why power relations are enduring even in the face of collective resistance. Activism, like that at USPATH, presents opportunities to challenge institutional and structural stickiness. In this manuscript we considered how different discursive and material functions get "stuck" together by way of texts and how this sticking depends on a history of association and institutionalization. We argue that public relations can challenge the affective assemblages that comprise and perpetuate these systems, unsettling the historical discourses that have governed gender variance by establishing new communicative possibilities.

Pulling it all together

This article challenges the public relations research that has traditionally focused on activist impact on corporate performance (Adi, 2019), and it acknowledges activists' achievements in institutional and structural change. As Weaver (2019) reminds us, "recent work that has reinterpreted activism as part of PR history is not without challenge or controversy" (p. 12). On the one hand, historically there was considerable resistance to the notion of activism as public relations work, because according to Grunig and those in the "Excellence" camp the role of public relations was to help mitigate negative impacts on corporations from potential activists (see Ciszek, 2015). On the other hand, some activists may not agree with being associated with public relations, because they might regard the term as tainted with corporate ideologies (see Coombs and Holladay, 2012). While some scholars point to consensus oriented communicative actions within activism and public relations (e.g. advocacy, dialog, engagement), other scholars emphasize the importance of dissensus where dissymmetrical relationships exist (Ciszek and Logan, 2018; Place and Ciszek, 2021). Our article argues that sometimes facilitating "understanding, sharing and forgiveness" (Toledano, 2016: 280) should not be the goal of activist public relations, especially within the historical context of groups whose lives and identities have been pathologized and marginalized.

Public relations has the opportunity to challenge the stickiness of affect, moving discourses of marginality away from structures of oppression. Affect is implicated in communicative practices, and to challenge sticky assemblages, new forms of communication are needed that present alternative potentialities. We contend public relations is an

affective practice, whereby communicators—including activists—can bring together different cognitive, social, cultural, and affective dimensions to shift the discourse around gender variance and create opportunities for future research and theory-building. There has been a "deafening silence in public relations practice and research on transgender perspectives" (Ciszek, 2018: 7), and thinking through an affective lens allows us to better understand the how public relations can challenge pathology and marginalization.

Both practically and theoretically, one of the most important implications of this manuscript is a consideration of how affective markers of institutional texts stick across time and space and how they may be challenged by activist public relations. As an institutional text, the DSM produces and circulates power. But power is not all encompassing and can be challenged through moments of activism and resistance. The potential impacts of reflective, community-generated public relations include the destabilization of institutions that are undergirded by texts like the DSM and are perpetuated through affective stickiness. Paradoxically, since documents like the DSM are created to navigate hegemonic terrain, resistance often recreates the power structure of that which it resists. In this manuscript we raise theoretical questions as to how we understand and reproduce affect, arguing that the DSM has planted the seeds for larger forms of institutional erasure and violence. Future research should examine how institutional texts influence and are influenced by power and agency, and how these texts shape the production and consumption of meaning. If, as Ahmed argues, affect is realized in and through its constant repetition, it can also be detached and reconstituted. Public relations scholars should explore the role of affect in promotional communication, attending to the role public relations plays in perpetuating and challenging institutional and structural stickiness. This article demonstrates the rich opportunities to study the flow of discursive texts in shaping the understanding of historically marginalized groups and the resulting material and institutional conditions that shape the experiences of these populations.

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Notes

1. While homosexuality was removed from the DSM-II in 1973, not long thereafter, the Gender Identity Disorder (GID) diagnoses found their way into DSM-III in 1980.
2. It should be noted that WPATH is the largest organization focused on transgender health and publishes the influential standards of care document (currently on its seventh edition), which is utilized by clinicians and insurance companies to dictate the terms of affirmation care for gender transgressive persons. These standards of care include the guidance that persons seeking hormone care should seek a behavioral health provider for a letter that states their mental health is sufficient. Further, for gender affirmation surgeries, letters from two behavioral health providers are required in these standards.

References

Adi A (2019). Protest public relations: Communicating dissent and activism–An introduction. In: Adi A (ed.) *Protest Public Relations: Communicating Dissent and Activism*. New York, NY: Routledge pp.1–11.

Ahmed S (2004). Affective economies. *Social Text* 22(2): 117–139.

Ahmed S (2010) Happy object. In: Gregg M and Seigworth GJ (eds.) *The Affect Theory Reader*. Durham: Duke University Press, pp.29–51.

Ahmed S (2014) *The Cultural Politics of Emotion*. Edinburgh: Edinburgh University Press.

Alarcón RD, Becker AE, Lewis-Fernandez R, et al. (2009) Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry. *Issues for DSM-V: The role of culture in psychiatric diagnosis*.

Arune W (2004) I *am* Arune. *Transgender Tapestry* 106: 44–51.

Ashley F (2020) Homophobia, conversion therapy, and care models for trans youth: Defending the gender-affirmative approach *Journal of LGBT Youth* 17(4): 361–383.

Aultman B (2014) Cisgender *TSQ: Transgender Studies Quarterly* 1(1–2): 61–62.

Beemyn G (2013) A presence in the past: A transgender historiography *Journal of Women's History* 25(4): 113–121.

Boag P (2005). Go west young man, go east young woman: Searching for the trans in western gender history *Western Historical Quarterly* 36(4): 477–497.

Brown RE (2010) Symmetry and its critics. In: Heath RL (ed.) *Sage Handbook of Public Relations*, 2nd edn. Thousand Oaks, CA: Sage, pp.277–292.

Brown SD and Tucker I (2010) Affect, somatic management, and mental health service users. In: Gregg M and Seigworth GJ (eds.) *The Affect Theory Reader*. Durham: Duke University Press, pp.229–249.

Butler J (1993) *Bodies That Matter: On the Discursive Limits of Sex*. London: Routledge.

Butler J (2004) *Undoing Gender*. London: Routledge.

Cermele JA, Daniels S and Anderson KL (2001) Defining normal: Constructions of race and gender in the DSM-IV casebook. *Feminism & Psychology* 11(2): 229–247.

Ciszek EL (2015) Bridging the gap: Mapping the relationship between activism and public relations. *Public Relations Review* 41(4): 447–455.

Ciszek EL (2017) Public relations, activism and identity: A cultural-economic examination of contemporary LGBT activism. *Public Relations Review* 43: 809–816.

Ciszek E (2018) Queering PR: Directions in theory and research for public relations scholarship. *Journal of Public Relations Research* 30(4): 134–145.

Ciszek E and Logan N (2018) Challenging the dialogic promise: How Ben & Jerry's support for Black Lives Matter fosters dissensus on social media. *Journal of Public Relations Research* 30(3): 115–127.

Cleves RH (2014) Beyond the Binaries in Early America: Special Issue Introduction. *Early American Studies* 12(3): 459–468.

Coombs WT and Holladay SJ (2007) The negative communication dynamic: Exploring the impact of stakeholder affect on behavioral intentions. *Journal of Communication Management* 11(4): 300–312.

Coombs WT and Holladay SJ (2012) Fringe public relations: How activism moves critical PR toward the mainstream. *Public Relations Review* 38(5): 880–887.

Crowe M (2000) Constructing normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing* 7(1): 69–77.

De Moya M and Bravo V (2016) The role of public relations in ethnic advocacy and activism: A proposed research agenda. *Public Relations Inquiry* 5(3): 233–251.

Drescher J (2010) Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. *Archives of Sexual behavior* 39(2): 427–460.

Foucault M (1965) *Madness and Civilization: A History of Insanity in the Age of Reason*. New York, NY: Vintage Books.

Golombisky K (2015) Renewing the commitments of feminist public relations theory from velvet ghetto to social justice. *Journal of Public Relations Research* 27: 389–415.

Harper DJ (2013) On the persistence of psychiatric diagnosis: Moving beyond a zombie classification system. *Feminism & Psychology* 23(1): 78–85.

Hayes M (2018) Doctor fired from gender identity clinic says he feels 'vindicated' after CAMH apology, settlement. *The Globe and Mail*, 7 October.

Holtzhausen D (2007) Activism. In: Toth E (ed.) *The Future of Excellence in Public Relations and Communication Management*. Mahwah, NY: Lawrence Erlbaum Associates, pp.357-379.

Holtzhausen D (2012) *Public Relations as Activism: Postmodern Approaches to Theory and Practice*. New York, NY: Routledge.

Keegan CM (2020) Transgender studies, or how to do things with trans. *The Cambridge Companion to Queer Studies*, 66.

Kim J and Sriramesh K (2009) Activism and public relations. In: Sriramesh K and Vercic D (eds.) *The Global Public Relations Handbook: Theory, Research and Practice*. New York, NY: Routledge.

Lafrance MN and Mckenzie-Mohr S (2013) The DSM and its lure of legitimacy. *Feminism & Psychology* 23: 119–140.

Loring M and Powell B (1988) Gender, race, and DSM-III: A study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior* 29(1): 1–22.

Manheim JB and Holt AD (2015) Contraband: Activism and leveraging of corporate reputation. In: Carroll G (ed.) *Handbook of Communication and Corporate Reputation.* West Sussex: John Wiley.

McWhorter L (1999) *Bodies and Pleasures: Foucault and the Politics of Sexual Normalization*. Bloomington: Indiana University Press.

Monro S (2005) Beyond male and female: Poststructuralism and the spectrum of gender. *International Journal of Transgenderism* 8(1): 3–22.

Morris A and Braine N (2001) Social movements and oppositional consciousness. In: Mansbridge J and Morris A (eds.) *Oppositional Consciousness: The Subjective Roots of Social Protest*. Chicago: University of Chicago Press, pp.20–37.

Place K and Ciszek E (2021) Troubling dialogue and digital media: A subaltern critique. *Social Media + Society* 7(1), 2056305120984449.

Pyne J (2014) The governance of gender non-conforming children: A dangerous enclosure *Annual Review of Critical Psychology* 11: 79–96.

Reese H (2013) *The Real Problems With Psychiatry*. The Atlantic. Available at: https://www.theatlantic.com/health/archive/2013/05/the-real-problems-with-psychiatry/275371/ (accessed 25 March 2021).

Serano J (2016) Placing Ken Zucker's clinic in historical context. In: Whipping Girl. Available at: http://juliaserano.blogspot.com/2016/02/placing-ken-zuckers-clinic-in.html (accessed 25 March 2021).

Skidmore E (2011) Constructing the "Good Transsexual": Christine Jorgensen, Whiteness, and Heteronormativity in the Mid-Twentieth-Century Press *Feminist Studies* 37(2): 270–300.

Smith MF and Ferguson DP (2010) Activism 2.0. In: Heath RL (ed.) *The Sage Handbook of Public Relations*. Los Angeles: Sage, pp.395–408.

Spade D (2003) Resisting medicine, re/modeling gender *Berkeley Women's Law Journal* 18(1): 15–37.

Stokes AQ and Atkins-Sayre W (2018) PETA, rhetorical fracture, and the power of digital activism. *Public Relations Inquiry* 7(2): 149–170.

Stone S (1991) The Empire strikes back: A posttransexual manifesto. In: Epstein J and Straub K (eds.) *Body Guards: The Cultural Politics of Gender Ambiguity*. New York, NY: Routledge, pp.280–304.

Stryker S (2008) *Transgender History*. New York, NY: Seal Press.

Tebbutt C (2012) "Transgender History by Susan Stryker / Bodies in Doubt: An American History of Intersex by Elizabeth Reis". Women's History Review 22(3): 505–509.

Thomas JM (2014) Medicalizing racism. *Contexts* 13(4): 24–29.

Thompson P (2016) Dissent at work and the resistance debate: departures, directions, and dead ends *Studies in Political Economy* 97(2): 106–123.

Toledano M (2016) Advocating for reconciliation: Public relations, activism, advocacy and dialogue. *Public Relations Inquiry* 5(3): 277–294.

Trimble S (2010) (White) rage: Affect, neoliberalism, and the family in 28 Days Later and 28 Weeks Later. *The Review of Education, Pedagogy, and Cultural Studies* 32(3): 295–322.

Wade DT and Halligan PW (2004) Do biomedical models of illness make for good healthcare systems? *British Medical Journals* 329(7479): 1398–1401.

Weaver CK (2019) The slow conflation of public relations and activism: Understanding trajectories in public relations theorising. In: Adi A (ed.) *Protest Public relations: Communicating Dissent and Activism.* New York, NY: Routledge, pp.12–28.

Winters K (2016) *Media misinformation about trans youth: The persistent 80% desistance myth*. GID Reform. Available at: https://gidreform.wordpress.com/2016/07/26/media-misinformation-about-trans-youth-the-persistent-80-desistance-myth/ (accessed 25 March 2021).

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Exhibit 6

Videorecording of meeting at 2017 USPATH conference,
https://www.youtube.com/watch?v=rfgG5TaCzsk.

Exhibit 7

Abigail Shrier, *Top Trans Doctors Blow the Whistle on "Sloppy" Care*, THE FREE PRESS (Oct. 4, 2021), https://www.thefp.com/p/top-trans-doctors-blow-the-whistle.

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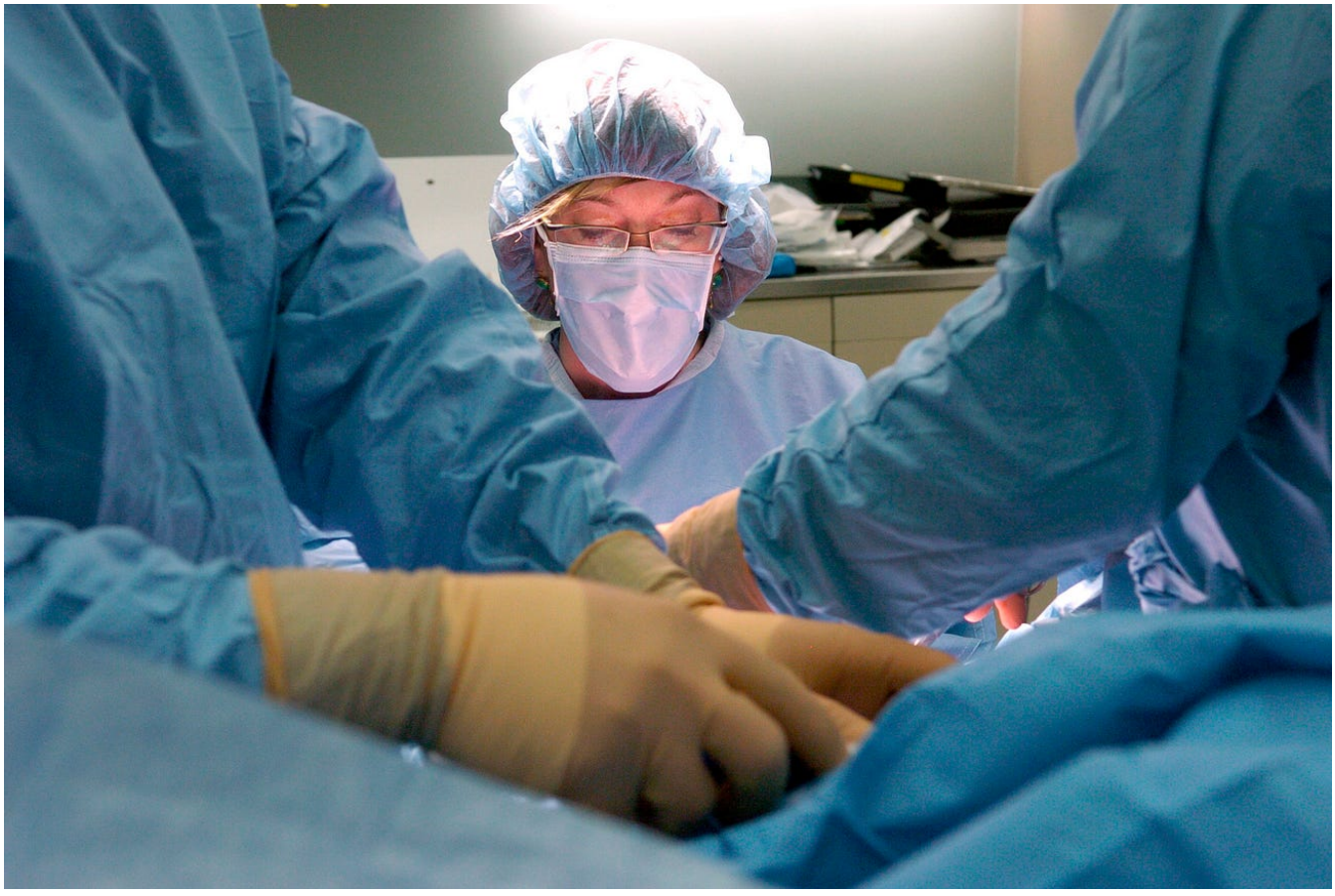

Dr. Marci Bowers performs gender reassignment surgery in Trinada'ss Mount San Rafael Hospital. (Glenn Asakawa/The Denver Post via Getty Images)

Top Trans Doctors Blow the Whistle on 'Sloppy' Care

In exclusive interviews, two prominent providers sound off on puberty blockers, 'affirmative' care, the inhibition of sexual pleasure, and the suppression of dissent in their field.

By Abigail Shrier
October 4, 2021

For nearly a decade, the vanguard of the transgender-rights movement — doctors, activists, celebrities and transgender influencers — has defined the boundaries of the new orthodoxy surrounding transgender medical care: What's true, what's false, which questions can and cannot be asked.

They said it was perfectly safe to give children as young as nine puberty blockers and insisted that the effects of those blockers were "fully reversible." They said that it was the job of medical professionals to help minors to transition. They said it was not their job to question the wisdom of transitioning, and that anyone who did — including parents — was probably transphobic. They said that any worries about a social contagion among teen girls was nonsense. And they never said anything about the distinct possibility that blocking puberty, coupled with cross-sex hormones, could inhibit a normal sex life.

Their allies in the media and Hollywood reported stories and created content that reaffirmed this orthodoxy. Anyone who dared disagree or depart from any of its core tenets, including young women who publicly detransitioned, were inevitably smeared as hateful and accused of harming children.

But that new orthodoxy has gone too far, according to two of the most prominent providers in the field of transgender medicine: Dr. Marci Bowers, a world-renowned vaginoplasty specialist who operated on reality-television star Jazz Jennings; and Erica Anderson, a clinical psychologist at the University of California San Francisco's Child and Adolescent Gender Clinic.

In the course of their careers, both have seen thousands of patients. Both are board members of the World Professional Association for Transgender Health (WPATH), the organization that sets the standards worldwide for transgender medical care. And both are transgender women.

Earlier this month, Anderson told me she submitted a co-authored op-ed to The New York Times warning that many transgender healthcare providers were treating kids recklessly. The Times passed, explaining it was "outside our coverage priorities right now."

Over the past few weeks, I have spoken at length to both women about the current direction of their field and where they feel it has gone wrong. On some issues, including their stance on puberty blockers, they raised concerns that appear to question the current health guidelines set by WPATH — which Bowers is slated to lead starting in 2022.

WPATH, for instance, recommends that for many gender dysphoric and gender non-conforming kids, hormonal puberty suppression begin at the early stages of puberty. WPATH has also insisted since 2012 that puberty blockers are "fully reversible interventions."

When I asked Anderson if she believes that psychological effects of puberty blockers are reversible, she said: "I'm not sure." When asked

whether children in the early stages of puberty should be put on blockers, Bowers said: “I’m not a fan.”

When I asked Bowers if she still thought puberty blockers were a good idea, from a surgical perspective, she said: “This is typical of medicine. We zig and then we zag, and I think maybe we zigged a little too far to the left in some cases.” She added “I think there was naivete on the part of pediatric endocrinologists who were proponents of early [puberty] blockade thinking that just this magic can happen, that surgeons can do anything.”

I asked Bowers whether she believed WPATH had been welcoming to a wide variety of doctors’ viewpoints — including those concerned about risks, skeptical of puberty blockers, and maybe even critical of some of the surgical procedures?

“There are definitely people who are trying to keep out anyone who doesn’t absolutely buy the party line that everything should be affirming, and that there’s no room for dissent,” Bowers said. “I think that’s a mistake.”

Bowers is not only among the most respected gender surgeons in the world but easily one of the most prolific: she has built or repaired more than 2,000 vaginas, the procedure known as vaginoplasty. She rose to celebrity status appearing on the hit reality-television show “I Am Jazz,” which catalogues and choreographs the life of Jazz Jennings, arguably the country’s most famous transgender teen.

In January 2019, Jeanette Jennings threw her famous daughter a "Farewell to Penis" party. Over a million viewers looked in on guests feasting on meatballs and miniature wieners in the Jennings' Mediterranean-style Florida home. Family and friends cheered as Jazz sliced into a penis-shaped cake. The rather complicated upcoming procedure came to seem as little more than a Sweet Sixteen.

By that point, Jazz was already Time magazine's top 25 most influential teen, the co-author of a bestselling children's book and the inspiration for a plastic doll. She had served as youth ambassador to the Human Rights Campaign, and she had about one million Instagram followers. Hers was no longer just a personal story but an advertisement for a lifestyle and an industry.

On the day of the procedure — dutifully recorded for Instagram — Jazz's sister, Ari, teasingly wiggled a sausage in front of the camera. As Jazz was about to be wheeled into the operating room, she snapped her fingers and said, "Let's do this!"

The vaginoplasty she underwent is what surgeons call a "penile inversion," in which surgeons use the tissue from the penis and testicles to create a vaginal cavity and clitoris. With grown men, a penile inversion was eminently doable. With Jazz, it was much more difficult.

Like thousands of adolescents in America treated for gender dysphoria (severe discomfort in one's biological sex), Jazz had been put on puberty blockers. In Jazz's case, they began at age 11. So at age 17, Jazz's penis was the size and sexual maturity of an 11-year-old's. As Bowers explained to Jazz and her family ahead of the surgery, Jazz didn't have enough penile

and scrotal skin to work with. So Bowers took a swatch of Jazz's stomach lining to complement the available tissue.

At first, Jazz's surgery seemed to have gone fine, but soon after she said experienced "crazy pain." She was rushed back to the hospital, where Dr. Jess Ting was waiting. "As I was getting her on the bed, I heard something go pop," Ting said in an episode of "I Am Jazz." Jazz's new vagina — or neovagina, as surgeons say — had split apart.

Gender dysphoria, which Jazz had suffered from since age two, is very real, and by all accounts, excruciating. For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was .01 percent of males (roughly one in 10,000).

For decades, psychologists treated it with "watchful waiting" — that is, a method of psychotherapy that seeks to understand the source of a child's gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body.

Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it — many go on to be lesbian or gay adults — the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn't always know best.

But in the last decade, watchful waiting has been supplanted by "affirmative care," which assumes children *do* know what's best. Affirmative care proponents urge doctors to corroborate their patients' belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don't, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the "right" body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery.

The widespread use of puberty blockers can be traced to the Netherlands. In the mid-1990s, Peggy Cohen-Kettenis, a psychologist in Amsterdam who had studied young people with gender dysphoria, helped raise awareness about the potential benefits of blockers — formerly used in the chemical castration of violent rapists. Pharmaceutical companies were happy to fund studies on the application of blockers in children, and, gradually, what's called the Dutch Protocol was born. The thinking behind the protocol was: Why make a child who has suffered with gender dysphoria since preschool endure puberty, with all its discomforts and embarrassments, if that child were likely to transition as a young adult? Researchers believed blockers' effects were reversible — just in case the child did not ultimately transition.

Cohen-Kettenis later grew doubtful about that initial assessment. "It is not clear yet how pubertal suppression will influence brain development," she wrote in the European Journal of Endocrinology in 2006. Puberty is not merely a biochemical development; it is also "a psycho-social event that occurs in concert with one's peers," Doctor William Malone, an endocrinologist and member of the Society for Evidence Based Gender

Medicine, told me. Hormones do not merely stimulate sex organs during puberty; they also shower the brain.

But at the very moment when Dutch researchers were beginning to raise concerns about puberty blockers, American health providers discovered it. In 2007, the Dutch Protocol arrived at Boston Children's Hospital, one of the preeminent children's hospitals in the nation. It would soon become the leading course of treatment for all transgender-identified children and adolescents in the United States. One of them was Jazz Jennings.

In 2012, a surgeon implanted a puberty blocker called Supprelin in Jazz's upper arm to delay the onset of facial hair and the deepening of her voice, among other things. Without these conventional masculine features, it would be easier, down the road, for doctors to make her look more feminine — more like the budding young woman she felt she was deep inside.

At the time, doctors knew less than they do now about the effects of puberty blockers. "When you enter a field like this where there's not a lot of published data, not a lot of studies, the field is in its infancy, you see people sometimes selling protocols like puberty blockers in a dogmatic fashion, like, 'This is just what we do,'" Bowers told me.

Once an adolescent has halted normal puberty and adopted an opposite-sex name, Bowers said: "You're going to go socially to school as a girl, and you've made this commitment. How do you back out of that?"

Another problem created by puberty blockade — experts prefer "blockade" to "blockage" — was lack of tissue, which Dutch researchers noted back in 2008. At that time, Cohen-Kettenis and other researchers noted that, in natal males, early blockade might lead to "non-normal pubertal phallic growth," meaning that "the genital tissue available for vaginoplasty might be less than optimal."

But that hair-raising warning seems to have been lost in the trip across the Atlantic.

Many American gender surgeons augment the tissue for constructing neovaginas with borrowed stomach lining and even a swatch of bowel. Bowers draws the line at the colon. "I never use the colon," she said. "It's the last resort. You can get colon cancer. If it's used sexually, you can get this chronic colitis that has to be treated over time. And it's just in the discharge and the nasty appearance and it doesn't smell like vagina."

The problem for kids whose puberty has been blocked early isn't just a lack of tissue but of sexual development. Puberty not only stimulates growth of sex organs. It also endows them with erotic potential. "If you've never had an orgasm pre-surgery, and then your puberty's blocked, it's very difficult to achieve that afterwards," Bowers said. "I consider that a big problem, actually. It's kind of an overlooked problem that in our 'informed consent' of children undergoing puberty blockers, we've in some respects overlooked that a little bit."

Nor is this a problem that can be corrected surgically. Bowers can build a labia, a vaginal canal and a clitoris, and the results look impressive. But, she said, if the kids are "orgasmically naive" because of puberty blockade, "the clitoris down there might as well be a fingertip and brings them no

particular joy and, therefore, they're not able to be responsive as a lover. And so how does that affect their long-term happiness?"

Few, if any, other doctors acknowledge as much. The Mayo Clinic, for instance, does not note that permanent sexual dysfunction may be among puberty blockers' risks. St. Louis Children's Hospital doesn't mention it, either. Oregon Health & Science University Children's Hospital and University of California at San Francisco don't. Nor was there any mention of sexual dysfunction in a recent New York Times story, "What Are Puberty Blockers?"

Jack Turban, the chief fellow in child and adolescent psychiatry at Stanford University School of Medicine, wrote, in 2018: "The only significant side effect is that the adolescent may fall behind on bone density."

But lack of bone density is often just the start of the problem. Patients who take puberty blockers almost invariably wind up taking cross-sex hormones — and this combination tends to leave patients infertile and, as Bowers made clear, sexually dysfunctional.

On an episode of "I Am Jazz," Jazz revealed that she had never experienced an orgasm and may never be able to. But she remains optimistic. "I know that once I fall in love and I really admire another individual that I'm going to want to have sex with them," Jazz said at 16, in an episode that aired in July of 2017.

In the year after her operation, Jazz would require three more surgeries, and then defer Harvard College for a year to deal with her depression. In 2021, she opened up about a binge-eating disorder that caused her to gain nearly 100 pounds in under two years.

Jazz has insisted she has "no regrets" about her transition. (I reached out to Jazz for an interview and never heard back). But subjecting patients to a course of serious interventions that cannot be scrutinized — even by experts — without one risking being tarred as anti-trans seems unlikely to be in anyone's best interest.

Bowers told me she now finds early puberty blockade inadvisable. "I'm not a fan of blockade at Tanner Two anymore, I really am not," she told me, using the clinical name of the moment when the first visible signs of puberty manifest. "The idea all sounded good in the very beginning," she said. "Believe me, we're doing some magnificent surgeries on these kids, and they're so determined, and I'm so proud of so many of them and their parents. They've been great. But honestly, I can't sit here and tell you that they have better — or even as good — results. They're not as functional. I worry about their reproductive rights later. I worry about their sexual health later and ability to find intimacy."

Bowers knows what the loss of fertility and sexual intimacy might entail: She has three children, all born before she transitioned, and she spent a decade tending to victims of female genital mutilation. "Those women, a lot of them experience broken relationships because they cannot respond sexually," she said. "And my fear about these young children who never experience orgasm prior to undergoing surgery are going to reach adulthood and try to find intimacy and realize they don't know how to respond sexually."

In 2007, the year the U.S. began implementing the Dutch Protocol, the U.S. had one pediatric gender clinic, and it overwhelmingly served patients like

Jazz: natal males who expressed discomfort in their bodies in the earliest stages of childhood. (At age 2, Jazz reportedly asked Jeanette when the good fairy would turn him into a girl. Jazz's own social transition did not appear to proceed from peer influence and predated social media.)

Today, the U.S. has hundreds of gender clinics. Most patients are not natal males, like Jazz, but teenage girls. I wrote a book about these girls, "Irreversible Damage," which was based on interviews with them and their families. Peer influence and exposure to trans influencers on social media play an outsized role in their desire to escape womanhood. Unlike the patients of the Dutch Protocol, who were screened for other mental health comorbidities, these young women almost always suffer from severe anxiety and depression or other significant mental health problems — and those problems are often overlooked or ignored.

When public health researcher and former Brown University Professor Lisa Littman dubbed this phenomenon "rapid onset gender dysphoria" in 2018, the university apologized for her paper and ultimately pushed her out. Activists called the hypothesis of a social contagion among teen girls a "poisonous lie used to discredit trans people."

But Littman's research about the sudden spike in teen girl trans-identification has become increasingly difficult to deny: A recent survey by the American College Health Association showed that, in 2008, one in 2,000 female undergraduates identified as transgender. By 2021, that figure had jumped to one in 20.

While both Anderson and Bowers pointed out that "ROGD" has yet to be accepted as a diagnosis, Anderson said: "At our clinic at UCSF, for two years

now running, we're running two to one natal females to natal males." Two to one.

"As for this ROGD thing," Bowers said, "I think there probably are people who are influenced. There is a little bit of 'Yeah, that's so cool. Yeah, I kind of want to do that too.'"

Anderson agreed that we're likely to see more regret among this teenage-girl population. "It is my considered opinion that due to some of the — let's see, how to say it? what word to choose? — due to some of the, I'll call it just 'sloppy,' sloppy healthcare work, that we're going to have more young adults who will regret having gone through this process. And that is going to earn me a lot of criticism from some colleagues, but given what I see — and I'm sorry, but it's my actual experience as a psychologist treating gender variant youth — I'm worried that decisions will be made that will later be regretted by those making them."

What, exactly, was sloppy about the healthcare work? "Rushing people through the medicalization, as you and others have cautioned, and failure — *abject* failure — to evaluate the mental health of someone historically in current time, and to prepare them for making such a life-changing decision," Anderson said.

I asked Bowers about the rise of detransitioners, young women who have come to regret transitioning. Many said they were given a course of testosterone on their first visit to a clinic like Planned Parenthood. "When you have a female-assigned person and she's feeling dysphoric, or somebody decides that she's dysphoric and says your eating disorders are not really eating disorders, this is actually gender dysphoria, and then they

see you for one visit, and then they recommend testosterone — red flag!" Bowers said. "Wake up here."

Abigail Shrier is the author of "Irreversible Damage," which the Economist named one of the best books of 2020. Read more of her work at her newsletter, The Truth Fairy.

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Tuesday, January 10, 2023

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Exhibit 8

Laura Edwards-Leeper & Erica Anderson, *The Mental Health Establishment is Failing Trans Kids*, WASH. POST (Nov. 24, 2021), https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/.

The mental health establishment is failing trans kids

Gender-exploratory therapy is a key step. Why aren't therapists providing it?

By Laura Edwards-Leeper and Erica Anderson

November 24, 2021 at 5:54 p.m. EST

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CORRECTION

A previous version of this essay said that a quarter of study subjects who reversed their gender transitions did not report this change to their doctors. In fact, three-quarters did not share the information.

At 13, Patricia told her parents she was a transgender boy. She had never experienced any gender dysphoria — distress at a disconnect between gender identity and the sex assigned at birth — she said. But a year earlier, she'd been sexually assaulted by an older girl. Soon after this trauma, she met another older girl who used they/them pronouns and introduced her to drugs, violent pornography and the notion of dissociation from her body. Her lingering psychic wounds, coinciding with a raft of new and unsettling ideas, plunged her into depression and anxiety. Patricia's parents took her to a therapist so she could talk through her shifting identity and acute mood swings.

The job of a mental health provider here should have been clear: Perform an assessment, ask how long she'd experienced dysphoria and investigate how mental health issues and any other changes in her life might be contributing to it. Instead, on first meeting, the therapist simply affirmed her new identity, a step that can lead to hormonal and eventually surgical treatments. Was Patricia ready for these next steps — or, her parents wondered, was this a normal bout of teenage confusion stemming from a recent trauma? The therapist instructed them to "support" their child's trans self-diagnosis and to socially transition her. If they didn't, Patricia might end her own life: 41 percent of unsupported children commit suicide, they were told. Would Patricia's parents rather have a dead child or a trans one?

They sought another therapist, one who was more curious and less certain, one who listened closely. After a year of exploring who she was, Patricia no longer felt she was a boy. She decided to stop binding her breasts and wearing boys' clothes.

We are both psychologists who have dedicated our careers to serving transgender patients with ethical, evidence-

based treatment. But we see a surge of gender dysphoria cases like Patricia's — cases that are handled poorly. One of us was the founding psychologist in 2007 of the first pediatric gender clinic in the United States; the other is a transgender woman. We've held recent leadership positions in the World Professional Association for Transgender Health (WPATH), which writes the standards of care for transgender people worldwide. Together, across decades of doing this work, we've helped hundreds of people transition their genders. This is an era of ugly moral panic about bathrooms, woke indoctrination and identity politics in general. In response, we enthusiastically support the appropriate gender-affirming medical care for trans youth, and we are disgusted by the legislation trying to ban it.

But the number of adolescents requesting medical care is skyrocketing: Now 1.8 percent of people under 18 identify as transgender, double the figure from five years earlier, according to the Trevor Project. A flood of referrals to mental health providers and gender medical clinics, combined with a political climate that sees the treatment of each individual patient as a litmus test of social tolerance, is spurring many providers into sloppy, dangerous care. Often from a place of genuine concern, they are hastily dispensing medicine or recommending medical doctors prescribe it — without following the strict guidelines that govern this treatment. Canada, too, is following our lead: A study of 10 pediatric gender clinics there found that half do not require psychological assessment before initiating puberty blockers or hormones.

The standards of care recommend mental health support and comprehensive assessment for all dysphoric youth before starting medical interventions. The process, done conscientiously, can take a few months (when a young person's gender has been persistent and there are no simultaneous mental health issues) or up to several years in complicated cases. But few are trained to do it properly, and some clinicians don't even believe in it, contending without evidence that treating dysphoria medically will resolve other mental health issues. Providers and their behavior haven't been closely studied, but we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery. As a result, we may be harming some of the young people we strive to support — people who may not be prepared for the gender transitions they are being rushed into.

American opinions about transgender youth have shifted dramatically in the past 15 years. The pendulum has swung from a vile fear and skepticism around ever treating adolescents medically to what must be described, in some quarters, as an overcorrection. Now the treatment pushed by activists, recommended by some providers and taught in many training workshops is to affirm without question. "We don't actually have data on whether psychological assessments lower regret rates," Johanna Olson-Kennedy, a pediatrician at Children's Hospital in Los Angeles who is skeptical of therapy requirements and gives hormones to children as young as 12 (despite a lack of science supporting this practice, as well), told the Atlantic. "I don't send someone to a therapist when I'm going to start them on insulin." This perspective writes off questions about behavioral and mental health, seeing them as a delaying tactic or a dodge, a way of depriving desperate people of the urgent care they clearly need.

But comprehensive assessment and gender-exploratory therapy is the most critical part of the transition process. It helps a young person peel back the layers of their developing adolescent identity and examine the factors that contribute to their dysphoria. In this stage, patients reflect on the duration of the dysphoria they feel; the continuum of gender; the intersection with sexual orientation; what medical interventions might realistically entail; social media, Internet and peer influences; how other factors (e.g., autism, trauma, eating disorders/body image concerns, self-esteem, depression, anxiety) may help drive dysphoria, rather than assuming that they are always a result of dysphoria; family dynamics and social/peer relationships; and school/academic challenges. The

messages that teens get from TikTok and other sources may not be very productive for understanding this constellation of issues.

There are several reasons the process can move too quickly and hurtle toward medical treatment. For one, the stigma around mental health in general, along with the trauma caused to transgender adults by the health-care field in the past (yes, including conversion therapy), has made our peers extremely skeptical of becoming "gatekeepers" — experts who deny the needed help because they supposedly know best. Slowing down the process and encouraging deeper, thoughtful exploration is considered, many tell us, unnecessary and unaffirming. Providers may also be afraid of being cast as transphobic bigots by their local colleagues and referral sources if they engage in gender exploring therapy with patients, as some have equated this with conversion therapy. We've personally experienced this backlash at professional conferences.

All this means only that the purpose of assessment is improperly understood. The approach WPATH recommends is collaborative and aims to provide a developmentally appropriate process that involves the parents and takes the complexities of adolescence into consideration. (The constituency of agitated parents who feel excluded is also growing rapidly. These are not conservative evangelicals who don't believe trans people exist or deserve treatment. They're usually progressive, educated, loving people who all say, *If our kid is really trans, we'll fully support them. We just want to be as sure as possible, and we can't find a provider who will actually engage in gender exploring therapy. Instead, doctors and psychologists and social workers are ready to start hormones after one short visit*.)

Another reason that teens can receive substandard mental health care is that gender clinics are disastrously overwhelmed. Most have a single social worker who completes a brief "intake," relying instead on other mental health clinicians in the community to assess patients and offer their conclusions. Frequently, those community clinicians, just like the parents, assume that a more comprehensive assessment will occur in the gender specialty clinic. But in our experience, and based on what our colleagues share, this is rarely the case. Most clinics appear to assume that a referral means a mental health provider in the community has diagnosed gender dysphoria and thereby given the green light for medical intervention.

When working in gender clinics, we've also both received letters from therapists who had "assessed" patients they were referring to us. An astonishing number of these were nothing but a paragraph that stated the youth identified as trans, had dysphoria and wanted hormones, so that course was recommended. There are nearly 200,000 members of the American Psychological Association and the American Psychiatric Association. Add to that the clinical social workers, marriage counselors and family therapists. The overwhelming majority of those well-intentioned professionals receive limited or no training in the assessment of gender-diverse youth. (We receive requests frequently from people eager for more comprehensive, nuanced trainings, which we both deliver.) In simple terms, the demand for competent care has outstripped the supply of competent providers.

In professional circles, we hear from pediatric endocrinologists and others who prescribe hormones for trans youth. Many openly discuss how they use the adult informed-consent model of care with their teen patients, which almost always means no mental health involvement and sometimes no parent input, either. "If you are trans, I believe you," says A.J. Eckert, the medical director of Anchor Health Initiative in Connecticut. Eckert is wary of psychologists who follow the guidelines by completing a comprehensive assessment before recommending medical intervention for youths. "Gender-affirming medicine," Eckert holds, means that "you are best equipped to make decisions about your own body," full stop. These providers do not always realize they've confessed to ignoring the standards of care. (Contacted by The Post for comment on this essay, Eckert said that "no medical or surgical interventions are provided to anyone who has not started puberty" but added that, as Anchor Health sees it, "Therapy is not a requirement in this approach because being trans is not a pathology.")

Some providers may move quickly because they believe that an adolescent's clarity around their gender identity is no different than that of transgender adults, whose care is now typically based on simple informed consent. Some assume that a person with gender dysphoria who declares they are transgender is transgender and needs medical interventions immediately. Yet we know this is not always true. In a recent study of 100 detransitioners, for instance, 38 percent reported that they believed their original dysphoria had been caused by "something specific, such as trauma, abuse, or a mental health condition." Fifty-five percent said they "did not receive an adequate evaluation from a doctor or mental health professional before starting transition."

A handful of studies supposedly showing the suicide risk of gender minority youth who are not supported are also not entirely conclusive. The term "support," for instance, is defined differently across studies, and it is never defined as "starting medical interventions." Supporting trans youth may include using the correct name/pronouns or allowing the young person to present in a way that aligns with their affirmed gender (e.g., clothing, hairstyle). These studies also show correlations between teen-transition hurdles and suicidality, but not causal relationships. Suicide is a horrifying outcome for too many gender-diverse youth, but its specter should not be used to push forward unrelated medical treatment without professional care or attention for each patient.

Longer-term longitudinal studies are needed to better understand the role of medical interventions on lifetime psychological health, particularly with the newer subset of adolescents presenting with no childhood dysphoria and significant mental health concerns. Research is needed to help determine whether quick medical treatment or a more cautious approach is best in these cases. Based on our experience with patients, we suspect that there will be variability based on age, when gender identity questions first emerged and other factors — which is why an individualized approach with careful assessment is so critical.

Trans youth, more than most patients in the health-care system, require an interdisciplinary approach: Their doctors rely on mental health colleagues for direction, and it is crucial that those therapists take the reins. Without proper assessment, many youths are being rushed toward the medical model, and we don't know if they will be liberated or restrained by it. National figures do not yet exist, but the rising number of detransitioners that clinicians report seeing (they are forming support groups online) indicates that this approach can backfire. This is not the most common outcome of a transition process, but it is hardly unheard of, either. These are typically youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it later. Only a quarter of them told their doctors they had reversed their transitions, making this population especially hard to track.

Many trans activists want to silence detransitioners or deny their existence, because those cases do add fuel to the conservative agenda that is pushing to deny medical treatment to all transgender young people. (Those conservative views are unacceptable, and medically unsound.) Instead, we should be learning from them and returning to the empirically supported careful assessment model recommended by WPATH. And none of this means that we shouldn't be listening to the views of gender-diverse teens; it only means that we should listen in the fullest and most probing way possible.

The pressure by activist medical and mental health providers, along with some national LGBT organizations to silence the voices of detransitioners and sabotage the discussion around what is occurring in the field is unconscionable. Not only is it harmful to detransitioned young people — to be made to feel as if their lived experiences are not valid, the very idea that the gender-transition treatment is meant to remedy — but it will undoubtedly raise questions regarding the objectivity of our field and our commitment to help trans people. The fact that some people detransition does not mean that transgender people should not receive the services they need.

The energy currently spent fighting this political battle would be much better directed toward improving care for all gender-diverse young people. They deserve nothing less.

Exhibit 9

Joint Letter from USPATH and WPATH (Oct. 12, 2022), https://www.wpath.org/media/cms/Documents/Public%20Policies/2021/Joint%20WPATH%20USPATH%20Letter%20Dated%20Oct%2012%202021.pdf.

WPATH
WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

USPATH
UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

Joint Letter from USPATH and WPATH

The United States Professional Association for Transgender Health (USPATH) and the World Professional Association for Transgender Health (WPATH) stand behind the appropriate care of transgender and gender diverse youth, which includes, when indicated, the use of "puberty blockers" such as gonadotropin releasing hormone analogs and other medications to delay puberty, and, when indicated, the use of gender- affirming hormones such as estrogen or testosterone. Guidelines for the assessment of transgender and gender diverse youth, as well as for the use of pubertal delay and gender affirming hormone medications have been published by reputable professional bodies, including the Endocrine Society, the World Professional Association for Transgender Health, and the American Psychiatric Association.

USPATH and WPATH support scientific discussions on the use of pubertal delay and hormone therapy for transgender and gender diverse youth. We believe that such discussions should occur among experts and stakeholders in this area, based on scientific evidence, and in fora such as peer-reviewed journals or scientific conferences, and among colleagues and experts in the assessment and care of transgender and gender diverse youth. USPATH and WPATH oppose the use of the lay press, either impartial or of any political slant or viewpoint, as a forum for the scientific debate of these issues, or the politicization of these issues in any way. Furthermore, individual decisions about gender- affirming interventions and treatments for transgender and gender diverse youth should be made only among the patient, their parent(s) or guardian(s), their medical and mental health provider(s), and any other identified stakeholders on a case-by-case basis, and opposes any attempts to dictate or restrict, by statute, judiciary, or otherwise, access to such treatment when recommended according to accepted standards and guidelines.

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Exhibit 10

Genevieve Gluck, *Top Trans Medical Association Collaborated With Castration, Child Abuse Fetishists*, REDUXX (May 17, 2022), https://reduxx.info/top-trans-medical-association-collaborated-with-castration-child-abuse-fetishists/.

The World Professional Association for Transgender Health (WPATH), the international association which sets guidelines for the medical 'transitioning' of children, has been collaborating with participants of a fetish forum that hosts and produces fictional child pornography and extreme sadomasochistic content.

On December 3, 2021, WPATH released draft guidelines which included, for the first time, the category of 'eunuch' as a protected "gender identity." WPATH's updated 8th edition of their Standards of Care (SOC), which recommends medical treatment and services for those with a self-declared 'gender identity,' describes the relationship between "eunuch-identified people and other transgender people."

The document states, "Eunuch-identified people may share with other gender-diverse people a desire for reduction or elimination of masculine physical features, masculine genitals, or genital functioning."

It also goes on to claim that "eunuch-identified people may suffer the same minority stress as other stigmatized groups," and refers extensively to research collected from a hardcore fetish site called the Eunuch Archives — a site that features child sexual exploitation fantasies centered around stopping little boys from going through puberty.

The Eunuch Archive began in the late 1990s in collaboration with Body Modification Ezine (BME) and was initially hosted on the same site. BME achieved some notoriety in the early 2000's for a viral video titled "Pain Olympics" which featured men mutilating their genitals on camera.

Prior to the official launch of the Archive itself, members would congregate on a Usenet forum by the same name, which advertised itself in a newsgroup dedicated to sadomasochism: alt.sex.bondage, a discussion group credited with coining the acronym BDSM in 1991.

In the newsgroup alt.eunuchs.questions, members shared castration fantasies, offered services, traded castration photos and videos, sought to connect with young men to "feminize," asked for advice on chemical castration, and recommended doctors willing to perform surgeries without psychiatric evaluations.

An FAQ document published at the beginning of the site's development recommended several other torture and bondage pornography forums for users to share images and request "cutters."

Notably, Usenet forums were the target of the FBI's first investigations into internet-based pedophile rings, as it provided a space for organizing and exchanging of child sexual abuse materials, including written pornography.

Once the Archive was established, many of the notable members moved over to it.

DURING A MONTHS-LONG INVESTIGATION INTO THE FORUM, REDUXX FOUND THAT A NUMBER OF THOSE MEMBERS APPEAR TO HAVE BEEN DIRECTLY INVOLVED IN THE DEVELOPMENT OF PSYCHIATRIC AND MEDICAL STANDARDS RELATED TO GENDER IDENTITY AFFIRMATION.

One of the Eunuch Archives' most prominent participants is an unidentified site administrator who uses the moniker 'Jesus.'

'Jesus' claims to have been involved in editing the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), issued by the American Psychiatric Association (APA) and WPATH's newest Standards of Care draft.

In 2010, the pseudonymous 'Jesus' posted to the forum on how WPATH authorities had come to perceive the term "gender identity disorder" as outdated, saying he was in attendance at a 2009 meeting in Oslo, where there was consensus to implement the term "gender dysphoria" in the subsequent edition of the Standards of Care.

"The draft for the next edition of the Diagnostic and Statistical Manual of Mental Disorders (the DSM-5) suggests 'Gender Incongruence,' which I much prefer," he wrote, "The body and mind are out of sync, with no mental illness implied!"

In 2016, 'Jesus' claimed to have been specifically chosen to rewrite a portion of the Standards of Care by former WPATH president Eli Coleman, who "pointed at me and announced that I was expected to provide input on eunuchs for the revision. Now is our opportunity to help devise the standards of care that will be most helpful," wrote Jesus.

In 2018, 'Jesus' announced the upcoming revisions to the guidelines and invited collaboration from members of the community.

In response to WPATH's newly-released draft Standards of Care in December last year, one site member professed to being "absolutely delighted," and said he would "gladly throw millions under the bus" in order to secure "a future where doctors must obey and have no right to demand reasons or withhold surgery and medication."

In WPATH's draft Standards of Care, the Eunuch Archive's 'Fiction Archive' is directly acknowledged and named. But the document does not mention the large amount of stories within the archive that directly involve the sadistic sexual abuse of children.

The stories primarily focus on the eroticization of child castration. In some, little boys request the procedures themselves and express gratitude to the adults who perform the operations. In others, children may be forcibly castrated under extreme duress. Some narratives contain violent sexualized depictions of children with stunted puberty being raped by doctors, written in sickening detail.

During our investigation, *Reduxx* was able to enter a password-protected area of the site within the Eunuch Archives community by completing a membership application.

New members who apply for registration are presented with a series of boxes to tick depending on their interest in joining the forum. Among the options are 'transgender, nullification, forced castration, and female superiority / dominance' – a BDSM genre commonly referred to as "femdom."

Within the protected fiction archives, there were over 3,000 stories involving minors, including the explicit sexual abuse of children, and 'minor' was a specially-curated tag that users could select to easily access stories specifically featuring children.

The fictional pornography includes themes such as Nazi doctors castrating children, baby boys being fed milk with estrogen in order to be violently sex trafficked as adolescents, and pedophilic fantasies of children who have been castrated to halt their puberty, 'freezing' them in a childlike state.

A long-standing site contributor with connections to WPATH is Dr. Krister Hildahl Willette, who, according to his Facebook profile, studied Medical Sciences at Ohio State University.

Willette uses the moniker 'Kristoff' on the forum, alongside an avatar of a nun with a photograph of his face superimposed, hiking up her habit to reveal lingerie and a pink chainsaw.

In June 2009, Willette was invited by WPATH to speak on "The Development of Standards of Care for Individuals with a Male-to-Eunuch Gender Identity Disorder" at a conference in Oslo. In May 2010, the contents of Willette's Oslo lecture were published in *The International Journal of Transgenderism*, an academic journal issued by WPATH. Willette, who co-authored the report, sources surveys conducted with the participation of members of the Eunuch Archives.

"A large number of men with gender dysphoria who desire to be emasculated do not fit the classical pattern of MtF transsexualism," reads the abstract. "They loathe their manhood, but do not identify as, nor wish to be, female. Instead, they seek castration to become something outside the binary sexes."

IN 2011, WILLETTE PRESENTED A PAPER TITLED "BODY INTEGRITY IDENTITY DISORDER AND CASTRATION" AT A *WPATH* SYMPOSIUM IN ATLANTA, GEORGIA, AGAIN ARGUING FOR THE INCLUSION OF INDIVIDUALS WITH A "MALE-TO-EUNUCH GENDER IDENTITY DISORDER."

There are two disturbing videos of Willette posted to his Youtube channel. In both, he is dressed in a nun's habit, holds a cigar, and shouts obscenities. In "Sister Krister on Cussing," he roleplays as though addressing an audience of children while reading out a list of swear words.

In the other, "Sister Krister's Safe Sex Message," he waves around a condom while addressing children about the importance of prophylactics.

Willette has made many repeated appeals for financial contributions from forum members. According to a 2019 post by Willette, the website at that time received over 20 million hits per month and was run on seven different servers, a situation that he was personally subsidizing.

Donations were being accepted via Paypal and through a "charitable educational corporation" set up by Willette. Donors were instructed to send cash payments to a P.O. Box in Minneapolis registered under the name Wyrm Wyvern.

Documents obtained by *Reduxx* reveal that Wyrm Wyvern was dissolved by the state of Minnesota for a violation of the Nonprofit Corporation Act, which asserts that the organization's activities may not be for "personal gain."

For nearly two decades, the Eunuch Archive has hosted an annual "Meeting of Members." The event is held in Minneapolis, Minnesota, Willette's area of residence, and is co-hosted by Willette and the pseudonymous Jesus.

Minneapolis is also where WPATH's headquarters were based for years, as well as the city where former WPATH president Eli Coleman currently lives and works. Coleman served as a lead chair overseeing the most recent updates to the WPATH Standards of Care.

In 2008, a group of researchers from Canada and California collaborated on a research project on the topic of the male castration fetish and published their findings in a paper titled, *A Passion for Castration: Characterizing Men Who Are Fascinated with Castration, but Have Not Been Castrated*.

According to the research, the majority (52%) of "wannabes" who fantasized about castration — whether chemical or surgical — selected sexual fantasy as their origin of interest in castration. Several respondents wrote about becoming sexually aroused when witnessing animal castration.

Over seven hundred individuals responded to a survey shared on The Eunuch Archive, describing their reasons for their 'ambition toward eunuchdom.'

"For some, castration was a very important first step toward an MtF transition," the study's authors noted. "As MtF transsexuals, they sought to rid their bodies of unwanted testosterone, with or without supplemental estrogen to further their transition."

One respondent wrote of his desire for "becoming 'it'—a submissive guy without sex drive. More common was the slave metaphor, 'as a slave it would allow a greater focus on serving the pleasure of the Master.'"

UPDATE 5/21/22: *Reduxx has now learned the identity of the top site members mentioned in this piece who were previously unable to be identified. A comprehensive follow-up has now been published revealing 'Jesus,' a member of the forum who works extensively with WPATH, is a Professor Emeritus at California State University Chico.*

This investigation was made possible by Reduxx's generous donors and supporters. ***Reduxx is an unapologetically pro-woman, pro-child safeguarding source of news and opinion. We 100% reader-funded!*** *Support our mission by joining our Patreon, or consider making a one-time donation.*