Deep Cuts: Zines as Community Archive of DIY Medical Transition in 1990s-2010s America

Due to barriers for transgender (trans) people to access gender transition healthcare, many are choosing Do-It-Yourself (DIY) methods of medical transition. The DIY trans subculture began as a grassroots movement and survival strategy in 1970s and 1980s America, when medical transition and gender clinics were expanding but barred trans people from gaining access. Whisper networks in the 1970s spread knowledge of trans women experimenting with synthetic livestock hormones, smuggling estrogen across the U.S.-Mexico border for others in their community, and conducting self-orchiectomies—removal of the testes—with under the (operating) table assistance from a sympathetic doctor. Pilot clinics started by collectives in the 1980s, such as the Transsexual Action Organization (TAO), offered gender-affirming surgery at a fraction of the cost of surgeries at medical establishments (Gill-Peterson 2022).

Although these stories and many others circulated widely, resources and guides on DIY transitioning did not appear in trans print culture until the 1990s, when the Internet began to play a crucial role in information dissemination, as well as online commerce for pharmaceuticals that were often trans people's only viable option for procuring hormones. Small-circulation and self-published words and images, or zines, were produced by individuals and small collectives and circulated physically and digitally. In this paper, based on analysis of zines produced from the 1990s-2010s, I will argue that responses from American trans people to the development of medical transition can be sorted into three concurrent trends: manipulation of medical institutions to gain access to care, rejection of institutions and subsequent self-administration of care, and complete rejection of trans medical care for its conditions of assimilation. I will also discuss the origins of these categories in the history of the trans and intersex human sciences.

I should note that I will use terms from zines that are now considered obsolete or offensive by some, such as transvestite, transsexual, and sex reassignment, in their original, historical context. Moreover, I must mention that historiographies of trans DIY are limited, due to a lack of research and meta-analyses, incomplete medical archives, and obscure terminology or lack of identification with transness. Thus, it is difficult to estimate the prevalence of different responses among trans people, as well as time-variant overlaps in response. Relative prevalence is gleaned from the ubiquity of zines found in the Digital Transgender Archive, the Queer Zine Archive Project, and TransReads, three of the most accessible digital archives of zines created by queer and trans people, though this is certainly an imperfect method.

As Lichen (2023) notes, before medical transition was available, all social transitions were in a way DIY: the medicalization of transness resulted in the medicalization of trans DIY. New medical language for transness did not achieve bodily freedom for trans patients, but instead subjected them to physical, emotional, social, and psychic scrutiny (Phillippa 4). The medicalization of transness has its origins in the study of intersex bodies. Successful attempts to forcibly normalize intersex bodies with non-normative female and/or male characteristics suggested a temporary timeframe in which sex could be reassigned. Sex was first defined by the presence of gonads, and then hormone levels, where the presence of a testis or ovary, and later the dominance of testosterone or estrogen, determined the patient's 'real' sex, regardless of the rest of their body or their sense of self (Gill-Peterson 2018, 96). These paradigms were insufficient in practice, as too many intersex patients "exceeded its narrow definition of 'true' binary sex" by having both male and female gonads or discrepancy among gonads, hormone levels, and other markers of sex like secondary sex characteristics (Gill-Peterson 2018, 73). Thus, the indeterminacy of intersex bodies threatened the conceptual collapse of the sex binary,

leading to the concept of gender as a psychosocial dimension of sex. Unlike sex, which was determined by physical characteristics, gender was based on assigned sex at birth. Sex reassignment now considered both the feasibility and social reception of medical interventions: sex optimization needed to match the gender assigned at birth. Under this definition, gender was a stricter phenotype than sex, for the gender binary did not need to accommodate the natural 'mix' of masculine and feminine physicality observed in intersex patients. Through this sex-gender slippage, transgender patients were systematically barred from accessing medical transitions due to having a 'normal' physical form: their sex and gender already aligned.

Trans people who were aspiring patients carefully manipulated medical professionals and their own bodies to gain access to safe and reliable transition healthcare. Gill-Peterson (2018) describes the case of Agnes, a young trans girl who pursued her own hormonal transition by stealing estrogen pills from her mother and then presenting her changed body as proof of an intersex condition, successfully convincing doctors (123-124). Transfeminine people are documented to have castrated themselves in order to force emergency genital operations; unlike the self-orchiectomies mentioned before, these were not performed with medical guidance and would not heal properly (Gill-Peterson 2018, 137). Mascara & Hope echoes this practice in their guide for navigating transfeminine medical transition in the UK, a process they describe as "diamonds through a perforated colon" (2013, 2). They outline an onerous process for acquiring approval for care, as "the only thing they test you on is whether you can put up with their shit for two years. This is their primary diagnostic tool" (8). This timeline is punctuated with instances where the reader will need to manipulate an uncooperative practitioner or an institution to continue the process in a timely manner. Recommendations include full-time gendered presentation during the probationary period before treatment; never discussing doubts about

transition with a practitioner; ignoring questions meant to "gatekeep" treatment, such as ones about sexuality or mental health (12-14, 22). Gender Machine Works accomplishes something similar for transmasculine readers and includes additional information about harm reduction, such as regular chest exams for breast cancer and safe sex practices (2002, 9-18, 23-26). Likewise, *Queersafe* discusses a thorough list of STIs, penile and vaginal health, and safe sex practices for queer and trans people, regardless of their genitalia. Potter et al. write, "whether a flesh penis, a dildo, a zucchini…it still needs to be protected" (2006, 25).

Holt (1995) applies a similar ethos of manipulation to law in an argument for transsexuality to be legally categorized under disability, suggesting that trans people should take advantage of legal loopholes to secure equal rights and legal protections. Based on precedent, other methods of securing this protection, such as sex discrimination lawsuits and the freedom of expression argument, were inadequate, since transsexuals were not a protected class, and transsexuality was not a choice. Thus, she cites the DSM-IV definition of Gender Identity Disorder to construct trans people as a protected class under medical disability, which would "demand accommodation by employers, housing authorities, government managers," ensure that transness was also protected from discrimination, and promote governmental support of trans medical care (16-17).

While self-advocacy allowed American trans patients the agency to explain their own needs and manipulate systems as needed, it forced them to navigate medical and legal language that was clearly biased against them and their allies in medical institutions. Indeed, Beatty (1994) cautions medical professionals against exhibiting a "pro-trans bias," lest it affect their credibility and abilities to make change (37). Trans activist Rachel Pollock, in conversation with Gabriel (1995), compares the American practice of self-advocacy to her experience receiving transition

healthcare in Denmark, where the medical ethos was that "it is not up to you to prove something to the doctors, it's up to you to know what you're doing" (Gabriel 1995, 46). She noted a significant difference in that "there's not as much shopping around for surgeons as you have here [in America]," due to nationalized health insurance (Gabriel 1995, 46). Pollock argues that aspiring patients should have "a great deal of self-knowledge" and self-assessment prior to getting surgery, with regards to their motivations and realistic expectations of the procedure (Gabriel 1995, 56).

At the same time, Beatty cautions aspiring patients against adopting a genital paradigm of gender for its uneven focus on surgical interventions, suggesting that "there is an unspoken pressure to want surgery and to obtain it" (1994, 37). Denny (1995) similarly argues against the "divination of surgery;" she calls it merely "an option, not a holy rite" (52-53). Sally (1995) responds to these sentiments in a later issue of *TransSisters*. She disagrees with these claims of pressure to get surgery, citing the complicated process of being approved for procedures, suggesting that patients may instead be feeling "post-op [operation] remorse" since "hermaphroditism" or gender nonconformity were no longer an option. By staging these claims, patients are representing surgery as unnecessary, but this compromises the right to healthcare for people who require surgery to alleviate their dysphoria (54). Sally's arguments were corroborated by other contributors to the same issue of the zine.

Despite these debates, most zines about navigating trans healthcare did not make any arguments about the necessity of medical transition or the state of trans healthcare, but simply gave information about a person's options for treatment. Theis included detailed descriptions of various surgical and hormonal interventions, criteria for access, and portrayals of the authors' lived experiences of these procedures. The difficulty of accessing care was discussed in almost

every work. Altadonna explained that according to the Harry Benjamin International Gender Dysphoria Association's (HBIGDA) standards of care, she had to first see a therapist for three months, undergo testing and examination by a licensed psychiatrist, and complete a 300-question survey (that she suspected "was to determine whether or not I was clinically insane") before consulting an endocrinologist (2007, 3). Samb warns aspiring patients that getting approved for medical transition is only the first obstacle, as it took multiple tries to find treatments and healthcare providers suited to their needs:

> "8 different prescriptions + 7 different withdrawals + 6 counselors + 6 years of medication + 3 family doctors+ *[sic]* three suicide attempts + 2 naturopaths + 2 mental health diagnoses + 2 psychologists + 2 years of mental health advocacy work + 1 psychiatrist + 1 herbalist + […] + a wide support network" (2005, 7).

Though this brutal honesty may seem like fearmongering, Samb arguably wishes to minimize the arguably worst parts of their experience: they spell out "three suicide attempts," which attracts less attention than using the numeral "3," and end the list on a positive note.

Writers detailed the physical effects of their medical transitions. Altadonna illustrated the biochemical mechanisms driving her various therapies, such as spironolactone and the synthetic estrogen Premarin, as well as how the mind and body change in response. For some, being on female hormones felt euphoric. For others, it felt like going through puberty again, both in terms of emotional havoc and the growing pains of developing new secondary sex characteristics (Altadonna 2007, 4-6). Readers were also warned of the practical consequences of medical transition. Norma's diary detailed her experience with electrolysis, hormone replacement therapy (HRT), psychiatry, legal name change, and surgery. She documented her motivations, day-to-day emotions of "the woman in me," and complications such as losing her job after changing her

gender presentation and having to pay out of pocket for the procedure (1994, 39-43). Altadonna reveals the high cost of her treatment medically and financially: her treatment has rendered her low-libido and sterile, and her starting supply of pills cost over 100 dollars (2007, 3-4, 7).

I will note here that the majority of zines analyzed for this paper were written from a transfeminine perspective, so there is limited insight into the physical experiences of transmasculine transitions. "Transmasculine resources are practically non-existent [...] we almost don't have anything written on us," professed Tristan, a trans organizer in Montreal. In this 1993 interview, he urges his transmasculine peers to join together in advocating for further research in transmasculine genital surgery, but at the time of writing, the three digital archives I consulted still contained a limited number of contributions from trans men, of which few explicitly discussed medical transition ("Conversation with Tristan," 11). This gap may be due to the fact that transfeminine people have been able to procure estrogen more easily than transmasculine people due to the governmental regulation of testosterone, as seen in the case of Agnes (Gill-Peterson 2018, 123). Moreover, transfeminine genital surgeries were more advanced than the respective transmasculine surgeries for creating neogenitals that functioned similarly to perisex, cisgender genitals (i.e. where gonads, genitals, and hormones match a typically male or female profile). This trend carried into the trans medical imagination. Brown (1995) gave fantastical suggestions for alternatives to surgical sterilization—nonexistent at the time, but theoretically feasible—surgeries which leave gonads intact while constructing the desired external genitalia. Her proposed transfeminine surgery could use existing tissue to construct a neovagina, but her proposed transmasculine surgery would use synthetic materials like biocompatible polymers to construct the neopenis (59).

Zines rarely addressed medical professionals, who were not expected to be readers of trans print culture due to demonstrated neglect of their patients. An appropriated article from the American Educational Gender Information Service (AEGIS) in *Gendertrash* (1995) reports that some surgeons do not appreciate the extent of dysphoria caused by vaginoplasties that use scrotal inversion and result in a hair-bearing vagina: a surgeon remarked at a HBIGDA meeting that his patients "did not seem to mind" these results, contradicting testimonials collected by AEGIS (4). Though the article concludes with some recommendations to surgeons, its reprinting was clearly intended as a warning for aspiring patients. Likewise, in a 1995 issue of *Transisters*, Stoehn urges trans women who are prescribed Premarin to switch to an alternative, plant-derived synthetic estrogen that is identical in efficacy and price. By highlighting her reader's ignorance of the animal abuse involved in producing Premarin, she tacitly suggests that the doctors prescribing the hormones are withholding valuable information from their patients, since there may be health risks associated with using Premarin (14). Ogborn and Chase (1994) are more direct in their claim. They detail a self-experiment on orgasm after genital surgery, which was conducted by seventeen post-operation transsexual women and one intersex woman. They report high prevalence of sexual dysfunction after surgery, and suggest that this information has been masked from their peers by surgeons who prioritize appearance and function in heterosexual intercourse over sensation and orgasm. They suspect that transgender patients are unable to discuss this issue amongst themselves, for "any criticism of SRS [sex reassignment surgery] surgical results may endanger the very availability of surgery in the future," an availability that was already restricted and precarious (22). The authors end with recommending that surgeons collect unbiased post-surgical reports of sexual function and educate their patients on risks and outcomes as a "part of the process of obtaining informed consent" (Ogborn and Chase 1994, 22).

Due to incidents like these, the most recent of a history of exploiting and mistreating intersex and trans patients, many trans people distrusted the medical establishment, but still desired to undergo medical transition. Arguably, a number of these people sought to control their own transition after experiencing systematic discrimination from medical institutions. The most 'meta' zines of the trans DIY subculture are those about DIY HRT, the procurement and self-administration of hormones. DIY HRT is still practiced today, arguably in greater numbers due to the greater availability of hormones through online pharmacies and other extragovernmental establishments. It is estimated that anywhere between 20% and 80% of trans people in urban areas self-administer HRT, though these figures are variable due to the lack of comprehensive research (Edenfield et al. 179).

Transgender herbalism, or plant alternatives to hormone therapies, create possibilities for autonomous, cooperative, and DIY health practices that resist institutional and hierarchical arrangements of power and knowledge. FlyingOtter, author of the zine *The Transgender Herb Garden*, argues that both herbs and pharmaceuticals require optimization periods, mainly through trial-and-error and a calibrated bodily self-knowledge (2009, 1). She describes specific estrogen-like herbs, combinations, and routines for facial and body feminization in the form of fat redistribution, and hopes that similar zines will be written from a transmasculine perspective on masculinizing herbs, such as the testosterone-like ashwagandha (FlyingOtter 2009, 1-2, 5-6).

Zines about DIY HRT thus inverted power dynamics with regards to information gathered on trans people, who could now use it to their benefit to administer and control the care they did not receive from healthcare providers. Their treatment was situated in their self-knowledge of gender, rather than superficial medical theories or experimentation. Indeed, DIY is based in self-determination, which includes non-normative methods of presentation; not

everyone could afford surgery nor wanted it. There was a sexual element to this phenomenon: some trans people constructed their gender through their sexuality. *Fucking Trans Women* by Mira Bellwether, perhaps the most notable zine about non-normative bodies and sex, finds common ground with a lesser-known zine from 2003 by Jess Dugan, *Gender Fuck Me.* Dugan, who is transmasculine and genderfluid, on testosterone, and does not have a penis, but he describes having sex with his partner as "fuck[ing] you with my dick of a hand" and "your gender meet[ing] my mouth" (2003, 11-12, 15). His definition of "genderfuck" is simultaneously gender nonconformity and non-conforming sexuality, echoing the original medical definition of sex, meaning both 'biological sex' and sexuality. He toys with medical institutions' initial conflation of transness with transvestism and homosexuality, at a time when transvestism and other temporary expressions of gender nonconformity were practiced for primarily occupational reasons, such as nightlife or sex work, and did not require medical transition (Dugan 2003, 11-12; *From Cross to Trans* 2010, 6). Transvestites were more acceptable to cisheterosexual society since their gender expressions were generally reversible; transgender people were deemed "hormone queens" for permanently altering their gender expression (Heaney 2017, 258).

The final category of zines are those which reject medical transition wholesale, a response to the earlier forced normalization of intersex bodies through surgery and HRT, as well as the later conditions of trans assimilation to access medical transition. In the 1970s, the World Professional Association for Transgender Health (WPATH) formed and released the first edition of standards of care for trans healthcare (Edenfield et al. 178). These guidelines emphasized informed consent and agency and provided information on the types of hormonal and surgical interventions, but undermined their ethos by making this care conditional. WPATH advocated for an incremental process of accessing surgery, which required third-party consent from

practitioners through extensive medical and psychiatric evaluation, hormone therapy, a trial period of living publicly in the desired (binary) gender identity, and presenting as cisgender heterosexual after completing medical transition. The tacit expectation that a medically transitioned trans person will assimilate into the cisgender population and no longer publicly associate with transness held a certain eugenic logic. This politic of invisibility was strengthened by the condition of assimilation immediately before and after transition, which impaired the public imagination of transness and forcibly disappeared transness in favor of the sex and gender binary. Trans people certainly desired to be invisible and "pass off as genetic," but doing so naturally undercut the state of trans advocacy ("Conversation with Tristan" 1993, 11-12). Zine contributors in opposition to these conditions politicized visibility as a form of activism by refusing to "model ourselves on cis bodies and lives" (Lang/Levitsky 2021, 4). Kylie Paintain (1997) concurs, "until very recently transsexuals where *[sic]* supposed disappear once they had 'successfully' transitioned but now there are a growing number of us who will not disappear [...] If that means distorting other peoples *[sic]* safe views on what is gender then so be it" (22).

Rejection of medical transition as a whole rejected the paradigm of "nontranssexual people being the model for transsexual people," as Pollack puts it (Gabriel 1995, 57). Indeed, the glorification of institutional trans medical care led to self-surveillance and adherence to a narrow, binary script of transness to maintain access to care. Borck & Moore (2019) argue that the recursive "production, consumption, and reproduction" of these scripts only further restrict the definition of what medical institutions consider transness (632). People who rejected a complete assimilationist philosophy, but still wished to pass, might decide to socially transition without the use of medical interventions. Guides to social transition have roots in trans literature that predate widely accessible medical transition, such as guides to femininity from the 1970s (Slavik 1975,

1-2). Mona X (1996) explains multiple techniques for chest masculinization through binding, as well as their efficacy based on anatomy. A 2003 zine includes illustrations of some of these techniques, juxtaposing them with illustrations of makeshift tourniquets and slings, perhaps implying a common narrative of struggle and resilience (Mimi 2003, 15-16).

Other writers further rejected expectations of passing from their trans peers, which functioned as surveillance by members of the community. In the inaugural volume of *Gendertrash*, editor Xanthra Phillippa (1993a) welcomes the reader to "the world of gender trash / our gender world," place where trans peers can "develop our own gender culture." This space is to be free of the "gender oppressive controls," "self hatred," and "self censorship" that plague the trans community from within (3-5). In the second part of her welcome, Phillippa rejects further the expectation of passing, which she describes as a survival mechanism and a "horrible, sickening, never-ending nightmare" of constant monitoring and scrutiny by her peers (1993b, 7-8). As established earlier, medical transition was still highly inaccessible in the 1990s. Gender scrutiny by peers could exacerbate what Markbreiter (2022) calls "dysphoric jealousy" based on class, where certain physical results were simply not possible without access to money. Unsurprisingly, the first person in the United States widely known for having genital surgery was a white, wealthy woman named Christine Jorgensen. Her highly publicized transition set a paradigm of full medical transition, especially for trans women (Denny 1995, 52). Even 20 years after Jorgensen's transition, people of her race and class continued to be the only people who had full access to transition technologies. This obviously included medical interventions, but also included social transition tools like clothing, hair, and makeup. Even 40 years after her transition, Medicare still did not cover the costs of social transition, and thus publicly presenting as one's

gender identity, making meeting just the conditions for medical transition financially inaccessible (Markbreiter 2022; Paintain 1997, 15, 22).

Gender nonconformity, which was discussed prior in the context of selective or DIY medical transitions, through social transition became the default state for openly trans people who did not want to medically transition or could not yet access it. Several zines speak to the 'natural' state of this presentation, hearkening back to the initial medical belief in the plasticity of sex and the natural bi-sexuality present in intersex youth. Pollack endorses self-identification, calling herself "the daughter of belief," as her identity "is based primarily on my believing it; it's not based on proof" (Gabriel 1995, 61). The author of *From Cross to Trans* (2010) writes that although others view their gender nonconformity as a "visual, direct, radical act" of political speech, they have no such intentions; this expression just comes naturally to them (5). Barley (2010) concurs, saying that genderfluidity is less about perception and more about radical self-honesty (8). Moreover, they show that dysphoria is not definitive of transness: even though they do not want top surgery, they bind their chest to avoid others gendering them through it (13). Through elective gender nonconformity, people like Barley have grown to "love gender," rather than dismantle it, and "let it take me places that heteronormativity never could" (8).

Taken together, zines of the trans DIY subculture of the 1990s-2010s are invaluable for the resources they provided to trans communities. They amplified previously obscure methods of gaining access to gender-affirming healthcare, guided newcomers through their options for medical and social transition, provided alternative methods of transitioning for people with social or financial barriers to access or non-normative transition goals, and lent support and community to individuals who did not cleanly fit into any of the aforementioned categories.

With the popular use of the Internet, zines spilled over into online forums and personal webpages. Today, there are entire websites, Youtube channels, Tumblr blogs, and Twitter accounts dedicated to various aspects of transitioning. Zines are also still produced, but circulated digitally rather than physically. In this case, form informs content, as seen in Lichen's 2023 digital zine *DIY Voice: A Voice Masculinization Resource Guide*. Lichen lists multiple digital resources such as Youtube and Tiktok videos for trans vocal training and software which visualizes the pitch and resonance of one's voice.

It is disheartening to consider that perhaps not much has changed in the 30 years since the online evolution of the trans DIY zine era, as these contemporary resources also suggest methods of manipulating medical institutions and insurance to gain access to medical transition, as well as the option of DIY HRT. The eugenic logic of assimilation and normalization has also strengthened in recent years in the English-language world, where conservative, anti-trans movements and moral panic are gaining traction among constituents and legislators alike. There are currently 406 anti-LGBTQ bills advancing legislatures across the United States, while the Council of Europe has condemned the United Kingdom for the rise in anti-trans rhetoric across the government and populace (ACLU 2023; PACE 2022). People die after waiting for years to be treated by the NHS, and in one weekend, at least four drag events in the US were shut down by "Neo-Nazis, Proud Boys, militiamen, Christian nationalists, and culture warriors" (Murphy 2022; Owen 2022). While all conservative or part of the far-right, the actors and ideologies evoked in these few examples are diverse, suggesting there are several distinct, but related, historical and cultural reasons for the rise in transphobia.

Far-right groups, technocrats, and ultraconservative public figures are some of the most impactful producers of anti-trans rhetoric on the Internet. Elon Musk, the CEO of Twitter, is one

of many examples of techie transphobia, having liked, endorsed, and posted anti-trans content online (Hurley 2022). Ironically, he owns the very platform through which so many trans people have found community and survival. Alarmingly, his company has failed to adequately protect trans users from harassment and hate speech. These trends ultimately trace back to the exploitative and discriminatory history of American transgender and intersex human sciences and medicine. As trans people continue to navigate the challenges of transitioning against a resurgence of transphobia, the Internet will undoubtedly play a crucial role in shaping the future of trans organization, education, resistance, and community.

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