Deviant Bodies:
Understanding trans becoming from the perspectives of medico-psychiatry and trans-subjectivity

Joanne May Flannery
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- by -

Joanne May Flannery BA Hons, MSc (Leicester)

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Abstract

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Joanne May Flannery.

Drawing upon a range of documentary sources, as well as questionnaires and semi-structured interviews with GPs and 'gender specialists', the first aim of the thesis is to explore those stories produced within the medico-psychiatric domain, which have attempted to make sense of trans becoming. Imbued with this is an analysis of the extent to which medico-psychiatric discourses inform clinical practice.

The thesis complements the analysis of stories produced within medico-psychiatry with an analysis of stories told by 'trans' women, in order to account for the ways in which transsexuality is subjectively experienced, as well as the relationship between these two types of stories. By suggesting that 'trans' women were active agents in the construction of a trans identity from around the late nineteenth century, as well as now, the thesis suggests new ways of thinking about the relationship between medico-psychiatry and trans-subjectivity which overturns much current theorizing which casts 'trans' women either as the dupes of the medico-psychiatric profession, or else, duplicitous towards it. Finally, an analysis of 'trans' women's stories of becoming reveals that these narratives are used to position their sense of self within a medical as opposed to a queer paradigm. Also revealed are the ways in which 'trans' women's narratives engage with gendered embodiment, whilst simultaneously allowing for changes in somatic materiality. It is from this that the thesis is able to problematize not only the assumption of 'trans' women as simply involved in a process of either literalizing or deliteralizing the norms of sex/gender, but also a grand 'turn to Transgender'. It is suggested that while so many 'trans' women espouse an essentialized narrative of self, whereby transsexualism is firmly positioned within a medical paradigm, they nonetheless open up a conceptual space 'between 'male' and 'female' as well as present a very real challenge to medico-psychiatric stories of their identities, despite not identifying within a queer paradigm.
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Finally, it is to the University of Leicester and its commitment to funding this thesis that my thanks must primarily go, for without them, this would all have been a pipe dream.
Author's Declaration

The work presented in this thesis was carried out in the Department of Sociology, Leicester University, and is entirely my own work except where other authors have been referred to and acknowledged in the text. It has not previously been submitted for a degree in this, or any other University. The views expressed in this thesis are my own, and not those of the University.

Signed:

[Joanne May Flannery]

Date:
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Introduction

Trans studies have increasingly become a key domain within the gender theory, with a plethora of academic papers discussing this feature of gendered selfhood. From the history and construction of transsexualism (Billings and Urban, 1996; Hausman, 1995; King, 1993, 1996; Meyerowitz, 1998; Prosser, 1998), to its relationship with medico-psychiatry (Bolin, 1988; King, 1987; 1993, 1996; MacKenzie, 1994; Nataf, 1996; Califia, 1997; Namaste, 2000), it would appear that no aspect of the trans phenomenon has been left unturned.

More recently, scholars have begun to move away from addressing the issues of medico-psychiatric imperialism and have turned their attention to the more ‘sexy’ issues of trans identity politics (Garber, 1992; Bornstein, 1994; Whittle, 1996; Halberstam, 1994, 1998). Advocating a queer position, such writers have attempted to make evident the need to deconstruct the ways in which we think about the sex/gender binary. Feminists too have turned their attention to the implications of transsexualism for a feminist theory (Raymond, 1979, Millot, 1990; Jeffreys, 1996). However, feminist and queer theorists have often abstractly theorized to the neglect of the voices of those about whom they write. Here then, a theory is often constructed which bears little resemblance to the lives of many ‘trans’ women, and certainly those who were involved in this research. We need then to take a step back, to fully understand the multiple temporalities of trans-subjectivities before we can attempt to write a theory of their lives. What follows then is, I hope an attempt to do just that; to place the voices and experiences of my respondents at the core of my writings, and to build from that a more rounded picture of ‘trans’ women’s experiences and their relationships with the medico-psychiatric profession.

Aims of the Research

Drawing upon the work of Plummer (1995, 1996a, 2003), I have chosen to approach the question of the complex relationship between medico-psychiatry and trans-subjectivity through an understanding of story-telling. I am interested in the ways in which personal stories of trans becoming have come to be transformed into, and spoken through the public discourse of medico-psychiatry, together with the effect that this has had upon the private
lives of those people talking, and being talked about. In order to understand the ways in which both ‘trans’ women and the medico-psychiatric profession make sense of transsexualism I have found it useful to think of the world as ‘storied’. That is, a world that is “articulated and animated” (Gubrium, 1995: 23) through a multiplicity of narratives told by each and every one of us through our role as story-tellers. It is from such a starting point that I would argue, we need to conceive of the (trans)gendered world as subjectively meaningful, “told about and conditioned by processes and circumstances of telling” (Gubrium, 1995: 23). However, I am also interested in the ways in which the medico-psychiatric profession have both utilized these personal stories of self, as well as constructed a variety of ‘Othering’ stories, to make sense of those whom they study, whilst simultaneously reaffirming the ‘normalcy’ of their own self.

Discourse or Story-Telling? Two Paradigms for Understanding Trans Becoming

Throughout the thesis I talk at length about ‘discourse’ or more specifically ‘discourses’. It is worth spending some time then looking at what is meant by discourse, and what this implies for understanding the construction of transsexualism as a subject position. Moreover, by taking a critical stance towards a discursive analysis of transsexualism I hope to make apparent my reasons for choosing to follow Plummer’s (1995, 1996a) understanding of identity construction, which is informed by symbolic interactionism.

Discourse and a Discursive Analysis of Transsexualism

Understandings of what constitutes ‘discourse’ is a contentious area within the sociological literature. Derrida, for example, sees discourse as synonymous with the entire social system, in which discourse(s) literally constitute the social and political world. It is Derrida’s (1987a: 280) contention that, “when language invaded the universal problematic … everything became discourse.” Contrastingly, writers such as Laclau and Mouffe (1987: 84) use the concept of discourse to “emphasize the fact that everyday social configuration is meaningful,” in which case “the discursive is coterminous with the beings of objects.” In terms of social structure, Foucauldians and other poststructuralists regard discourses as inherently ambiguous, incomplete and contingent systems of meaning. Foucauldian discourse analysis
is intent on showing the connection between ‘discursive’ practices and ‘non-discursive’ activities and institutions (Foucault, 1972, 1981b, 1991a). From this perspective, discourse constitutes symbolic systems and social orders. In his later writings concerned with genealogy, Foucault (1979, 1981a) is concerned with the ways in which discourses are shaped by social relations and institutions, and it is in this way that Foucault is able to produce an epistemological view of identities as “produced by and existing in discourse” (Shilling, 1993: 75).

It is worth considering what a Foucauldian approach to the construction of transsexualism might look like. Following Hall’s (2001: 73-4) framework, we can suggest that a Foucauldian approach to the normalization of transsexualism would necessarily contain the following elements. Firstly, there need to be assertions about transsexualism, which give us a type of knowledge about it, secondly, there need to be rules which both impose and exclude certain ways of talking about transsexualism. Thirdly, subjects are needed who epitomize that discourse. These subjects would be recognizable given the ways in which knowledge about the topic is constructed at a particular moment in time. Fourthly, those ways of thinking about transsexualism would need to acquire an authoritative position, that is, they would come to be seen, at a given historical moment, as representing the ‘truth’, fifthly, institutions which deal with transsexualism would need to be formed which serve to regulate and control their subjects according to the ideas that surround them at a given historical moment and finally, one must be aware that different ways of knowing, or talking about a subject would arise at later historical moments and supersede former ‘truth’ claims with those of their own.

Whilst such an approach undeniably provides us with a useful way of thinking about the construction and regulation of identities in a given historical moment, there are a number of problems with it. By providing a “structuralist” (Turner, 1995: 213) approach, Foucault treats bodies and identities as the effect of social and institutional change, and as such ignores the ways in which that identity is ‘lived’. Furthermore, the subject is missing from this analysis and as such we have little detail on how and why certain individuals resist controls on their lives and identities. Moreover, Foucault fails to pay attention to the ways in which discourses can be said to be constructed as a result of negotiations and information exchanges between the subject and discourse, or the people who define that discourse. It is because of this that I have found it more useful to follow Plummer’s trajectory of ‘story-telling’ (see below and Chapter 5), which to my mind, more effectively accounts for the socio-historic emergence of identities and subject positions. My use of discourse is then a means of designating a story which has moved out of the private realm of individual telling and into the public realm of
discussion or debate; that is, when a story has been successfully told. Moreover, moving away from discourse and identity formation as it is discussed within Foucauldian inspired debates (See Hausman, 1995) as well as from within some labelling theory (see McIntosh, 1981), it is my contention that a trans identity can be seen to have been constructed prior to its official entry into language, and instead constructed during the period of the late nineteenth century as a result of individual narrativization, and the crucial role played by sexologists, who effectively enabled their subjects to speak.

**Understanding the Story-Telling Process**

In order to understand the story-telling process I have found it useful to draw upon the works of Plummer (1995, 1996a, 2003) and Bhattacharyya (1998). Plummer conceives of storytelling as a process of symbolic interactions, which gain momentum and support as they move from the personal to the social world. The telling of stories is an important means by which we are able to make sense of ourselves as well as the selves of Others. Following Plummer we can suggest that a story has been successfully told once it has moved away from a privatized telling and toward the social world of discourse. Here then, ‘discourse’ is used to refer to a story that has been successfully told, which occurs when “a community has been fattened up, rendered ripe and [is] willing to hear such stories” (Plummer, 1996a: 36) (see Chapter 5 for a fuller discussion of this process).

By building upon the work of Plummer, I hope to be able to show the ways in which storytelling works in both the private world of individual telling – that is how ‘trans’ women articulate a sense of ‘difference’ – as well as how story-telling works in the social world – how the ‘trans’ woman comes to understand herself as such through the reading of other narratives, as well as how particular stories attract communities of identification and hence enter the public world; that is, it becomes discourse.

In a vein not dissimilar to Plummer’s trajectory, I have also found it useful to consider what I have termed ‘Othering stories’, which draw largely upon the work of Bhattacharyya (1998). These Othering stories are the stories told by the more powerful social groups and are two-fold in their affect, in that they both construct a ‘subject’ whilst simultaneously reaffirming the self of the power-holder (see also Epstein, 1995). What is of particular use in following Bhattacharyya’s notion of Othering stories, together with Plummer’s trajectory for the successful telling of a story, especially when considering those current debates circulating
with regards to trans politics, is that it enables us to question why, at certain moments the stories of the more powerful groups have begun to decline, thus opening up a conceptual space for the emergence of new and different stories; stories told by those once Othered.

It is necessary to be mindful of the fact that the destruction of the power of one group necessarily creates a power-vacuum that must be filled, a challenge that has often been taken up by community leaders of the once Othered. So for example, citing Dank (1976), Plummer (1981: 55) writes that “liberationists themselves have started to become key definers of a homosexual role and hence ironically started to become their own sources of regulation”. Similarly, some of the recent Transgender debates and politics have sought to espouse what they see as an ‘authentic’ trans identity, and politics, which pivots around the deconstruction of sex/gender. Importantly, such a newly emerging politics has often excluded as many people as it has embraced. Here then, we see that the usefulness of combining the works of Plummer and Bhattacharyya, is the ability to begin to document the complex hierarchializing of stories, and importantly, the reasons for shifts in the hierarchy of telling that occurs at specific historical and cultural moments.

**Key Arguments and Theoretical Contributions**

The shift in writings on transsexualism away from transsexualism’s relationship with medico-psychiatry and towards identity politics and sex/gender deconstruction would seem to suggest that much has been achieved in improving upon and debating the relationship between transsexualism and medico-psychiatry, and that a more current concern is with transsexualism’s relationship to sex/gender. However, I hope that what I present within this thesis problematizes such an assumption. By revealing that the medico-psychiatric imperialism of trans identities continues to structure so many of the lives and experiences of the ‘trans’ women speaking here, my research reveals that much still needs to be done to improve the relationship between medico-psychiatry and trans-subjectivity.

As will become apparent, it is my contention that it was the period of late nineteenth century sexology and not the 1950s that saw the emergence of a trans identity. Whilst I am by no means alone in suggesting this (see, for example Prosser, 1998; Meyerowitz, 1998), I hope that my work suggests ways in which this can be applied to other ways of thinking about trans-subjectivity. Principally, I hope this thesis suggests new ways of thinking about the
relationship between medico-psychiatry and trans-subjectivity, which do not seek to reduce ‘trans’ women to either the dupes of the medico-psychiatric profession (Raymond, 1979; Hausman, 1995), or cast them as duplicitous in their ‘manipulation’ of it (Shapiro, 1991; Billings and Urban, 1996). By according agency to ‘trans’ women, and thus seeing them as active agents in the construction of a trans identity, whilst simultaneously recognizing the sometimes subtle, sometimes obvious means by which the telling of one’s life is constrained, I hope to have been able to problematize such a simplistic typology.

Furthermore, the thesis presents an argument that critiques the prevalent medico-psychiatric assumption of one ‘true’ or ‘authentic’ trans narrative – as evidenced by the diagnostic tropes of ‘true’ or ‘primary’ transsexualism (Benjamin, 1966; Stoller, 1968, 1973, 1975). Instead, I argue for the recognition of multiple trans subject positions, some of which identify closely with the sex/gender binary (that is ‘trans’ women who identify as women) and hence medico-psychiatric definitions of trans identification. Other trans subject positions do not identify within, but rather, outside of such a binary (as is the case with those who identify as third-sex, non-gendered or as Transgendered), and who as such contradict medico-psychiatric assumptions, both to the ‘truth’ of transsexualism, and the ‘nature’ of sex/gender.

Moreover, the argument of the thesis helps to problematize some recent Transgender theory, which sees those ‘radical’ subject positions, which claim not only to deconstruct, but make evident the falsity of binarized ways of knowing, as somehow more ‘authentic’ expressions of (gendered) selfhood (see Whittle, 1996) than transsexual expressions of self. Here then, it is my intention to show that the ways in which ‘trans’ women negotiate their own becoming demonstrates the ways in which many are able to open up a conceptual space between ‘male’ and ‘female’. Moreover, by thinking in terms of the multiplicity of trans-subjectivities, we are able to challenge Transgender’s assumption that it’s scriptings for a trans sense of self are more appropriate and perhaps more ‘authentic’.

I hope that by having taken seriously the experientially derived knowledge of my respondents, elicited through detailed narrative inquiry, I have been able to present a piece of research which is not too far removed from the experiences of many ‘trans’ women. Moreover, the multifaceted methodology employed throughout this research goes in some way to producing a well-rounded account of the relationship between the two domains of medico-psychiatry and trans-subjectivity, and their perspectives on trans becoming.
Some Problems with the Research

Although I write of the need to recognize the multiplicity of trans-subjectivities, and resist attempts to homogenize the trans experience, I am aware that my sample of trans respondents may not be reflective of this multiplicity. In the first instance my failure to involve 'trans' men within the research has meant that I have had to shift my emphasis away from 'trans' people and exclusively towards addressing the life histories of 'trans' women. To talk collectively of 'trans' men and women, when no 'trans' men were involved would have made me complicit in the academic silencing of the voices of 'trans' men (Cromwell, 1999), whereby the experiences of both genders is thus homogenized.

Secondly, I was unable to talk with people who identified as Transgendered. Here then, my research is limited in its ability to speak only for those individuals who identify as 'trans' women, or as women. Importantly however, this is not an exhaustive piece of research, but is something that I hope will prove to be on-going. Taking the thesis as my starting point, I hope in the future to be able to extend what I have discussed here and thus produce a more cohesive reflection of the trans phenomenon in its entirety.

A Question of Numbers

The number of known 'trans' people within Britain has increased dramatically since the 1960s (by this time, gender identity clinics had been established within Britain, and the medico-psychiatric naming of 'transsexualism' had begun apace). Turtle (1963, cited in Whittle, 1995: 10) estimated the number of 'trans' people within Britain in 1963 as between 3,000 to 15,000. According to Press for Change (Britain's largest trans activist group) the number of post-operative 'trans' people within the UK in 2000 was estimated at approximately 5,000 (Home Office, 2000: 3). Given that incidence figures tend to reflect the number of 'trans' people who are known about, or who have presented to one of the various gender identity clinics (GICs), we can hypothesize that the actual number of trans people within Britain at any one time far exceeds any estimated figure. Thus, when attempting to estimate the incidence of transsexualism within Britain we need to consider not only those individuals who are currently attending gender identity clinics, or have attended one in the past, for these statistics can only ever present a partial account. Instead, we must also consider incidence rates which are reflective of those individuals who have yet to establish
contact with the medico-psychiatric community, as well as those trans identified people who have actively decided not to make this contact. In light of this then it can be rather conservatively estimated that a more reflective incidence rate would be at least double that recorded within ‘official statistics’.

Debating Sex/Gender: ‘Essentialist’ versus ‘Constructionist’ Accounts

The relationship between sex/gender is one of the most contested debates of the twentieth and twenty-first centuries. The proliferation of debates about what precisely we mean by sex and gender, as well as the nature of the relationship between sex and gender has “open[ed] the way for numerous strategies aimed at defining, explaining and hence regulating” our sexed and gendered ‘being’ (Harding, J. 1998: 8). The two broad approaches to the investigation of sex/gender are ‘essentialist’ explanations on the one hand, and ‘constructionist’ explanations on the other. Within the former approach, sex/gender is firmly rooted within a (bio)logical (Sharpe, 2002) paradigm, which asserts that sex is a ‘natural’ phenomenon, existing outside of culture and society (Weeks, 1995). Further to this, the fixed and inherent drives of ‘sex’ – residing within the body – are believed to dictate our gender identity.

According to Weeks (1985), theorists subscribing to the ‘essentialist’ paradigm often hold that the sex/gender system needs to be held in check by social, moral and medical mechanisms, whereby “the individual is the subject of investigation and of necessary (for society to be possible) repressions” (Harding, J. 1998: 9). Following Plummer, we can suggest that those sex researchers who subscribe to an ‘essentialist’ view of sex/gender, have become “morally suspect” (1975: 4) and in an effort to secure and defend their positions “have become little more than propagandists of the sexual norm” (Weeks, 1985: 79) as it stands at any particular historical moment. This can be evidenced in the context of transsexualism by the extent to which medico-psychiatric professionals draw upon a range of performative and somatic assumptions as to the congruence of sex/gender as a means by which to both diagnose and assess the prognosis of the ‘transsexual ambitions’.

In recent years, ‘essentialist’ theories of the ‘nature’ of sex/gender have come under scrutiny from theorists from within the ‘constructionist’ paradigm which advances a view of “our experiences of the body and its desires [as being] produced externally through the range of social discourses and institutions which describe and manipulate them” (Segal, 1994: 73).
For constructionists, there is no inherent essence to either sexed or gendered behaviour, which should rather be understood in terms of "a configuration of cultural meanings which are themselves generated within matrices of social (power) relations" (Harding, J. 1998: 9; see also Segal, 1994; Gagnon and Parker, 1995; Weeks, 1995), which has the attendant effect of privileging some sexed/gendered forms of 'being' over others. In understanding specific historical and cultural configurations of sex/gender it may prove fruitful to borrow from symbolic interactionism the conceptualization of 'sexual scripts' (Gagnon and Simon, 1974). Sexual scripts can be applied to our understanding of the construction of gender and allow us to critique notions of a pre-given sex/gender congruence separable from its social and cultural constructions.

Taking the constructionist project to its limit, poststructuralists and queer theorists alike have attempted to demonstrate the 'fictionality' (Halberstam, 1994) of our perceptions of sex/gender. Through a radical project of deconstruction, writers from these perspectives seek to challenge our ontological assumptions, and argue that rather than being grounded in (bio)logical sex, gender is in fact the result of what Butler (1990) has termed 'performative utterances'. Appealing as these theories are, it is nonetheless important to heed Segal's warning:

"The uncanny strength of conventional sexual and gendered binaries is their ability to triumph over the repeated attempts, both theoretical and performative, to dismantle and deconstruct them."

(Segal, 1999: 61)

It is because of this that we must be mindful of the ways in which sex/gender has come to perform and be charged, through medical, legal and social discourses, with the role of a very real social institution (Mauss, 1925) that exerts controls over our lives and bodies. Whilst queer theory proves alluring in its promise of sex/gender freedom, it offers no comfort to those 'trans' women who are the victims of discrimination or acts of transphobia. To forget the way in which gender is embodied creates then the risk of theorizing so abstractly as to negate lived experience.
Constructing the Trans Subject

The constructionist paradigm enables us to see how particular sexed/gendered configurations emerged within specific historical and cultural contexts. Whilst the existence of trans individuals has been documented in the historical and sociological literature as existing across time and space (see Green, 1969; Bullough, 1975; Feinberg, 1996), we must approach this line of thought with some caution, ensuring that we recognize the important distinctions between trans desires and trans identity.

In contrast to writers such as Hausman (1995) and Billing and Urban (1996) who contend that a trans identity is a unique construction of the 1950s facilitated by the availability of and demand for the technologies of ‘sex change’, it is my contention that the trans identity can be seen to have emerged long before it was named as such by the medico-psychiatric profession in the 1950s. Whilst trans desires – that is, feeling oneself to be a member of the ‘opposite’ sex; living in the role of that sex and in some cases, altering aspects of the outer body to more fully conform with that sex have existed transculturally and transhistorically (Marshall, 1913; Hoyer, 1933; Hodgkinson, 1989; King, 1993; Nataf, 1996), the notion of a specific trans person or identity did not appear until the later nineteenth century, where under the rubric of ‘inversion’, narratives akin to contemporary trans narratives were being recorded in the case histories of a number of eminent sexologists (Ulrichs, 1864-68; Westphal, 1870; Krafft-Ebing, 1887; Ellis, 1936a).

Prior to the medico-psychiatric naming of transsexualism in the 1950s then, I would suggest that, through the telling of personal stories of ‘gender difference’ to those sexologists who would sympathetically listen, and the sharing of those stories trans people can be said to have been active agents in the formalization of a coherent trans identity before it was named as such. Where the period of the 1950s holds significance is that it saw these trans narratives being given a name, and hence medical legitimacy.

Whilst it may appear that the medico-psychiatric naming had only negative consequences for trans-subjectivity in that it “control[ed], inhibit[ed] and restrict[ed]” expressions of self, it would be foolhardy not to recognize, as Plummer does, the paradox of this naming process, which is that such intense categorizations “simultaneously provided comfort, security and assuredness” (Plummer, 1981: 29; see also Sagarin, 1978). It is important then that we understand the ways in which both early sexologists, through listening to embryonic trans narratives, and medico-psychiatrists, through defining a ‘condition’ to which a greater number
of people could belong, played a crucially enabling role in the dissemination of a trans identity.

A Note on Terminology

Before proceeding it is important to make clear the reasons behind my use of specific terms within this thesis. Debates loom large within the various trans communities as to the most appropriate terminology to be used when referring to 'transsexual people'. Some propose the use of the noun 'transsexual', whilst others prefer to use 'transgendered'. For others, the descriptive nouns of 'man', 'woman' and 'person' are all that is needed. Mindful of such debates, I have chosen to employ the term 'trans' where reference is made to the broader communities. My reasoning comes from my contact with the 'trans' women involved in this research, the majority of whom preferred the terms 'transsexual' or 'trans' over 'transgendered'. More specifically, my use of 'trans' as opposed to 'transsexual' is a reflection of the need to challenge popular conflations of trans with (homo)sexuality and/or fetishism. It is for the same reasons that I talk about 'transsexualism' rather than 'transsexuality'. Finally, rather than use the standard term 'male-to-female transsexual', which makes explicit reference to a (bio)logic presumption on the nature of sex/gender, I have chosen to use 'trans' woman. Moreover, placing 'trans' within inverted commas is an attempt to problematize the category of 'trans' women as somehow distinct from 'other' (non-trans) women, whilst continuing to highlight the multiplicity of trans-subjectivities - that for some, people their subjectively experienced gender is that of woman, rather than 'transsexual', whilst for others it is indeed that of 'trans-woman'.

Finally, throughout the thesis I refer to 'trans' women using female pronouns, even when referring to gendered status pre-reassignment. If this makes complicated reading then I make no apologies. If the reader is confused by this, then consider how the trans person, especially as a young child, must feel when trying to understand their sense of self they are constantly referred to via pronouns that seem antithetical to their 'being'.
The Structure of the Thesis

The structure of the thesis follows the trajectory of trans becoming as a storied process, in terms of both the individual and the social world of meaning making. Each of the three themes of the thesis represent specific moments in the individualized articulation of a trans sense of self as well as the successful entry of transsexualism into the social world. The first theme - 'Definitions and Pathology: The Origins of Transsexualism' - involves the establishment of what transsexualism is, through the search for and competing accounts surrounding the definition of transsexualism as a social phenomenon. The second theme - 'Telling Stories, Creating Histories: The Politics of Trans Becoming' - looks at who transsexuals are, that is the various stories of trans becoming that abound within both medico-psychiatry and trans communities. The third and final theme - 'Resisting the Binaries? The Politics of Trans' - concerns debates in trans politics and reflects current theorizing surrounding transsexualism and its relationship to the sex/gender system, whilst simultaneously addressing the ways in which those 'trans' women interviewed position themselves in relation to that dyad.

Chapter Outlines

The thesis has been constructed according to the three themes that have emerged from my research: 'Definitions and Pathology'; 'Stories of Trans Becoming' and 'Trans Politics'. Each of these three themes I explored in a theoretical chapter, a chapter in which the results from the research are laid out, and concludes with a discussion chapter which establishes links between theory and my research findings.

Chapter 1: Research Design and Methodology: A Review

The thesis begins with a review of the research methodology, in terms of sample, design and analysis. It then moves on to discuss some of the research findings, as well as their implications for further research. For example field relations and issues of power and gender are discussed revealing the need for reflexivity in the research process as a means by which we can begin to break down traditional assumptions about the nature of sociological inquiry.
Theme 1: Definitions and Pathology: The Origins of Transsexualism

The aim of this first theme is to provide an account of the emergence of transsexualism as a specific object of scientific inquiry, as well as the degree to which the speaking subject – that is the ‘trans’ woman – has played a crucial role in the construction of a medico-psychiatric narrative of transsexualism (Chapter 2). Once medico-psychiatric definitions have been addressed, the theme moves on to look at the ways in which definitions of transsexualism work within clinical practice (Chapter 3), noting any necessary continuities and changes over time. Issues of ‘treatment’ are also discussed as a way of highlighting those debates surrounding questions of ‘ownership’ and ‘authorship’. In both Chapter 2 and Chapter 3 we see how competing claims to the ‘ownership’ of the trans phenomenon have impacted upon how ‘treatment’ is structured within British gender identity clinics. The theme also addresses the differing ways in which transsexualism has been understood by those people who participated in this research (Chapter 3). The theme concludes (Chapter 4) by making connections with and highlighting any discontinuities between the medico-psychiatric and sociological literature and the findings of my own research.

Theme 2: Telling Stories, Creating Histories: The Politics of Trans Becoming

The aim of this theme is to understand the relationship between medico-psychiatry and trans-subjectivity through an analysis of the stories told about how people become transsexual, as told by academics, including social scientists, clinicians and ‘trans’ women themselves. Chapter 5 addresses the notion of trans becoming, firstly as it is structured through the two opposing accounts of ‘demand’ (Hausman, 1995) and ‘narratology’ (Prosser, 1998) and then moves on to look at the ways in which trans becoming is understood within the medico-psychiatric profession in terms of the various aetiological accounts. The chapter then moves on to look at what I have called the ‘politics of diagnosis’, and as such looks at those stories told and perpetuated by the medico-psychiatric profession with regards to what constitutes an ‘authentic’ trans narrative. The chapter concludes by looking at those sociological and feminist approaches which have sought to explain ‘trans’ women’s relationships to medico-psychiatry within a duped/duplicitous dyad.

Chapter 6 seeks to empirically ‘test’ the debates that are discussed in Chapter 5. The intention here is to look at, and suggest answers for the complex relationship between medico-psychiatry and trans-subjectivity, as well as the relationship between medico-
psychiatric discourse and clinical practice. As such, the differences and continuities between
the ways in which transsexualism is understood, in terms of aetiology and diagnostic
accounts, within medico-psychiatric discourses, clinical practice, and finally ‘trans’ women’s
own understandings of the phenomenon are addressed. Chapter 7 draws the debates and
findings of the research together and suggests some alternative ways of thinking about the
ways in which we understand trans becoming.

Theme 3: Resisting the Binaries? The Politics of Trans

The aim of this final theme is to assess that literature (Chapter 8) which seeks to address the
relationship between transsexualism and the sex/gender system. Following on from this,
Chapter 8 also assesses that literature which argues for a change in trans identification away
from a ‘normative’ sense of self and towards a queer sense of self as expressed through the
idiom Transgender. With regards to my empirical investigations (Chapter 9), it was important
to understand the ways in which those ‘trans’ women involved in my research positioned
themselves within the sex/gender dyad. From this we can also address the ways in which the
various challenges to medico-psychiatric hegemony by Transgender groups have been
received by ‘trans’ women involved in this research. Chapter 10 makes necessary
connections between the theory presented within the theme and my own research findings.
The aim of this chapter is to provide a detailed account of the research methods utilized within this research, together with the epistemological decisions upon which my methodology is based. Drawing largely upon feminist methodologies and epistemologies I also discuss the problematic issues that arose during my time in the field, such as those concerned with power, ethics and access. By discussing in some detail the ways in which I have approached my research, I hope to make clear the need to recognize that as researchers, the ways in which we approach the field, act in it as well as the ways in which we negotiate field relations has enormous implications for the sorts of material gathered as well as the ways in which that material is analysed.

**Narrative Inquiry and the Emancipatory Project**

Narrative interviewing is a qualitative method which aims to capture the experiences of another, and thus seeks to study lived experience from the narrator’s point of view. As such it is an important means by which emancipatory research can be developed, for as Geiger (1986: 335) suggests, “it is a method which enables the uncovering of the experiences of a silenced group.” This is because life histories “tell it like it is” (Letherby, 2003: 89), from the perspective of the lived experience of the person or people doing the telling (Manning and Cullum-Swan, 1994).
Emancipatory research is defined here as giving voice to respondents and a means by which to break down traditional research relationships of researcher/expert versus respondent/subject. This involves making ourselves as researchers vulnerable in order to equalize the relationship between researcher and respondents (Stanley and Wise, 1993). In this way emancipatory research can be seen as critical research, for as Kincheloe and McLaren (1994: 140) suggest, critical research

“must be connected to an attempt to confront the injustices of a particular society or sphere within the society. Research thus becomes a transformative endeavour unembarrassed by the label ‘political’ and unafraid to consummate a relationship with an emancipatory consciousness.”

It is also a technique that enables respondents to take a greater degree of control over the research process. What follows is an attempt to tease out some of the key debates and arguments concerned with conducting a piece of emancipatory research via the use of narrative methods of inquiry.

Small-scale narrative research has been criticized for failing to tells us what we need to know about the lives of our respondents and following Kelly et al (1994), it could be argued that it is unclear whether any material gathered via such a method can be used to provide evidence for the lives of many ‘trans’ women in general and/or be applied to those ‘trans’ women who, although in the same situation, have not had their voices made public. Importantly, however, whilst narrative research may attempt to understand the lives of the specific individuals involved in the research, the life histories told by respondents do indeed reveal certain common problems and experiences, and it is in this way that Letherby argues that “individual life histories often give us insights into the lives of many” (2003: 90).

A Consideration of Debates on Power in the Field

Attempting to conduct a piece of emancipatory research with socially disenfranchised and vulnerable groups is undoubtedly desirable, in that it attempts to reduce the inequality of power that usually surrounds the research process. This is because emancipatory research endeavours to place the voices of respondents at the centre of any investigations, and as such
aims to reduce the disparity of power that often exists in the researcher/subject relationship. However, within feminist literature we find a number of debates regarding the negotiations of power relations that are often said to be endemic to the research process.

Oakley (1981) suggests that emancipatory research can be achieved by appealing to a sense of collective understanding through a shared history. However, this perspective presupposes that a researcher is only able to research those with whom they share a collective history. Thus, for example, we have the assumption that only women can interview women. Secondly, such a premise would seem to suggest that the researcher who occupies the position of ‘outsider’ can not be concerned with, or able to, empower those with whom they engage in social research. Again we see the assumption that, in the case of my research, a ‘non-trans’ woman cannot conduct a piece of emancipatory research with ‘trans’ women, and if she does research the lives of ‘trans’ women she will not be able to empower them in the process. This epistemology presents a fairly closed approach to social research, which serves to essentialize the identities of the researcher and respondent. Despite my ‘non-trans’ status, I believe it misguided to assume that I can neither empathize with nor seek to empower my trans respondents. Field relations, as well as identity positions, exist on more than one level, in my case trans/non-trans, and I would suggest that despite our different gendered subjectivities, my respondents and I were able to enter into a relationship based on a common goal of overturning the social stigmatization of transsexualism.

With regards to the issue of power, the emancipatory project is necessarily contradicted for some by the suggestion that as researchers we ultimately possess the most power in the research situation (Letherby, 2003; Millen, 1997; Kelly et al, 1994). However, it is important to present a more nuanced picture of the ways in which power operates within social research. In this vein, Cotterill (1992) and Millen (1997) consider the ways in which research is jointly constructed. It is in this way that researchers cannot always be said to have control over the relationship, especially when our respondents “are older, more experienced [and] more knowledgeable” (Letherby, 2003: 115) than us. Moreover, to suggest that our respondents cannot be given, or hold a powerful position in the research is, to my mind pacify them.

Leaving the field and handling research material is a further exercise surrounded by tensions and concerns. Cautious of claims to fully egalitarian research, feminists such as Stacey (1991), Cotterill (1992), Iles (1993) and Letherby (2003) remain mindful of the ways in which we, as researchers, when leaving the field are the ones who ultimately have control over the material, as well as the “authoritative resources” (Letherby, 2003: 117) vis-à-vis the writing
up and dissemination of that material. It is because we take with us the words spoken by our respondents, as well as have the ability to edit those words, that Stacey (1991) and Fine (1994) argue that as researchers, we are ultimately the ‘official authors’ of the stories we hear, and as such any material that we produce is reflective not of the words of our respondents but of our interpretations of those words. The result is that our respondents become passive in the research process. It is because of this that Stacey contends that “elements of inequality, exploitation and even betrayal are endemic to [research]” (1991: 114).

While I agree that all research holds the potential to be abusive, or at least self-serving, I would suggest that it is by recognizing this potential in our own work that we are able to take steps towards lessening our control. Thus, it is through making apparent any changes that we have made to the research material in our writing and dissemination that we are able to make our research, as well as our position to it, more accountable.

Moreover, it is by engaging our respondents in the writing up process, for example, by enabling them to review chapters before dissemination and giving them the opportunity to withdraw from the research if they are not satisfied with how they are being represented, that we can begin to lessen our control of the research material. It is not my intention to suggest that such a strategy will necessarily create a fully egalitarian relationship – such an assumption would be epistemologically naive – but it is to suggest that we should not give up on our efforts to try and reduce the power differential which can be argued to be an inherent feature of social research. The need to reduce the disparity of power that exists between researcher and respondent is important because in doing so we recognize that our respondents and not us, especially when we occupy an ‘outsider’ status, are the experts of their lives. Furthermore, attempting to involve ourselves in a more egalitarian relationship can help to lessen the potential harm that we may do to our respondents, by simply reducing them to mere subjects and thereby failing to value their voices, opinions and beliefs.

A Consideration of the Debates on Ethics in the Field

Relationships within the field, together with their consequences for the collection of material involve a number of complex negotiations, many of which are dependent upon how we conduct ourselves as researchers. One of the prominent concerns discussed within feminist methodological texts relates to the ways in which we deal with the large amount of ‘emotion
work' that we experience in the field. This ‘emotion work’ includes, according to Frith and Kitzinger “regulating and managing the feelings of others and oneself in order to conform to dominant expectations in a given situation” (Frith and Kitzinger 1998, cited in Letherby, 2003: 110). The danger of ‘emotion work’ is apparent then for both the researcher and the respondent, and as McRobbie states, it may leave the researcher feeling that she is “holidaying on people’s misery” (1982: 5), given that the researcher is able to leave a distressing situation having gathered the necessary material, leaving the respondent to deal with the situation. Whilst the dangers of exploitation are undeniable, in contrast to McRobbie’s assertions, feminist scholars such as Cotterill (1992), Opie, (2002) and Letherby (2003) believe that, as Letherby summarizes:

“It is morally indefensible to distract someone from talking about something that they feel the need to talk about, and being able to reflect upon and re-evaluate experiences as part of the research can be therapeutic and/or help the respondent re-evaluate their position.”

(Letherby, 2003: 111)

My experiences in the field lead me to support the latter supposition, and as I shall seek to show in the next section, it was apparent that the ‘trans’ women involved in my research were keen to talk about issues that were of a sensitive nature.

**Reflections on the Research Process**

The aim of this section is to address the aims and intentions of my research. Moreover, having addressed a number of feminist debates regarding the questions of power and ethics in the field, in what follows is a discussion of the ways in which I was faced with and attempted to resolve such issues during my own research.

**Aims and Intentions of the Research**

The key to producing a piece of emancipatory research is reducing the power imbalance traditionally associated with positivist research. This has, I hope been achieved in some small way by approaching the research conducted with ‘trans’ women as a relational dialogue. By
rejecting the stance of the ‘neutral’ and ‘objective’ researcher, and by listening to the voices of my respondents, I hope to have gone some way towards empowering them, enabling those involved to speak their stories in their own words and within their own frames of reference.

The Status of Knowledge

The main justification for choosing to conduct a piece of emancipatory research relates to my conceptualization of the status of knowledge. To fail to conduct this research via such a method would be to assume that I and not my respondents are the experts of transsexualism. To suggest that I am privy to ‘a superior kind of knowledge’ because of my academic status is antithetical to the way in which I view myself and my involvement in the field. Moreover, the assumption that as an academic I have access to ‘a superior kind of knowledge’ that is not available to my respondents was contradicted by my time spent within trans communities. A great many trans people read all that is written of, and for them, whether that be of a sociological, a medico-psychiatric, or an autobiographical nature. Thus, to argue that as an academic, I have access to an intellectual capital that my respondents do not, does not appear to hold true in this context.

Negotiating Access

Negotiating access is an important part of field relations and it was important for me that I did not assume the role of the archetypal researcher, and presume an authoritative knowledge of the lives of those ‘trans’ women who were involved in this research. Fortunately, the notion of myself as somehow ‘expert’ and authoritative is not something which sits easily with me. Instead, I found it easier to approach the interactions as a ‘friendly stranger’ (Finch, 1984). All respondents were made fully aware of my intentions for the research from the outset and we entered into conversations about myself and my understanding of transsexualism prior to the interviews taking place, via email, on the telephone and during face-to-face-discussions. This was important in order to break down potential barriers between researcher and respondent.

Moreover, my decision to generate a sample of ‘trans’ women via the method of ‘self-selection’ correlates with my intention to produce a piece of emancipatory research. Respondents were not coerced into becoming involved in the research, neither were they
pressurized to take part out of politeness, instead only those individuals who wanted to involve themselves did so. Not being one of life's most assertive of people I find it nigh on impossible to assume the position of the authoritative researcher. Instead, I prefer to stand back and take a non-assuming position within the field. So it was that I decided that an effective way of establishing contacts from within the trans communities was simply to be myself, a strategy which fortunately worked. Thus, my visits to support groups saw me initially look somewhat like a frightened rabbit, looking out of place and anxiously hoping that someone would talk to me. Relying upon people's natural curiosity and friendliness however, I quickly became embroiled in conversations with people who I could be certain wanted to talk to me, and who in turn introduced me to others. This non-confrontational approach meant that no individual was knowingly placed in an awkward situation, and once word had got round that there was a researcher in their midst, people could choose to actively ignore my presence or engage with what I was doing.

An Ethical Dilemma? A Discussion of Field Strategies

The research conducted with 'trans' women involved the use of what can be described as a narrative style of interviewing, where the intention was to gather stories and experience from those who identified as 'trans'. My intention was to enable those 'trans' women involved in the research to speak for themselves as well as to set the research agenda and content of the discussions. As such, the use of narrative interviewing techniques related to my intention to produce a piece of emancipatory research.

Giving respondents the chance to lead the interviews gave them the opportunity to talk about those issues that were important to them. Moreover, at the close of the interview respondents were asked if there was anything else that they would like to discuss that they felt had not already been covered. A conversation with one of my respondents, Cerridwen (pseudonym), highlighted for me the need not to curtail respondents from talking about the things that mattered to them. At the close of the interview Cerridwen stated that she wished to talk more about the issue of 'denial' (interview transcript), which she saw as being important to her life. Even though talking about this caused Cerridwen a great deal of distress, it was clearly something that she felt she wanted to talk about. To evade this topic, I believe would have been harmful, making it seem that I really wished to discuss only those issues that I believed to be of relevance to the research. Whilst Finch (1984) warns that the 'friendly stranger' approach is likely to encourage vulnerable people to reveal personal aspects of their lives, my
experiences in the field suggested that something quite different was at work, and that rather than pacifying my respondents, their willingness to ‘reveal all’ was taken at face value. Whilst I was initially wary of exploiting my respondents, in that I was asking them to tell me very sensitive information about their lives, it soon became apparent that those involved wanted to talk about such issues.

Disclosing Intimacies: The Role of the Rehearsed Narrative

The willingness of my respondents to reveal their ‘inner selves’ can, I suggest be understood through reference to what Plummer terms the postmodern practice of “disclosing intimacies” (2003: 25). Here we see that people are, more than ever before, willing to talk about and reflect upon their inner-most feelings and aspects of self.

Moreover, when considering the willingness and ease with which the ‘trans’ women involved in this research spoke about their lives and experiences, we must consider the significance of the ‘rehearsed narrative’. Whilst we are all involved in a continual process of story-telling as a means by which to make sense of our self and our position in the social world, ‘trans’ women are perhaps in a unique position in that their apparent ‘gendered difference’ has meant that the telling of their story has had to be more thought-out and less assumed. As such, their trans status has meant that they have had to disclose intimate aspects of their lives not only to themselves, but to their significant others, as well as to members of the medico-psychiatric profession.

It is as a result of this continual process of self-disclosure that many ‘trans’ women have developed a ‘rehearsed narrative’ of their lives, which is a clearly structured and well articulated story of self that can easily be told. Moreover, the rehearsed narrative becomes somewhat crucial in the clinical setting, where the individual is expected to tell, and is judged upon their ability to elucidate a coherent narrative. It perhaps comes of no surprise then that so many ‘trans’ women offer to help in research projects, television documentaries and magazine articles. Because their story has been told so often, they become in many ways detached from it; that is, it is something which comes to be said without the immense degree of introspection that existed at the point of its original telling.
The Limits of Empowerment

Perhaps crucially, interviewing the medical profession, and ‘gender specialists’ in particular comes with its own ethical concerns, not least that the research conducted with this group ultimately contradicted my intentions to conduct a piece of emancipatory research. Thus, I had a clear hypothesis – the big bad ‘gender specialists’ – and this was something that I appeared almost determined to find. It was from this vantage point that I was constantly aware of the sheer volume of leading questions that I was asking. The only consolation was the ease with which so many of the ‘gender specialists’ interviewed enunciated statements that I would consider to be evidence of their mis-conceptualization of the lived reality of transsexualism.

Here then, the most significant problem with my decision to conduct a piece of emancipatory research was that my work with medical professionals was clearly anything but emancipatory. The very same issues of giving voice, reducing the disparity of power, and a concern with representation did not cross my mind when considering how to collect and analyse material gained through such interviews. This left me pondering the question: ‘Is it not problematic to exploit one group in order that another group be empowered?’ This is a question to which the answers (rather cowardly) are left to the reader to decide, and for me to continue to postulate.

Power and Abuse: A Discussion of Field Strategies

Wherever possible, it has been my intention to minimize my control over the research material. So, for example, where respondents misquoted, or wrongly phrased something (to my mind), or urmed or erred I left it alone. To give some control back to the ‘trans’ women involved in the research, once each Theme had been written, copies were sent to those who had been cited and they were able to freely change what had been said and remove statement and hesitancies. While copies were sent to all of the ‘trans’ women cited, only four responded. The main changes suggested related to moments of hesitancy and /or inaccuracy. By including the literature and discussion chapters, respondents were able to contextualize their words within my wider theoretical structure.

However, I inevitably remained in control. Out of the nineteen lengthy transcripts it was me who ultimately decided what was ‘important’. By giving respondents the chance to edit what was said, to read the context in which it was said, and ultimately withdraw if they wished, I
hoped to be able to make steps towards more fully equalizing the research relationship. It is not my intention to declare that researcher control was eliminated completely, as to do so would be unrealistic. Rather, it is to say that, wherever possible, my attempt was to reduce and redistribute the balance of power so that it did not rest completely with me.

A further problem to present itself in relation to the process of analysis is the extent to which we, as researchers ultimately fragment the lives of our respondents. It is because narrative research produces such a voluminous amount of material that, during the writing up process I was confronted with a limited amount of space in which to discuss an individual’s life and experiences. Despite wanting to challenge the simplistic representations of the lives of ‘trans’ women, I am aware that in many ways, my research may have contributed to this fragmentation and simplification.

A Relationship of Dependence

When discussing issues of power, it is useful to recognize that its flow is not one way - the researcher over the respondent - but must be thought of as a relational process and can perhaps be best understood as at times creating a ‘relationship of dependence’. Such a relationship can be understood as my dependence upon ‘trans’ women telling me their stories, so that I could write this thesis, and their dependence upon me, as a vehicle through which they could have their views heard, or at least heard in a way that had some ‘authority’ or ‘status’ attached. Whilst this was not a motivating force for all of my respondents, some involved clearly articulated that their reasons for taking part was due to the belief that I, a researcher, could say (publicly) say what they felt unable to.

That such a dependency relationship was formed with a small number of my respondents created a great deal of pressure for me; I knew that I would never be able to include all that they had said, and worried constantly that they may feel let down by the thesis. The only answer to this dilemma is that while representation may be more limited than I may have hoped for, it is at least better than no representation at all.
Intersections of Power

It is important to understand the dynamics of power that exists through every aspect of an individual's identity. While an individual may occupy a marginalized position as a result of their trans status, it is important to recognize that other intersections of power such as class, gender, sexuality, and racialized identity are also involved in the construction of self. This presented a paradox within my research, for while as a community, trans people are often marginalized, as individuals, many occupy a position of relative social power as a result of other facets of their self. For example, some of the people I met during the course of this research have occupied professional positions, and as such are able to draw upon these aspects of social power to lessen their individual marginalization. Connected to this, it is worth noting with regards to the ethics of conducting a piece of emancipatory research, that it may well have been the case that not all of my respondents will have wanted or needed to be empowered. This may be especially pertinent given some of the hostilities I encountered by some trans people not involved in the research, who expressed concerns over my 'outsider' status.

A Question of Gender

Perhaps unsurprisingly, during my time in the field, my gendered status, or the management of my gender identity became one of the most pronounced issues to affect my relationship with respondents and this had consequences for the type of material I was able to gather.

Much of the early sociological studies into transsexualism raise important issues for the negotiation between non-'trans' female researchers and 'trans' women. Bolin, for example, argues that "transsexuals highly value genetic women [sic]" (Bolin, 1988: 37). Despite Bolin's assertion, my experiences of interviewing 'trans' women paints a somewhat contradictory picture. Rarely, or ever, was I made to feel 'special' because of my sex/gender congruent 'female' status. When my gender did become a slight issue, this was less a result of my being female, as it was about me not being trans. Here, some individuals expressed concerns over a non-trans person attempting to research the lives and experiences of those who did identify in this way.

Interestingly, my gender identity was to become an issue when interviewing 'gender specialists'. During my time spent interviewing this group of professionals I became
surprised at the ease with which so many of them would elucidate remarks that I considered inflammatory. This can be explained in part, as a product of my age, gender and rather nervous demeanour. The felt need of so many of the white, middle-class men to ‘talk down’ to me and use quite basic language, seemed at times to result from their particular viewing of me – a young, slim, timid, girl (and therefore obviously unintelligent). However, I quickly came to realize that this was something that could be used to my advantage. In this situation then, gender truly is performative! By hamming up my girlishness and inferiority I soon realized that I was privy to all sorts of information that perhaps would not be disclosed to an older, intelligent man.

Such a viewing of my ‘inferior’ female status did not however appear to be shared during those relationships formed with the three female ‘gender specialists’ interviewed. By virtue of our shared gender identity, a consequent equalizing of gendered-power relations seemed to occur. Here then, the relationship took more of an egalitarian form, and in fact in the case of one interview, the power dynamic was reversed, with her viewing me as something of an ‘expert’ against her relative newness to this area of study.

The Reliability and Validity of My Research

The research did not seek to reproduce a cohesive representation of each community, rather it only gives clues to the experiences of those involved in the research. What follows throughout the thesis can only be described then as a reflection of the lives and experiences of those involved, and cannot be said to represent trans communities as a whole, nor specific trans communities, but can only speak through the specificities of the individual ‘trans’ women’s lives. However, and in spite of this, those life histories contained within this thesis did reveal certain common problems and experiences. It is because of the unique value of the narrative or life history method that we are able to make connections between an individual account and a group experience.
Research Objectives: A Discussion of the Methodology

Sample

General Practitioners

GPs were selected using the Internet database *Ultimate Health Gateway*. The sampling method was that of “systematic sampling” (O’Connell Davidson, 1994: 89), and the following process was used: the database organizes each primary care trust (PCT) by town in alphabetical order. Each letter was selected in turn, which then provided me with a list of towns. Where a large number of towns appeared I randomly selected five, and where only a small number of towns were listed under a given letter, one town was selected. Finally, having been presented with a list of PCTs within that town, every fifth PCT was selected to give me my final sample.

At the end of this process I was left with a sample of 335 national PCTs. Each of these was then contacted and sent a copy of Questionnaire 1 (Appendix 1a). At the end of this questionnaire the GP was asked whether s/he would be willing to participate in a second questionnaire (Appendix 1b) and/or a semi-structured interview (Appendix 1c). A total of 147 GPs (44%) responded to the first questionnaire, and from that 33 (22%) agreed to completed the second questionnaire and nine (27%) agreed to be interviewed.

‘Gender Specialists’

The selection of my sample of ‘gender specialists’ (psychiatrists, psychoanalysts, psychotherapists, gender counsellors, surgeons and endocrinologists) was based on a “non-random” method of sampling (O’Connell Davidson, 1994: 94) and was collated using the same website used to select the GP sample. Because there are very few ‘specialists’ working within Britain, all individuals listed were contacted. This list was supplemented with the names of other ‘specialists’ I already knew of. In total 40 ‘gender specialists’ were contacted and sent a copy of the questionnaire (Appendix 2a). Of those half (50%) completed and returned the questionnaire and nine (23%) agreed to be interviewed (Appendix 2b).
‘Trans’ Women

My sample of trans respondents was self-selecting. The first method used to contact trans individuals was through visiting two transvestite/transsexual (TV/TS) support groups in different areas of the country. In the second instance, I placed a request for research respondents on two Internet discussion groups. The request detailed the intentions of the research, what the interviews would entail and an assurance of confidentiality. This method proved to be enormously fruitful, with most of my respondents having been contacted in this way. Finally a number of respondents were contacted during a national trans conference. In total 28 individuals expressed an interest in becoming involved with the research, however, due to drop-out, of those 28, 19 ‘trans’ women were interviewed (Appendix 3a; see also Appendix 3b for a short biography of those involved).

Methods

Research with the Medical & Medico-Psychiatric Profession

Research with GPs and with ‘gender specialists’ involved firstly, the dissemination of a postal questionnaire, which incorporated both structured and semi-structured questions. The purpose of the initial questionnaires (Appendix 1a and Appendix 2a) was to establish the individual’s level of knowledge, training and experience of transsexualism. The questionnaires also included a series of statements relating to the diagnostic criteria for transsexualism, as contained within the literature. Respondents were asked the extent to which they agreed or disagreed with each statement. The aim here was to establish the extent to which GPs and ‘gender specialists’ agreed with a series of key diagnostic tropes as outlined within the medico-psychiatric literature. From this I hoped to be in a position to establish the extent to which an overlap exists between medico-psychiatric discourses and clinical practice, a conjecture that was addressed in more detail in the interviews (Appendix 1c and Appendix 2b).

A second questionnaire was sent to GPs who had agreed to participate further (Appendix 1b). The purpose of this was to add depth to those answers given in the first questionnaire. Also, it was anticipated that because of time constraints, few GPs would take up the invitation to participate in an interview.
The final stage of the research conducted with GPs and 'gender specialists' involved a semi-structured interview, which lasted on average for 15 minutes for GPs and 30 minutes to one hour for 'gender specialists'. The intention of the interviews was to further elaborate upon the ways in which they made sense of transsexualism. Whilst it was my intention to conduct each of these interviews face-to-face, I had to conduct one interview with a 'gender specialist' over the telephone, as he was too busy to meet in person. Whilst the interview was devoid of the nuances of face-to-face interaction, the information elicited was incredibly detailed.

Research with 'Trans' Women

Rather than barrage my respondents with a series of questions that I deemed to be important, it was my intention to enable them to tell me about what they felt was important to them. To achieve this, I decided not to use a set script as such, but to have a series of loose themes or areas that I wanted to cover (Appendix 3a), the content and order of which was to be directed by the respondents themselves. Interviews lasted for anything from one to three hours. Such a method enables respondents to narrate themselves rather than having their responses contained within a rigid and sometimes alien structure.

Where any editing was done it was as a means to secure anonymity, thus personal details - age, residential location, year of transition, etc - were removed, even when the person's own name was used. Finally, participants were given the option of whether to have their names used or whether they preferred to use a pseudonym.

Whilst the majority of interviews were conducted face-to-face, two interviews were conducted via email and one via letter writing. Such methods were chosen due to either constraints upon time, or because the individual was unwilling to meet face-to-face (unsurprisingly given that I was expecting those involved to accept that I was genuine when they knew little about me). Whilst such forms of interviewing were far shorter and more precise than those conducted face-to-face, they are nonetheless worthwhile. Moreover, it was important that I accepted individual's wishes about how they wanted to take part.
Analysing the Research Material

All transcripts (from GPs, ‘gender specialists’ and ‘trans’ women) were treated as a text and were made subject to thematic analysis. Each transcript was read several times, and was cross-checked with the original tape recordings.

The second stage of the analysis was more intensive. A conscious decision was made not to use qualitative data packages such as N*UDIST, instead I favoured the more traditional approach of colour-coding; a technique which I believe afforded me a greater degree of closeness with the material because of my constant contact with the raw material. During this stage of analysis, each transcript was examined and detailed notes were added in order to clarify meanings and subject areas. Frequency and content were taken as indicators of the mileage of a certain theme. By comparing and contrasting across entries, emergent themes that were found to be repeated were upgraded in status to recurrent themes that expressed some common and important elements of the experience of those ‘trans’ women involved in the research.

The final stage of the analysis was handed over to my respondents. Once each theme had been written up, copies were sent to those ‘trans’ women cited. Although only a small number made any changes, which generally involved the removal of moments of hesitancy, this was nonetheless an important exercise, ensuring that nothing they said had been taken out of context, as well as being a pertinent means by which to involve them in the authorship of their stories as well as the thesis. Moreover, it provided the respondent’s with the opportunity to withdraw from the research altogether if they disagreed with the direction that the thesis was taking. Fortunately this did not arise.

Conclusions

The aim of this chapter has been to assess the methodological and epistemological concerns of this thesis, together with my approach to those issues that arose from conducting a piece of emancipatory research, which draws largely upon the narrative tradition of interviewing. The chapter concluded by providing a descriptive account of what I actually did in terms of finding a sample, the methods of research and the analysis of research material.
Taking as my starting point the premise that research with silenced groups should be emancipatory, a stance informed largely by critical and feminist methodological and epistemological writings, I hope to have shown some of the ways in which this can be achieved, as well as some of the problems that arise from such an assumption. Moreover, I hope that my commitment to the emancipatory project has demonstrated some of the ways in which we, as researchers should, and indeed can, act in a manner which is ethically sensitive. Thus, my concern to allow ‘trans’ women to speak their stories revealed that this is an important factor of research, which should not necessarily be shied away from, but which can be an important strategy for respondents, who are, more often that not, all too willing to talk about such issues.

Finally, I have discussed some of the limits of an empowerment approach to social research. In the first instance, it may be problematic to assume that all of our respondents actually want us to empower them; an assumption which could be regarded as evidence of academic egocentricism. Also, there is the ever present issue of what to do when researching a group of people whom you do not want to empower. My work with ‘gender specialists’ showed this to concern to be a reality, and whilst it is an issue that I have not necessarily been able to resolve, I hope that by highlighting it as a matter of concern, I have demonstrated its importance to my work.
Theme 1

Definitions and Pathology: The Origins of Transsexualism
Transsexualism, Pathology and Social Control: A Review of the Literature

Whilst medical science provides an extremely limited understanding of transsexualism (or sexuality in general), this 'scientia sexualis' is nevertheless powerful and has the capacity to define and control people's lives in subtle as well as forceful ways.

(Rosario, 1996: 37)

Situated within sociological debates vis-à-vis discursive versus labelling perspectives and essentialist versus constructionist accounts which seek to understand the emergence of 'deviance' and especially sexual 'deviance' as a social category, the aim of this chapter is to provide an account of the emergence of trans as an object of scientific inquiry. As such the literature discussed traces the contemporary medico-psychiatric understanding of transsexualism, as well as the formalization of a trans identity to the sexological discourses of the late nineteenth century. Following Prosser (1998) it is my contention that a number of those individuals categorized as 'inverts' appearing in, and speaking through sexological case histories can be said to be the first authors of the trans narrative, thus constructing what we would now understand as a trans identity. Moreover, the enabling role of sexology meant that once those trans narratives were heard by the relevant professionals they came to be articulated within a discourse of science which "in large measure, created the terms for comprehending (trans)sexual desire and (trans)gender identification" (Sharpe, 2002: 17). The recognition of such a symbiotic relationship accredits a degree of agency to trans people, understanding that it is they who are the original authors of the trans narrative, and not the medico-psychiatric profession (see for example Hausman, 1995), whilst simultaneously recognizing the ways in which sexology enabled the successful telling of this narrative –
giving it a name and accrediting it with scientific legitimacy. A consequence of this was however, that the personal story was transformed into a discourse of pathology. It was during the period of the latter half of the nineteenth century that, as Foucault has suggested, “there emerged a world of perversion ... A setting apart of the unnatural as a specific dimension in the field of sexuality” (Foucault, 1976: 39-40). Sexual deviancy came then to be defined and the causes of that deviancy were espoused.

As King (1993) has noted, when seeking to understand a particular societal practice, it is important to look at the writings of those charged with authority over that practice, in terms of the ways in which a particular phenomenon has been given social meaning. In the case of transsexualism, those ‘experts’ charged with the authority to define it as a ‘condition’ have been members of the medico-psychiatric profession.

Moving on from a historical account of the emergence of transsexualism and its relationship with medico-psychiatry, the second half of this chapter looks at the ways in which this contentious relationship becomes sedimented within contemporary clinical practice. This section then addresses that literature relating to the role of ‘treatment’, and more specifically, the role of medico-psychiatric professionals as the gatekeepers to that ‘treatment’. The intention is then to consider the role of medico-psychiatry as well as the formalization of a protocol of care as it is structured through the edifice of medico-psychiatry, together with the profession’s dominance within contemporary gender identity clinics (GICs) as a means by which to begin to understand the ways in which, what I have termed medico-psychiatric imperialism, can be said to dominate the clinical ‘management’ of transsexualism.

Constructing ‘Deviance’

The aim of this section is to attend to two sociological perspectives which have sought to understand the emergence of specific forms of behaviour and their subsequent codification as ‘deviant’ – a discursive approach and a labelling approach. Doing this enables us to situate the emergence of transsexualism and its relationship to both discourses of ‘deviance’ and pathology, as well as its relationship to medico-psychiatry, within wider sociological theories. Moving on from looking at the ways in which the stigmatizing label of ‘transsexualism’ has emerged historically, the section also looks at two theories – the ‘discovery story’ of transsexualism, which is situated within an essentialist paradigm, and the ‘invention story’ of
transsexualism, which is situated within a social constructionist paradigm (King, 1993, 1996) – which both seeks to explain the relationship between medico-psychiatry and trans-subjectivity, as well as the origins and status of this area of medical knowledge.

Foucault and the Discursive Construction of ‘Deviance’

For Foucault, ‘discourse’ refers to “a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment” (Hall, 2001: 72). It is in this way that discourse is about both language and practice. By constructing issues of concern, discourse both defines and produces objects of knowledge, and as such governs what can be meaningfully said and known about something. In so doing, an important function of discourse is its ability to regulate the conduct of others.

Foucauldian discourse analysis seeks to understand the ways in which, historically, subjects have come to be defined as, as well as constituted through a range of discursive practices. One of the main focuses of this inquiry has been the discursive construction of sexuality, and the subjection, regulation and control of ‘deviant’ desires. With the transformation of desire into discourse – that is, social practices with powerful and ‘real’ material effects (Walkerdine, 1986), Foucault (1976) argues that from around the seventeenth century, if not earlier, language has been used to subjugate dissident sexualities. However, these dissident sexualities have not simply been repressed, rather they have been “multiplied and fractured” (Taylor, 1997: 118). Meanwhile, those discourses, or ways of talking about a particular practice have been “legitimized and empowered [in their ability] to define and control” (Taylor, 1997: 118).

The attendant effect of this turn to discourse was that ways of being sexual, which confronted established sexual hegemony, became known as ‘deviant’. It is in this way that discourses can be said to regulate subjects, by defining, at particular historical moments, that which is to be considered ‘normal’ and consequently, that which is to be considered ‘non-normal’. This ‘deviancing’ (Taylor, 1997) of behaviour through the discursive regulation of sexuality has had real material effects on its subjects. For instance, medical discourses that have constructed trans identities as pathological have positioned trans people within a discourse of deviancy and made them subject to its normalizing judgements (Foucault, 1979).
Moreover, by radically historicizing discourse, Foucault aims to suggest that it is only "within a definitive discursive formation that the object", in this case the transsexual, "could appear at all as a meaningful or intelligible construct" (Hall, 2001: 74). Further to this, the perspective suggests that it was only after a certain definition of 'transsexualism' was put into practice, that the subject – the 'transsexual' – could appear (see Hausman, 1995, for a fuller discussion of the ways in which a discursive theory can be applied to the emergence of a trans identity).

Arguably, as Malson (1997: 227) contends, a discursive approach to the construction of deviance is useful in that it "attends to meanings [and] to the ways in which objects, bodies and 'identities' are multiply constituted in discourse". However, where this theory falls down is, to my mind, in its negation of the subject as being active in the construction of their identity. Thus, such a theory fails to fully consider the ways in which identity can be constructed through a process of constant negotiation between the subject of a discourse and that discourse itself.

Labelling and 'Deviance'

The labelling approach to 'deviance' provides an exploration into how and why certain acts come to be defined as criminal or 'deviant'. From such a perspective it is possible to suggest that it is not the individuals who engage in such acts that are deviant, rather, it is that they have had that status placed upon them by wider social institutions.

The focus of the labelling approach is upon the reactions of other people and the subsequent effects of those reactions which create deviance. When it becomes known that an individual has engaged in 'deviant acts', she or he becomes segregated from society, and thus labelled 'transsexual', 'transvestite', homosexual', 'queer', 'fag' and the like. This process of segregation creates 'outsiders' and the label that is thus attached to an individual performs the function of a self-fulfilling prophecy – that is an individual responds to their label and engages in behaviour which is expected of them.

Such an approach to labelling and 'deviance' as externally imposed is somewhat deterministic, in that it fails to accept that people can, and indeed do, resist those labels, as well as failing to recognize the positive effect that labelling can potentially have for an individual – that is, by providing a name for a set of behaviours, individuals are able to situate their behaviours within a conceptual framework, as well as construct and locate communities.
of like minded others as a result of that label. However, a number of theorists have usefully applied labelling theory to the study of homosexuality (Simon and Gagnon, 1967; McIntosh, 1981; Plummer, 1981).

Plummer (1981) suggests two ways in which labelling approaches to homosexuality have been developed, and both can equally be applied to the labelling of transsexualism (see King, 1981). The first strand, Plummer terms the ‘labelling theory’ of deviance (1981: 21-23), which is concerned with “how historically produced stigmatizing conceptions surrounding [cross-sex] experiences have dramatic consequences for those experiences” (Plummer, 1981: 17). The second, Plummer terms a ‘labelling perspective on deviance’. Following McIntosh’s (1981) thesis on the construction of the ‘homosexual role’, and applying its central tenets to the construction of a ‘transsexual role’, we can see how this perspective works. From this perspective, at the point at which ‘transsexualism’ and ‘the transsexual’ became labelled, and thus became part of the social order, “the members of that social order started to act in terms of that conception” (Plummer, 1981: 23). The suggestion is that transsexualism could not be meaningfully known prior to the point at which it had been labelled. It is in this way then, that while trans experiences may well have existed across time and space, the trans role, or identity, is the product of a certain historical and cultural moment. Much like the discursive approach to ‘deviance’, the labelling perspective falls down on several grounds. Firstly it unproblematically assumes that the trans role or identity emerged in the 1950s; that is, at the moment of its entry into language. Related to this is the negation of agency; that is, the active role played by the trans person, in the construction of a trans identity.

Recognizing the limitations of this perspective, Plummer (1981) seeks to answer the central tenets of the labelling perspective – how do individuals come to be categorized within a specific identity? – by applying the tradition of symbolic interactionism, which draws upon the social constructionist paradigm and pays attention to the ways in which we interpret our sexed, gendered and sexualized self through ‘scanning’ our ‘past lives’ and “connecting these to ‘accounts’ available in [our] contemporary worlds” (Plummer, 1981: 69). It is in this way that a symbolic interactionist approach to labelling draws upon the ways in which we negotiate and construct a sense of self continually throughout our lives.

The usefulness of following the labelling perspective of deviance, especially as it is framed within symbolic interactionism, over a discursive approach is that it enables us to conceive of the active subject, who negotiates a sense of self in relation to ways of thinking about
particular identity categories. Moreover, it goes someway towards recognizing the instability of those labels, which can be played with, negotiated and potentially changed. Here, Foucauldian ‘resistance’ becomes played out on a more realistic stage which recognizes the continual interplay of power relations in the construction of the self.

Debates on the Origins of Transsexualism

Following the discussion of the ways in which labelling perspectives can help us account for the historical emergence of the category of transsexualism, we can use King’s (1993, 1996) dyadic typology – the ‘discovery story’ and the ‘invention story’ - to assess the origins of transsexualism and its relationship to medico-psychiatry as it is scripted within the opposing paradigms of essentialism and constructionism (see the introduction to this thesis for an account of the premise of each of these paradigms).

The medico-psychiatric community has defined transsexualism as being:

“A persistent sense of discomfort and inappropriateness about one’s anatomic sex and a persistent wish to be rid of one’s genitals and to live as a member of the other sex.”

(American Psychiatric Association [APA], 1980: 261-2)

However, it is important to discuss the debates concerning the origins of this definition.

Discovering Transsexualism: An Essentialist Perspective

Firstly, King details what he terms the ‘discovery story’ of transsexualism. In this story, told predominantly by a small number of medical professionals working within the field of gender and sexuality, transsexualism is understood as a condition whose existence “occurs independently of human thought about it” (King, 1993: 47) and as such “is a ‘given’ disorder which has been discovered” (King, 1996: 76) as a result of detached and objective scientific inquiry. Here then, transsexualism, rather than being thought of as a condition peculiar to our modern times, “is conceived of as a basically timeless and culture-independent condition or disorder” (King, 1993: 45). It is in this way that the ‘discovery story’ of transsexualism falls
within an essentialist paradigm, which asserts that transsexualism and other 'sexual deviancies' exist outside of social and cultural relations and rather, reside in the body. It is because of essentialism's coupling of 'deviance' with the 'un-natural' that those who subscribe to this perspective believe that individuals who engage in deviant practices must be kept in check by moral Others, in order to deflect any challenges to the sexual norm.

This scientific 'discovery' of transsexualism, with its attendant raft of research (see for example, Benjamin, 1953, 1954, 1966; Stoller, 1968, 1973, 1975) is said to remove intolerance and misunderstanding from a condition often drenched in prejudice. In this vein Erickson writes:

“Only after years of dedicated scientists who had to break through powerful barriers of superstition and prejudice ... [This] courageous and skilful group has ventured into the unknown area. Making their way through a confusing maze of mores, laying bare conflicting factless theories, they have disregarded the centuries of prejudice to blaze a trail for understanding and facts ... [So] where there was so much ignorance there is now some real detailed knowledge. Where there was so much prejudice, now there is less of it, and we have some solid data to counter the prejudice that remains.”

(1969: xii-xiii)

It is clear then that medical science, through its telling of this story, regards itself as the champion of transsexualism, liberalizing former 'social deviants' from the plethora of stigmatizing judgements.

However, in adopting a position of essentialism, which promotes a pathological theory of social deviance as residing in the body as a 'natural' and inevitable condition, medical science assumes:

“the existence of a group of people who can be separated out from the rest of humanity by virtue of possessing or suffering from this condition which determines their conduct. Moreover, the nature, or essence of this condition and these people is presumed to be independent of our knowledge about them.”

(King, 1993: 3)
In this way then, far from liberalizing our attitudes towards sex and gender, medical science has in many ways become ensnared in the production of discourses of pathology.

**Medicine and Social Invention: A Social Constructionist Perspective**

A second explanation for the origins of transsexualism and its relationship to medico-psychiatry is described by King as a 'story of invention'. The story of the 'discovery' of transsexualism, steeped in essentialist assumptions about sex and gender has been criticized for naturalizing what is in fact a social construction (Sagarin, 1978; Raymond, 1979; Billings and Urban, 1996). According to King (1987, 1993, 1996), the 'invention story' views the medical discovery of transsexualism as "an illusion, a fabrication whose explanation must therefore be sought in terms other that the putative 'thing' itself" (Ekins and King, 1996: 76). Moreover, writers from within this tradition claim that:

"once conjured up, legitimized and disseminated, this illusion [of gender deviance] has real social consequences through the actions of the medical profession, 'transsexuals' themselves and other members of society, all of who have been seduced into believing in it."

(Ekins and King, 1996: 76)

The theoretical paradigm in which the invention story is located is that of social constructionism. Social constructionism provides an alternative to the essentialist paradigm outlined in the 'discovery story'. By problematizing, and indeed overturning the essentialist assumption of a singular and objective 'truth' which simply awaits medico-scientific discovery, social constructionism is able to problematize the belief that certain phenomena can be explained away through reference to (bio)logical destiny, inner-'truth' or essence. Moreover, it is able to problematize the social relations of illness by unmasking the supposed objectivity of medical science.

Thus, for social constructionism, there is no inherent human drive which pre-exists the entry into language and culture (Ortner and Whitehead, 1981). Instead, as Weeks observes, "desire is constituted in the very processes of that induction, in which the component instincts of the polymorphous perversity of the young human are involuntarily conscripted onto the demands of that culture" (1982: 299).
Within this ‘inventionist’ story, transsexualism is viewed as a “product of social relations rather than as a discovery made by detached medical science” (King, 1987: 353). In contrast to the ‘discovery story’s’ portrayal of transsexualism as existing cross-culturally and transhistorically, writers positioned within the social constructionist paradigm view transsexualism as historically and culturally specific. From this perspective, medicine and scientific endeavour, rather than discovering transsexualism, can be seen as complicit in its construction.

Contained within the story of ‘invention’ is the need to distinguish between ‘real’ diseases which medicine can discover and ‘unreal’ ones which are invented. According to Sontag (1978), “forms of illness are always more than biological disease; they are also metaphors bearing existential, moral and social meanings” (cited in Billings and Urban, 1996: 112). This critical approach to biomedicine argues that the reified disease language of medical science serves to obscure the social origins of negotiated illnesses, which often have little basis in biology (Holzner and Marx, 1979).

A number of writers have used this critical approach to biomedicine to directly critique the medicalization of transsexualism. Sagarin (1978) argues, for example, that transsexualism is an invented condition, the incidence of which has been amplified as a result of its legitimization and dissemination. The real conditions, according to Sagarin (1978: 250) are effeminacy, homosexuality and transvestism. Yet a number of people embrace the transsexual diagnosis, Sagarin argues, because attributing their behaviour to a ‘legitimate’ medical condition, ‘curable’ only by means of surgery, relieves the stigma which they face.

Critical of these invention/constructionist stories of transsexualism, Prosser argues that they do nothing but “represent the transsexual as the archetypal constructed subject because of his/her medical construction” (Prosser, 1998: 8) and thus fail to examine the extent to which trans people are themselves active in the construction of their identity. The main concern with the ‘invention story’ then is its neglect of trans agency; that is, the trans subject’s ability to both effect her/his ‘change of sex’, but also their crucial role in shaping medico-psychiatric narratives of transsexualism. One potential problem of those debates emanating from within the field of social constructionism is that they often devalue the ‘not natural’ and so invalidate the subject’s claims to legitimate voice, by depicting them as constructed by, rather than active in the construction of their subjectivity.

King’s typology for the origins of the transsexualism, as it is scripted within the two opposing paradigms of essentialism and social constructionism proves very insightful and provides a
clear documentation of the opposing ways in which we can think about the historical emergence of transsexualism and its relationship to medico-psychiatry. However, this typology falls down in its failure to consider a third explanation – that of the narratological origins of transsexualism and the ways in which trans people can be said to have been active in the construction of a trans identity, together with an account of the historical emergence, silence and re-emergence of the trans narrative (see below) – an explanation which allows us more adequately to explain transsexualism’s relationship to medico-psychiatry as well as the ways in which that relationship has altered at different historical moments.

‘Trans’ Women’s Narratives and the Risk of Essentialism

Moving the essentialist/constructionist debates on from providing an insight into the origins of transsexualism, it is necessary to look at the ways in which ‘trans’ women’s understandings of self can be understood in relation to this paradigm. As we shall see in the chapter that follows, as well as in Theme 2, Chapter 5, the ‘trans’ women involved in this research espoused an essentialist view of transsexualism (transsexualism as an intersex condition of the brain, the origins of which are framed within a (bio)logical aetiology). This stands in stark contrast, as we shall see in Theme 3, to the claims of Transgender theorists (Garber, 1992; Bornstein, 1994; Halberstam, 1994; Cameron et al, 1996) who drawn upon social constructionist, and more specifically queer deconstructionist theories of the status and origins of transsexualism. Why is it then that all of the ‘trans’ women that I spoke to positioned themselves within an essentialist framework? The answer, I suggest can be found by looking at those humanist debates which suggest the ways in which essentialism acts as a ‘linguistic strategy’ (Locke, 1960; Scholes, 1987: see Fuss, 1989) as well as a powerful political strategy (Spivak, 1987). Moreover, and as Fuss suggests, it is perhaps because, unlike those who identify with a gay politics, ‘trans’ women “have more to lose by failing to subscribe to an essentialist philosophy” (1989: 98-9). Finally, from a Foucauldian perspective, we can suggest that it is by framing transsexualism and the category ‘transsexual’ within an identity politics that draws upon an essentialist assumption of ‘class’ that ‘trans’ women are able to construct a ‘reverse discourse’, whereby, rather than being the subject of discourse, they can actually talk for themselves and thus “demand that [their] legitimacy and ‘naturality’ be acknowledged” (Foucault, 1981a: 101).
In seeking to discuss why so many ‘trans’ women employ an essentialist understanding of identity, I have found it useful to consider the work of Diana Fuss (1989, 1991). In *Essentially Speaking* (1989), Fuss outlines the key debates which encourage us to critically think again the total devaluation of the ‘essential’.

In discussing the work of Scholes and his essay ‘Reading Like a Man’ (1987) Fuss highlights the use of Locke’s (1960) idea of ‘nominal’ versus ‘real’ essence. Here a ‘real’ essence refers to something which is thought to be ontologically stable, whilst ‘nominal’ essence “refers to the ranking and labelling of things not according to the real essence in them but the complex ideas in us” (Fuss, 1989: 24). For Scholes, feminism can only be truly effective if it employs the linguistic strategy of ‘a class of women’ as a nominal essence which draws upon the assumption of shared experiences of being a woman, and its implications for feminist theorizing and action. However, for Fuss the danger of thinking in terms of a ‘class’ of women, is assuming that we know what constitutes a shared experience. Whilst Fuss agrees that it is useful to view experiences as constructed as well as constructing (Scholes, 1987), the danger is in reifying ‘nominal’ to stand for ‘real’ essence. Here then, and applying this to the experiences of ‘trans’ women, whilst it may seem obvious that ‘trans’ women share similar experiences of their bodies, those experiences “are always socially medicated” (Fuss, 1989: 25). Thus, the trope of transsexualism – that of being trapped in the ‘wrong’ body – is something which is not merely constructed for them, but is also something which ‘trans’ women are themselves active in constructing. Moreover, it would be rather naïve to assume that there is a total acknowledgement of what makes up a ‘trans’ woman’s experience. Thus, just because something is experienced, it cannot necessarily be thought to constitute the ‘real’, the ‘essence’ of an identity.

However, it is the assumption of a ‘class’ of women, or ‘trans’ women, as a distinct identity category that has been a crucial take-off point for political empowerment. Whilst Butler, warns that such ‘class’ based identity politics has tended to involve the regulation of subjects, operating as “normalizing categories of oppressive structures” (Butler, 1991: 13), it is important to recognize, as Spivak does, the role of essentialism as a “strategy for our times” (1987: 207), in that it makes possible the articulation of ‘outsider’ positions as legitimate identity categories in their own right.

Documenting the words of Spivak (1987), Fuss notes how:
“When put into practice by the disposed themselves, essentialism can be powerfully displacing and disruptive ... it represents ... an approach which evaluates the motivations *behind* the deployment of essentialism rather than prematurely dismissing it as an unfortunate vestige of patriarchy.”

(Fuss, 1989: 32)

We can perhaps add to the need to look for the motivations of essentialism’s deployment, the need to understand the outcomes of its use by those who have been Othered. Thus, as I seek to show throughout this theme and the next, ‘trans’ women’s deployment of an essentialist narrative of self, not only serves to construct a strong and powerful position from which to speak (of medical legitimacy rather than psychological ‘perversion’), but also has the outcome (intended or otherwise) of seriously confronting the more powerful ‘truth’ claims to trans identity that abound within the realm of medico-psychiatry.

However, as Fuss (1989) heeds, whilst the temporary operationalization of essentialism can be beneficial, the question becomes one of “at what point does this move cease to be provisional and become permanent?” (Fuss, 1989: 32). For while as a temporary strategy, essentialism may prove useful, it may also create a “re-entrenchment of a more reactionary form of essentialism” (1989: 32). Here then, the articulation of a politics via oppositional identity categories needs to be understood as risky, in that it may well result in reaffirming the centrality of that which it seeks to resist (Fuss, 1991), and thereby naturalize difference (Scott, 1992). Here then, we return to the problem of the ‘nominal’ essence being assumed to be a ‘real’ essence, whereby identity categories become rendered fixed and permanent as opposed to historically and culturally constructed. Perhaps, however, Fuss (1989) contends, the value of the essentialist tale depends upon who is telling it. For indeed, when essentialism is a strategy used by those in a position of power, it acts as a “powerful tool of ideological domination”, yet when in the hands of the oppressed, such “humanism can represent a powerful displacing repetition” (Fuss, 1989: 32). Here then, ‘trans’ women’s tale of essentialism needs to be understood as a powerful means by which they can secure a legitimate position within a harsh and unforgiving world, whilst simultaneously presenting a challenge to those discourses constructed of and for them by medico-psychiatry, by using its frames of reference as the basis of political change.
A Historical Trajectory of Pathology and Normalization

Having discussed a number of ways in which we can think about the emergence of definitions of sexual deviance, as well as polarized accounts for the emergence of transsexualism as a distinct area of medico-psychiatric study, I now want to turn my attention to a broader discussion of the history of transsexualism and its relationship to medico-psychiatry, which builds upon my critique of King's typology. The intention here is not to provide a review of the literature so much as it is to set the historical scene for the emergence of transsexualism and its contentious relationship to medico-psychiatry. As such, this section stands as the backbone to one of the principle arguments of the thesis - that is, it shows the extent to which trans people were active in the construction of a trans identity, and that that identity position emerged prior to its medico-psychiatric naming. It is from this that I hope to demonstrate throughout the thesis the ways in which we can use this theoretical underpinning to critique and suggest new ways of thinking about the relationship between medico-psychiatry and trans-subjectivity as either one of reification or duplicity.

The transsexual was not officially named until 1949 when David O. Cauldwell diagnosed a 'trans' man who had written to him seeking 'treatment' with hormones and surgery, as a "psychopathic transsexual" (Cauldwell, 1949: 274-80). Four years later Harry Benjamin began the process of outlining what was to become the foundational theory of transsexualism, which emphasized its distinctiveness from transvestism and homosexuality (Benjamin, 1953). It would seem then that the transsexual and thus a trans identity had been born through this medico-psychiatric naming. However, following the work of Jay Prosser in his seminal publication Second Skins (1998) we can begin to suggest that that which we take to be a trans identity did in fact exist prior to this medico-psychiatric naming, and that rather "this naming of transsexuality was a response to pre-existent transsexual identity patterns and indeed embodiments" (Prosser, 1998: 9-10) occurring from around the late nineteenth century.

Reviewing the medico-psychiatric as well as the sociological literature on the subject reveals four distinct phases in the emergence and official sanctioning of a trans identity: the sexological period and the invert; psychoanalysis and homosexuality; the 1950s and the emergence of transsexualism and the paradigm shift from 'transsexualism' to 'gender dysphoria'. By following the work of Prosser (1998) and others (King, 1993, 1996; Sharpe, 2002) as well as drawing upon the medico-psychiatric literature relating to the definition of transsexualism, we can begin to develop a useful insight into the historical emergence of
transsexualism as well as the dynamics of power that exist within the relationship between medico-psychiatry and trans-subjectivity.

The Gendered 'Invert': Sexology and the First Trans Narratives

From the nineteenth century sexologists such as Ulrichs, Krafft-Ebing and Westphal published case studies relating to what was termed 'inversion'. If we study these first descriptions of inversion we are able to see that “the patient’s self-descriptions are phenomenologically akin to those of ‘transsexuals’” (Rosario, 1996: 40). Ulrichs description of the ‘Uriningen’; that is those with a female soul caught in a male body, primarily suggests the gender sentiments of transsexualism rather than homosexuality (Prosser, 1998), as suggested by a number of gay and lesbian historians (see for example, Katz, 1976; Wheelright, 1989; Hirschauer, 1996). The transsexual sentiments of this description can be clearly evidenced in the following passage by Ulrichs in reference to a female invert:

“Our characteristics, the manner in which we feel, our entire temperament is not masculine, it is feminine. [...] We only act male. We play the male just as an actress plays a man on stage [...] it is impossible for us to transform our female instinct into a male instinct.”

(Ulrichs, 1864, cited in Rosario, 1996: 40).

It is this articulation of inversion, centred upon disembodiment, which anticipated and gave life to the trans narrative that would, in the twentieth century, receive medical endorsement, thus effectively commencing “the mapping of transgender as an identity category in the west” (Prosser, 1998: 143).

According to Prosser, the reason behind the standard reading of inversion as being about same-sex desire is because readers of sexological texts “have examined in detail the sexologist’s analysis but have not looked at how inverts constructed themselves” (Prosser, 1998: 139). Thus, the narratives of inverts, constructed in the form of case histories, needs to be treated as foundational rather than peripheral, and in so doing we are able to reconstruct the invert as subject. Here then, “the value of these case histories that present the invert autobiographically is particularly significant” Prosser contends, “for they evidence that subjects could conceive of themselves as transgendered, that inverts identified themselves through cross-gender paradigms” (Prosser, 1998: 139). When read as personal narrative, the
case histories cannot wholly be reduced to homosexuality, but open up the possibility that some of those speaking subjects were in fact articulating a trans identity.

What Prosser is seeking to achieve then is the construction of a trans histiography which reveals, to varying degrees, subjects who identified with, appeared as, and at times sought out somatic change as a means to aid their transition to the ‘other’ sex. A project for which sexology was crucial, by providing “the narrative setting for the transgendered subject to become medicalized” without which “gender deviance would not have been hitched to the medical technology that ‘cures’ the transsexual through sex change” (Prosser, 1998: 139). The case histories of sexology then carved a space for the medicalization and diagnosis of the trans narrative; that is just as the invert should be regarded as transsexualism’s first autobiographers, sexologists ought to be viewed as their first readers.

Sexologists listened to their subjects, however, as a result of their interest in causal explanations rooted in biology, “they also sought to read inversion off bodies” (Sharpe, 2002: 21). So, for example, Ulrichs believed ‘Urnings’ to constitute a “third sex” (Califia, 1997: 12) or to be an example of congenital intersexuality. Consequently, the invert was positioned between the sexes, and their inversion was something that could be ‘read’ from the body. Thus, Ulrichs himself, while articulating the idea of a ‘female soul in a male body’, was bringing into question the very ‘maleness of that body’ (Califia, 1997). After listing what he considered to be “nine specifically ‘male features’: male organs; lack of breasts; Adam’s apple; male body; male voice; beard; manly habits; male inclinations; sexual love drive for women” (Hekma, 1996: 219) Ulrichs concluded that a number, or indeed most, of these habits were absent in the Uranian (Ulrichs, 1899, cited in Sharpe, 2002: 19). The specific corporeal text ‘read’ by sexologists underscores the idea that inversion was a trans(gendered) condition, whereby inversion’s somatic markers were the body’s cross-sexed characteristics. Consequently, “any embodiment of gender difference, any degree of what was considered an erring from the sexed norm” (Prosser, 1998: 141) was considered a predictor of sexual inversion.

As Prosser suggests, by “corporealizing inversion, sexologists practiced a kind of transgendered anthropometry” (1998: 142). By correlating sexed-intermediacy to cross-gender identity, “the assumption (the hope of sexologists as clinicians) was that the inverted body would render up its own identity narrative” (Prosser, 1998: 142).
It is important to remember however, that inversion was thought to constitute a sexual psychopathology, that is, an illness not so much of the body but of the mind, and as such it has important parallels with the way in which transsexualism is currently understood. In this respect, “sexology both begins modern psychiatry and spurs the development of psychoanalysis” (Prosser, 1998: 142). Whilst inversion was indeed an embodied state it was not always decipherable on the surface of that body. Diagnosing inversion lay then, not in the “corporeal markers, but in the subject’s speech” (Prosser, 1998: 142). Here then, the production of a narrative of cross-gender identification came to signify inversion. Through articulating the desire to ‘change sex’, it was possible for Westphal’s subjects to be diagnosed as inverts, which may in turn create their reclassification as transsexual. For Prosser, the subject’s narrative “constitutes the critical point of overlap between inversion and transsexuality” (Prosser, 1998: 142). Both inversion and transsexualism take as their primary symptom autobiography, a shared symptomization which has enabled sexologists to read transsexualism from the narratives produced by inverts, even where a bodily change of sex did not take place. So even before transsexualism emerged as a discourse in and of itself, inversion operated as a body narrative “with the subject’s narrative standing in for what the body of the invert could not speak” (Prosser, 1998: 142).

While the theory of inversion was central to most sexological work published in the wake of Ulrichs ‘Uranian’, it soon “became necessary to acknowledge, as Ulrichs himself had, that the figure of the gender invert failed to exhaust the phenomenon of same-sex desire and practice” (Sharpe, 2002: 22). The subsequent attempt to reclassify and indeed separate out different forms of same-sex desire led eventually to the foregrounding of sexuality and the use of the term ‘homosexuality’, coined first by Karl Kerthbeny in 1869 (Sharpe, 2002). Thus whilst the work of Ellis and Hirschfeld sought to carve out a discursive space for cross-gender identification separate from that of homosexuality, it ultimately failed to provide a lexicon for the subject’s desire for somatic sex change.

Psychoanalysis and the Silencing of the Trans Narrative

By 1900, the medical hegemony of congenital theories of inversion proposed by the likes of Ellis and Hirschfeld began to decline. The challenge to such theories was led principally by Freud’s reintroduction of an acquired theory of homosexuality (Sharpe, 2002), which increasingly replaced the language of inversion (Chauncey, 1982-3).
While Krafft-Ebing's subdivision of 'homosexuality' into inborn and acquired foreshadowed Freud's differentiation between 'sexual aim' and 'sexual object', for Freud and his followers, biology was to become increasingly marginalized in aetiological accounts. Freud's (1905) foregrounding of 'sexual object' over that of 'sexual aim' in his classification of sexuality was arguably a pivotal moment in the history of transsexualism, and one which, according to Prosser, amounted to "a massive discursive loss" (1998: 151), whereby medicine lost its capacity to transcribe and diagnose trans(gender) which led to the disappearance of recorded trans narratives. So, while confessions of gender inversion were not in themselves absent from the medical record, they were regularly asserted into models of 'deviant' object choice, in particular, homosexuality, in which "'contrary gender sensation' delusionally recreated the heterosexual dyad" (Rosario, 1996: 41). In short then, the emergence of the psychoanalytical model led to the erasure of the trans subject, due largely to the fact that psychoanalyst's stopped listening to their trans patients.

One reason why psychoanalysis ceased to listen to its subject's narratives lies in Freud's belief that "transgender narratives could not be taken literally. They are to be decoded by the analyst who must interpret their meaning" (Sharpe, 2002: 25). Thus the movement towards psychoanalysis signalled a dramatic change in the relationship of power between speaking subject and 'expert', whereby the former is constrained in her or his ability to generate the 'truth'. Tied to this is the rise of what can be termed the 'hermeneutics of suspicion' held by clinicians (see Theme 2), whereby the personal narratives of the speaking subject are treated with caution and suspicion, with only the clinician as 'expert' holding the key to the 'truth' of a phenomenon. Arguably then, "the story of inversion disappeared because medical practitioners stopped listening; psychoanalysis had its own story to tell" (Prosser, 1998: 151).

The coding of transsexualism as homosexuality influenced by Freud's work on fetishism, was taken up by later psychoanalysts such as Stekel (1922) and Gutheil (1922), "who applied it to practices of cross-dressing" (Bullough and Bullough, 1993; 214), leading "to a view of cross-dressing as a flight from homosexuality caused by some childhood event that created castration anxiety" (Sharpe, 2002: 25). While Gutheil (1922) differentiated (genuine) fetishism and transvestism, the connection made between cross-dressing and castration anxiety consolidated the understanding of cross-dressing as essentially (homo)sexual in nature, which further pushed the (trans)gender dimension out of view.

Despite the continued conflation of cross-dressing and homosexuality, by the 1950s there began to emerge a degree of disillusionment with psychotherapy which, coinciding with
advances being made in the field of endocrinology and surgical sex reassignment techniques, created a situation in which the language of transsexualism "emerged to describe the desire for sex transformation as something distinct from, though not necessarily unrelated to transvestism" (Sharpe, 2002: 25). Here then, the disembodied narrative of the invert, popularised by nineteenth century sexology began to resurface.

Medico-Discursive Naming and the Revival of the Trans Narrative

The (re)discovery and emergence of a new diagnostic category 'transsexual' (Cauldwell, 1949) captured the desire to change sex, which had been absent from previous medico-scientific articulations of cross-gender identifications. Rather than being the result of a theoretical breakthrough, the change in terminology "represented a response to the development of surgical treatments for the extreme form of 'transvestism', as the phenomenon of transsexualism had previously been described" (Sharpe, 2002: 26). Using the term "sex transmutationist" (1951) Cauldwell regarded the transsexual as "mentally unhealthy" (1949b), a "product of an unfavourable childhood environment" and referred to the use of surgery as "criminal mutilation" (cited in King 1996: 86). However, his definition of "psychopathia transsexualis", as an independent sexological category, was an important moment in trans history, through his insistence that while "[many] individuals have an irresistible desire to have their sex changed surgically" they are "not necessarily homosexual" (Cauldwell, 1949a: 274).

Whilst the conflation of transsexualism with homosexuality, evident in the work of psychoanalysis would continue at least into the 1970s (Randell, 1959; Socarides, 1969, 1970; Ostrow, 1974; Meyer, 1974, 1982), physicians from the 1950s onwards increasingly came to distinguish transsexuality from transvestism and homosexuality. While Cauldwell (1949a) was instrumental in coining the term, it was Harry Benjamin, an endocrinologist, who brought transsexualism into the mainstream medical literature. Benjamin regarded transsexuals as:

"the most extreme group of transvestites who wish to change their sex. Transvestism is the desire of a certain group of men to dress as women or of women to dress as men. It can be powerful and overwhelming, even to the point of wanting to belong to the other sex and correct nature's 'anatomical error'".

(Benjamin, 1953: 12)
In opposition to Cauldwell, Benjamin favoured a (bio)logical explanation for transsexualism. While giving credence to environmental influences, it was Benjamin's contention that 'fertile soil' in the form of genetic and endocrine constitution, must be present for any environmental influences to have an effect (Benjamin, 1953).

While Benjamin’s understanding of transsexualism is in many ways more fluid than some later conceptualizations, “his initial framing of the phenomenon helped establish an orthodoxy that continues to support and undermine claims of [trans] people within medicine” (Sharpe, 2002: 27). Within Benjamin’s characterization of the ‘true transsexual’ in terms of the desire to have the penis removed, emerges as a key diagnostic criterion: “for them ['trans' women], their sex organs, the primary (testes) as well as the secondary (penis and others) are disgusting deformities that might be changed by the surgeon’s knife” (Benjamin, 1966: 13-14). A further aspect of Benjamin’s typology of transsexualism “relates to the sexual identification of ‘trans’ women. Benjamin scripted as essential, in the case of the ‘trans’ woman, “sexual desire for a male post-surgically and the absence of desire for a female pre-surgically” (Benjamin, 1966: 126). In other words, surgery, according to Benjamin, could only be authorized if there was evidence of an ‘unambiguous’ heterosexual past.

Stoller, like Benjamin, sought to distinguish these categories, which he viewed as a form of perversion (1975), from transsexualism. In so doing, he presented a profile of what he considered ‘true’ or ‘primary’ transsexualism (Stoller, 1968: 251; 1973; 1975: 49, 139-40). It was only the ‘true’ or ‘primary’ transsexual that Stoller saw as eligible for sex reassignment. Like Benjamin, Stoller codes sexual pleasure as a sign of ‘inauthenticity’. In fact, he insisted that any evidence of having had gratification from the male genitals, whether that be through homosexuality, heterosexuality, or through the practice of ‘perversions’ such as fetishism and transvestism, precluded a diagnosis of ‘primary’ transsexualism. Stoller also insisted that early onset of feminine gender identity consolidated around the age of 2½ (1968: 65). This insistence upon the idea that ‘true’ transsexualism developed prior to the onset of adolescent sexuality, further sought to insulate transsexualism from homosexuality and transvestism.

The crucial significance of Stoller’s construction of the ‘true’ or ‘primary’ transsexual typology lies firstly in its relation to the construction of social divisions. Here then, individuals presenting at gender identity clinics can be demarcated along the lines of perceived ‘authenticity’. Thus, the ‘primary’ transsexual becomes a diagnostically distinct category; that is, distinct from other forms of cross-sex/gender expressions such as transvestism. Connected to this we can see a second significance of the typology of
'authenticity', and that is that it enables the construction of a coherent and definable medico-psychiatric paradigm of transsexualism. Through the construction and utilization of the 'primary'/'secondary' categorization, the medico-psychiatric profession is able to define exactly what constitutes the 'truth' of a transsexual identity through reference to a range of aetiological assumptions and diagnostic categories. Thus, the medico-psychiatric study of transsexualism could set itself up as distinct from other areas of concern, with transsexualism as a medico-psychiatric 'type' being clearly differentiated from other 'sexual pathologies'.

The literature during this period, following the work of Stoller, came to be dominated by the concept of gender. Thus, it was not until Robert Stoller added the concept of 'gender identity' to the panoply of the sexes (chromosomal, gonadal, hormonal, etc) that trans people were able to make claims about the incongruity between their gender identity and their expected gender role (Stoller, 1964: 220-26). According to Stoller, "the advantage of the phrase 'gender identity' lies in the fact that it clearly refers to one's self image as regards belonging to a specific sex" (Stoller, 1964: 220). The gender terminology related primarily to a body of literature which importantly stressed the independent nature of sex and gender identity, and the immutability of the latter, thus, according to King (1996) it was no longer necessary to claim a (bio)logical cause of transsexualism in order to legitimize changing sex.

Over time, however, it became increasingly apparent that individuals requesting sex reassignment surgery were extremely varied. Moreover, "few conformed to Stoller's picture of the 'primary' or 'true' transsexual" (King, 1993: 63). While Stoller continued to insist that departure from this type provided evidence of 'inauthenticity' and hence unsuitability for surgery, others working in the area began to provide new rationales for surgical intervention, with the effect of expanding the group to whom sex reassignment procedures might be made available.

A Paradigm Shift: From 'Transsexual' to 'Gender Dysphoric'

The concept of the transsexual and its apparent differentiation from transvestism and other 'conditions' outlined by Benjamin and others in the 1950s and 1960s began to lose ground somewhat, and in 1973 Fisk introduced the term 'gender dysphoria' to reflect the range of persons requesting sex reassignment surgery (SRS), who did not always and necessarily fit the classic picture of the 'true' transsexual (see, also, Laub and Gandy, 1973). This shift in terminology also sought "to suggest consistent with Stoller, that the primary transsexual
narrative was but one manifestation of an underlying condition" (Sharpe, 2002: 30), thus; 'gender dysphoric' patients shared the fact that they "were intensely and abidingly uncomfortable about their anatomic and genetic sex and their assigned gender" (Fisk, 1973: 10). Thus, in contrast to Stoller, Fisk opened up the access to SRS to persons whose narrative did not strictly relay that of 'primary' transsexualism, but suggested instead that some non-primary transsexuals, and specifically 'effeminate homosexuals' and 'atypical transvestites' might also benefit from surgery. In this way then, the discourse of 'gender dysphoria' has much in common with the earlier psychoanalytic approaches, which conflated transsexualism, homosexuality and transvestism. Thus, Fisk notes that "by conceptualizing our patients as having gender dysphoria syndrome we have obviously liberalized the indications and requirements for sex conversion surgery" (Fisk, 1973: 386-87). However, critics of Fisk's new diagnosis charged that it was "self-serving for the medical profession to justify the referral of non-transsexuals for sex reassignment surgery" (Lothstein, 1983: 59).

The 'phenomenological' approach suggested by the term 'gender dysphoria' witnessed a shift in clinical emphasis away from a strict adherence to a specific aetiological and symptomalogical picture, towards an emphasis upon behavioural criteria, as Billings and Urban (1996: 110) state, "with transsexualism largely denude of its diagnostic boundaries, physicians de-emphasized the technicalities of diagnostic differentiation and stressed behavioural criteria instead". This new focus upon the behavioural criteria of persons presenting to gender identity clinics "allowed physicians to re-group the categories of 'transvestism', 'transsexualism' and 'homosexuality' into a continuum of gender-aberrant behaviours" (Hausman, 1995: 127). Here then, the 'nonspecific descriptive clumping term' (Mackenzie, 1978) of gender dysphoria, became subdivided according to various schemes. Meyer and Hoopes (1974) suggested the following subcategories: (a) transvestite; (b) homosexual; (c) sadomachist; (d) psychopath; (e) schizoid (or borderline); (f) psychotic; (g) eonist; and (h) other, "with the term transsexual [being] reserved for the pre-operative sex reassignment patient" (King, 1993: 63).

Following the work of King (1993: 63-4) we can see that the significance of this change in terminology is four-fold. First of all, the shift toward 'gender dysphoria' had the obvious effect of underlining the element of gender and as such ties 'transsexualism' into "the whole concept and terminology" (King, 1993: 63). In so doing, it serves to consolidate a trend of the pathologization of gender, started in the 1960s by the work of Stoller, Green and Money, which created a polarity of gender deviance, which viewed homosexuality, Eonism, transvestism and transsexualism as existent upon a sliding scale of abnormality and gender
deviance. Secondly, the turn to ‘gender dysphoria’ also “legitimises another pattern that existed prior to its inception” (King, 1993: 63). Writers such as Stoller (1968, 1975) had defined transsexualism independently of the request for sex reassignment and argued that such a procedure should be offered to those people only who could be so defined. Most practitioners undoubtedly held a less narrow conception of the transsexual, and for this group, “referral to a surgeon was based less on reaching a formal diagnosis than on the success or otherwise of the patient’s attempts to live for a period of time in the other gender category” (King, 1993: 63). It was with the advent of the ‘gender dysphoria’ model that this approach was to become legitimated (see, Berger et al., 1979; Fisk, 1974). Consequently, SRS could be offered as a ‘treatment’ without specific diagnosis. ‘Gender dysphoria’ also has a third effect of potentially widening the area of expertise of the interests of the practitioner. As a practitioner, they were no longer simply interested in a specific kind of person, but in a whole range of ‘gender deviants’ including transsexuals, transvestites, and homosexuals, but also those who were physically intersexed (Mackenzie, 1978). However, what remained, despite this diagnostic differentiation and shift towards behavioural criteria, was the implicit use of the language of pathology. The discourse of ‘gender dysphoria’, as with wider medical discourses on this area constitute ‘moral discourses’ (Maego, 1995), and with its often superficial prescriptions for gendered experience, it sets up norms and deviations without regard to the range of possible pathways and outcomes for gendered development.

However, while the change in language may have occasioned or reflected the liberalization of access to SRS (Fisk, 1973) “it also produced negative discursive effects” (Sharpe, 2002: 30). Thus a final significance of this change in terminology is that “it turns the focus away from the actor and onto the condition and at the same time represents a reaffirmation of professional authority” (King, 1993: 63-4). By naming ‘gender dysphoria’ as a disease, it becomes then the property of the medical profession. In other words, desire was transformed into disorder.

Moreover by abandoning ‘transsexualism’ as a term we lose the connotation it held with ‘indeterminate sex’ and the capacity for self-definition that inheres with “states of being” (King, 1993: 64). Moreover, as Cromwell (1999: 30) observes, the language of gender dysphoria is simply inaccurate. Trans people in fact “usually claim to have a quite definite sense of their gender; it is their physical sex that is experienced as the problem” (Shapiro, 1991: 250). Thus a more appropriate term to use would be that of ‘body dysphoria’ or ‘body part dysphoria’, as typically, it is an expressed certainty about gender that leads to the request for surgery.
Accessing Treatment, Negotiating Clinical Protocol: Gender Identity Clinics and the Dominion of Medico-Psychiatry

Having looked at the ways in which transsexuality has emerged historically as both an identity category and a medical type, I now want to move on to discuss current debates regarding trans people's ability to access 'treatments'. The intention here is to assess the ways in which the historical relationship between medico-psychiatry and trans-subjectivity has impacted upon contemporary clinical protocol. By looking at the ways in which medico-psychiatry has both assumed and been given the role of gatekeeper to healthcare, as well as the ways in which discourses on transsexualism and appropriate 'treatment' methods have been incorporated into a standardized protocol, we are able to effectively see the ways in which medico-psychiatry enacts a position of power over the lives and bodies of 'trans' women.

According to Bolin (1988: 48), the two major groups to have had an impact upon transsexuality are firstly, the medical community, made up of psychiatrists, surgeons and endocrinologists, and secondly, the mental health profession, which incorporates psychologists, counsellors and social workers. The aim of this section is to review that literature, which principally addresses the role of the former set of professionals – that is, those working within the field of medicine, or as I have termed medico-psychiatry. Here then, the intention is to attend to the rise and proliferation of medico-psychiatric authority and control over the trans phenomenon, through the formalization of the Standards of Care (SoC).

The 'Standards of Care' and the Regulation of Treatment

According to Bolin (1988) the medico-psychiatric profession play a crucial role in the trans person's transition to somatic comfort. For it is the medico-psychiatric community alone who are imbued with the right to legitimately provide access to the services of hormonal and surgical sex reassignment. For that reason the relationship between the medico-psychiatric 'gatekeeper' and the trans person is both established and maintained via clinical protocol formulated by the Harry Benjamin International Gender Dysphoria Association (HBIGDA), a committee comprised of physicians, with the exception of Paul A. Walker, a psychotherapist, and the chair and principal author.
The clinical protocol governing the trans person's transition into their subjectively experienced gender was formalized by the HBIGDA in its writing of the Standards of Care (SoC), which has been regularly revised since its inception. The original Standards of Care were drafted and subsequently accepted by the participants of the 6th International Gender Dysphoria Symposium, held in San Diego in February 1979. These Standards, which act as guidelines to be followed by the individual embarking on the process of somatic transition, are according to Bolin (1988), following Chapple (1970), akin to a 'rite of passage', with its ritualistic proscription of rigidity and rightness. Consequently, the HBIGDA Standards of Care are described by Bolin "as the medical and mental health caretakers' 'management of life crisis' (c.f. Chapple, 1970: 302) through ritual mediation" (Bolin, 1988: 49). The understanding of the medicalized process of transition as ritualistic is premised upon Bolin's understanding of the development of a clinical protocol that aids both the individual and society to "cope with change by formulating procedures that, if followed, make things right" (1988: 49). Moreover, the regulation of the transition process by medico-psychiatric professionals enables such 'specialists' to perform their own "secular rituals" which, according to Bolin (1988: 49) "restor[es] equilibrium and stability to individuals' lives and relations to society."

Based upon years of research, the SoC is designed as a means of sifting out those individuals who are considered by the medico-psychiatric profession, to be 'poor' surgical risks. Thus, those individuals who meet all the rigid and uniform criteria as laid out in the SoC are thought to be 'good' risks for surgery. That much of what counts as a 'good risk' rests upon sound psychological function is, according to Bullough and Bullough an oxymoron:

"How can any male in his right mind want to have his penis and testes removed and a vagina constructed or conversely how can any female want to undergo a hysterectomy, an ovariectomy, and the removal of both breasts, and be given a penis of some sort or another? ... No sane person would want to change, but sane people do."

(Bullough and Bullough, 1997: 317)

Following Bolin's understanding of the medico-psychiatric profession as the 'gatekeepers' of transsexual transition, Nelson (1998) comments on the contents of the Standards of Care. For Nelson, our reading of the SoC must begin with those definitions provided within the document. The definitions provided relate to: the meaning of the interventions used ("hormonal" and "surgical sex reassignment"), the diagnosis ("gender dysphoria") and the
necessary professionals involved in the process (defined as “clinical behavioural scientists”). This last group, the “gatekeeper specialists” (Nelson, 1998: 220) authorize and legitimise the demands of those individuals seeking various somatic changes of the body. However, as Nelson remarks:

“in order for the relevant physicians and surgeons to make such interventions without committing what these guidelines [SoC] construe as malpractice, clinical behavioural scientists must certify that people desiring these interventions fall under the appropriate diagnostic category of the American Psychological Association’s Diagnostic and Statistical Manual.”

(Nelson, 1998: 220)

Here then, self-diagnosis is insufficient (Standard 1), on the grounds that sex reassignment is “extensive ... invasive ... [and] not reversible” (Principle 1) and may well be requested by individuals whose delusional desires are transitory, and who often regret their decision. Assessment, and indeed legitimation then, is left to the medico-psychiatric ‘specialist’, usually a psychiatrist who shares the “moral responsibility” for making the “recommendation in favour of hormonal and/or surgical sex reassignment with the physician and/or surgeon who accepts that recommendation” (Principle 7). The pathology-based model upon which clinical practice is based, has, according to Denny and Roberts (1997: 323) the affect of“coloniz[ing] transsexual people and trivializ[ing] our decision making abilities.” In a similar vein Stryker evocatively argues that:

“Through the filter of this official pathologization, the sounds that come out of my mouth can be summarily dismissed as the confused rantings of a diseased mind.”

(1994: 224)

Here then, the person, or group of people doing the pathologizing tends to silence the voices of the individuals being pathologized.

Hormonal and surgical reassignment are distinguished by the Standards, which maintain that the provision of hormones should precede breast and genital surgery. The reason for this is that the use of hormones can be both “therapeutic and diagnostic” (Principle 11). The principle behind the diagnostic usage of hormones is that those individual’s whose
'symptoms' are sufficiently relieved by the introduction of a minimal dosage of 'cross-sex' hormones, probably weren’t transsexual in the first place.

Before an individual can obtain hormones, they must produce a written recommendation from a psychiatrist or psychologist who has known the person in a ‘therapeutic relationship’ for a minimum of three months. To qualify for SRS, the attending surgeon must be presented with two written recommendations, one from the original psychiatrist and one by “a second clinical behavioural scientist” (Standard 7). Further to this, Standard 9 states that the individual must be in a position to prove that they have lived, full-time, for at least 1 year in the capacity of their subjectively experienced gender. This time frame is considered a minimum requirement, with other ‘caretakers’ suggesting qualifying periods of up to 2 years (as is the majority case within UK Gender Identity Clinics). It is this process that clinicians call the ‘real-life-test’ or ‘real-life-experience’, a process, which it is hoped will prove that the individual has been “rehabilitated hormonally, socially, vocationally, financially and interpersonally” into the role of their subjectively experienced gender (Money and Walker, 1977: 1292).

Whilst Bolin argues for the “undeniable” value of the Standards of Care “in preventing irreversible surgical mistakes” (1988: 51), she remains mindful of the disparity in power between ‘caretaker’ and ‘client’. With the disavowal of self-diagnosis, the assessment and indeed the revealing of ‘truth’ of a person’s subjectivity are deemed discernable only by the medico-psychiatric specialist. The result is that “the psychological evaluation may be, and often is, wielded like a club over the head of the transsexual who so desperately wants the surgery” (Bolin, 1988: 51). However, to think of the trans person as holding no power in the relationship is to look necessarily at only one side of the story. Bolin’s conceptualization of the ‘psychological evaluation’ as an ‘axe wielded’ by the psychiatrist over the trans person, places that individual firmly within the confines of the duped/duplicitous dyad. A conceptualization, which importantly fails to recognize the existence of multiple trans subject positions as a self-narrated subject position, co-opted by medico-psychiatry, but not, importantly, created by it. Nonetheless, a disparity of power is evident in the dismissal of subjectivity within the clinical relationship, whereby the person invested with the right to author transsexualism into existence is the medico-psychiatric professional, and not the ‘true’ author of that subject position.

The purpose of the Standards of Care was to standardize what had previously existed as a plethora of ideas into a more uniform documentation of medical type. Whilst we need to remain mindful of the existence of ideas of aetiology and indeed ‘treatment’ in terms of a
multiplicity of temporalities which may in some instances call into question the usefulness of a uniform approach to ‘care’, the formalization of the SoC nonetheless helps, in significant ways to “constitute the orthodoxy” of the medico-psychiatric profession (Nelson, 1998: 219), an orthodoxy that would allow clinical ‘specialists’ to claim ownership of as well as power over a personal subject position.

It is this very power-imbalance discussed by Bolin, which appearing intrinsic to the transsexual-gatekeeper relationship, together with the continued classification of transsexualism/gender dysphoria within the American Psychological Association’s DSM, that has fostered so much resentment and hostility on the part of so many sections within the trans communit[ies].

Conclusions

By tracing the origins of a trans identity back to the period of the late nineteenth century, and by reassessing sexological case studies of inversion we are in a position to recognize the ways in which ‘trans’ women were and indeed are active in the construction of a trans identity. It is such a recognition that allows us to place the ‘trans’ women in a position of relative power, because such a view facilitates an understanding of trans as a self-narrated as opposed to a purely medically constructed identity. It is in this way that ‘trans’ women can be said to be instrumental in shaping and negotiating those medico-psychiatric discourses that have been said to have been constructed of and for them. Moreover, the use in following the trajectory of the emergence, disappearance and re-emergence of trans-subjectivity through different historical moments, is that we are able to more effectively track the changes in the power dynamics that exist between medico-psychiatry and trans-subjectivity, as well as the implications of this for an understanding of the ‘ownership’ and ‘authorship’ of a personal subject position, as it exists at a particular historical moment.

While the invention story provides a powerful critique of, and insight into the medicalization of transsexualism and the ways in which medico-psychiatry acts as a powerful policing agent of social control, it fails to attribute agency to those people who it argues medico-psychiatry has constructed, and this is its major downfall. Thus, following Prosser’s (1998) transsexual histiography we can see that trans(gender) behaviours, identities and desires did indeed exist prior to its inception into the medical lexicon. However, the ‘invention’ story becomes a
useful tool for understanding the colonization of the personal story of *gendered-difference* into a medico-scientific discourse of *gendered-deviance* as a result of the widespread advent of psychoanalysis and its encroachment into the lives of trans people and its subsequent institutional clout in the treatment, diagnosis and definition of transsexualism.

What becomes apparent then, when reading the contemporary clinical literature and assessing the relationship between medico-psychiatry and trans-subjectivity, is that it is one characterized by a disparity of power. Here, through the formalization of clinical protocol, the medico-psychiatric profession have extended and indeed reinforced their power of authority over the speaking subject. What we see is a situation in which a group of non-trans, clinicians have assumed authority over transsexualism, from its definitions, its aetiology and the means by which people should receive ‘treatment’. As a consequence of this imperialism, the voices and the rights to ownership, self-pride and subjectivity have been largely removed from the individual trans person, and as such, they have been transformed into the object of scientific speculation and derision. It is with the silencing of the trans voice that medico-psychiatry is in a position to assert its ‘objective’ and ‘moral’ stance towards the ‘treatment’ of sex/gender identifications broadly, and transsexualism specifically, which could not be challenged because those people in a position to criticize this psychiatric imperialism have had their voices stolen. As we shall see in Theme 3 however, trans people are beginning to regain their voices, and consequently a number of sections from within the trans communities, and most notably the Transgender community, are presenting a challenge to the medico-psychiatric imperialism of their lives and bodies. However, as my research into Theme 3 makes clear, the whole-hearted rejection of medical controls is not seen as a desirable step by all ‘trans’ women.
Having addressed the changing medico-psychiatric definitions of transsexualism as found in the literature (see chapter 2) it is now time to turn our attention to the ways in which transsexualism is defined in clinical practice, noting continuities and changes. By empirically testing the workability of trans discourses within medico-psychiatric practice, we can begin to problematize the assumption of a coherent and hegemonic trans discourse pervading through medico-psychiatry. To this end, both those medical practitioners working within ‘Gender Identity Clinics’ (psychiatrists, psychologists, psychoanalysts and surgeons) as well as general practitioners (the first port of call for the majority of trans people seeking medical assistance) were asked about what they understood transsexualism to be, together with their understanding of the wider medico-psychiatric literature. In this way, I hope to be able to demonstrate the extent to which clinical practice, and the stories that these practitioners told about transsexualism, is informed by the plethora of discourses surrounding transsexualism.

In order to begin exploring the relationship between medicine and social identity it is important that we also look at the ways in which trans individuals make sense of their experiences, as well as the meanings that they attach to them. By looking at the words spoken by ‘trans’ women, we can begin to assess the extent to which they are situated within or outside of the wider medico-psychiatric discourses on transsexualism. Whilst a total shift in authority has yet to fully emerge, we can clearly see a number of ‘trans’ women telling a story of their experiences and identities far removed from its medical depiction.
Defining Transsexualism Today: A Medico-Psychiatric Perspective

Because transsexualism and its ‘care’ is regarded as an area requiring specialist expertise, and is a phenomenon about which the medical profession as a whole receive very little, or no formal training, it was not surprising to find that a number of GPs were somewhat confused in their response as to what constituted transsexualism, as is evident in the following:

“Erm ... I would have thought that it was when patients had maybe ambiguous physical characteristics, after maybe, after puberty, more than really at birth. Erm, and they were not, erm, maybe features of, of both sexes and, erm, the person themselves was undecided what way their sexuality or gender lay.”

(GP 101)

Not only does this GP confuse the concepts of transsexualism with intersex conditions, he also conflates transsexualism with (homo)sexuality, a misunderstanding found in areas of the clinical literature as well as being profuse amongst wider societal definitions of transsexualism. Further misunderstanding of the trans phenomena emanating from the speech of GPs expressed itself through the perception that transsexual motivation is linked to a lifestyle choice. Thus, as one GP explained

“It’s very much a lifestyle thing, rather than just [about] outward appearances.”

(GP 13)

The definitions of transsexualism provided by GPs appear somewhat limited, and while they demonstrate some knowledge of medico-psychiatric discourses, on the whole they share much in common with populist or social discourses. Those articulating some understanding of transsexualism framed their response accordingly:

“Erm, that’s rather difficult to define, obviously if you’ve got a male body and somebody feels that they are female inside, have a female outlook on life and wish to be female, that is the commonest form.”

(GP 3)
The basic definition of transsexualism articulated by GPs was widened considerably by those working within the medical field of 'gender science' and in this respect, the definitions provided by 'gender specialists' bear far more relation to the current medico-psychiatric literature. Here, the kinds of definitions proffered looked something like this:

"... it’s a serious disturbance of the sense of gender identity such that one subject feels that they have the body of one sex, but the mind and the psychology of the other sex."

(Psychiatrist: A)

as well as:

"... erm ... well, it’s a, it’s a desire to, to change to the opposite gender from that which was assigned at birth, in effect, to the chosen gender."

(Psychiatrist, D)

Adherence to the Diagnostic and Statistical Manual of Mental Disorders – the standard definition of transsexualism – was apparent in the words spoken by ‘gender specialists’, a definition, which figured greatly in their clinical practice. One psychiatrist articulated a view of the “DSM-IV” definitions as “being reasonable” (Psychiatrist, A), preferring that classification, with its emphasis on behavioural criteria, over that of the ICD-9 and ICD-10, which define transsexualism as a mentally subjective condition, something which this particular psychiatrist regarded as a “snare in the trap”. Moreover, a second psychiatrist, when asked what he saw as constituting a workable definition of transsexualism, simply paraphrased the DSM classification:

"It’s defined in the … DSM … it’s the desire to live one’s life in the biologically opposite sex, which has been present for a certain amount of time, isn’t associated with any other mental illness and the absence of any chromosomal or hormonal abnormality."

(Psychiatrist, B)

The conceptualization of transsexualism as constituting a form of ‘wrong embodiment’ forms a pivotal trope within medico-psychiatric discourses, and so it was not surprising to find it articulated within many of the medical professional’s understandings of transsexualism. Thus, contained within the words of a number of GP’s, we find the following reference
"Well, basically [transsexualism is], err, people’s perception that they are the wrong sex for the way they feel.”

(GP 64)

Another GP articulated the following sentiment:

“I understand it to be feeling erm, who feels that they have been born in the wrong body of the wrong gender and erm, so they feel themselves emotionally to be a different gender to what they are.”

(GP 14)

The fact that congruence between body and self is demanded within medico-psychiatric discourses, as a necessary means by which the apparent ‘naturalness’ of sex/gender is maintained, can be evidenced by the following extract from an interview with a GP, whereby the impression given is that congruency is an overriding concern of the trans person. Thus for this GP, a trans person is defined as:

“a person of either gender who thinks, erm, their psyche and their body don’t match, that they should, and that they should be in the body of the other gender.”

(GP 13)

A number of definitions provided by ‘gender specialists’ give further credence to the ‘wrong body’ discourse as being the trope of transsexualism, with sentiments such as the following being expressed:

“… transsexualism is … a … syndrome, a syndrome in which people have the … feeling of being in the wrong body, mentally, emotionally, and the personality of one gender and the body of another, that’s probably the best definition I think.”

(Psychiatrist H).

contained within the sentiments of the ‘wrong body’ discourse are important references to (bio)logic, that being, the ‘naturalness’ of the sexed body, as given in nature and as such, the ultimate predictor of a person’s gendered sense of self. Such sentiments are clearly evident in the following:
"So, I think it’s, it’s people who have got a sense of being female when they’re male.”

(Psychiatrist H)

And, as another psychiatrist explained:

“It’s a serious disturbance of gender identity such that one subject feels they have the body of one sex but the mind and psychology of the other sex.”

(Psychiatrist A).

Clearly indicated in this statement, is the view that any deviation form the assumed ‘naturalness’ of the sex/gender system is viewed as a delusion, “a serious disturbance” of the mind.

Locating Clinicians’ Stories Within Medico-Psychiatric Discourses

That there exists an overlap between the ways in which transsexualism is understood in medico-psychiatric discourses and in clinical practice (both in terms of GPs and ‘gender specialists’) is clearly evident in my research, with allusions to psychopathology being both implicitly and explicitly voiced. The implicit assumption that transsexualism constitutes a psychopathology is first evident through an analysis of the language used by GPs to talk about and describe transsexualism. Thus, we find statements like transsexualism is …

“the firm belief that you were born in the wrong body and the all consuming desire to change yourself.”

(GP 49)

or, as expressed by another GP:

“a deep seated desire.”

(GP 59)

Together with:
“... the patient's own belief that the true gender is opposite to the actual anatomical sex.”

(GP 24)

Similar language, although containing more elaborate descriptions, was used by many of the 'gender specialists' interviewed. Once again, then, we find sentiments describing transsexualism and trans people as:

“They have this fundamental belief that they are actually the opposite sex.”

(Psychotherapist G).

“... the intensity of the drive inside your head.”

(Psychiatrist, H)

as well as:

“... erm ... well, it's a, to change ... to the chosen gender.”

(Psychiatrist, D)

and finally,

“... the individual feels their lived-in gender is inappropriate.”

(Surgeon, C).

The use of terms such as 'feel', 'chosen gender', 'desire', and 'belief' are revealing in that they clearly demonstrate the clinicians' perceptions as to whether transsexualism constitutes a psychic or somatic phenomenon. If we follow the idea that transsexualism is somatic in origins, then stating that trans people 'feel' they are in the wrong body, or have a 'desire' to change sex, is simply inaccurate.

The psychopathologization of transsexualism is also made explicit in the statements of some 'gender specialists'. So, for example, one psychiatrist told me:

“I'm certainly not happy to call it an intersex condition ... I ... I suppose I'm happier to keep it as a psychological disorder ...”

(Psychiatrist, A)
Similarly, another remarked that:

"...they’re certainly quite different from intersex."

(Psychiatrist, H)

As we saw in the previous chapter, within late nineteenth century tales of inversion, the sexologist as clinician sought to read (trans)gender off bodies. However, with the shift towards the psychoanalytic and psychiatric governance of the trans phenomenon in the early twentieth century, and continued through today, the practice of ‘reading’ (trans)gender off bodies has declined. Along with this is a movement away from viewing transsexualism as a congenital intersex condition, towards an understanding of the phenomenon as constituting a psychopathology – that is, a disorder of the mind, not the body.

Within the literature its is widely suggested that the ‘gender dysphoria’ paradigm has become the principle working diagnosis within the clinical treatment of transsexualism (Lothstein, 1983). However, one aim of my research was to assess the extent to which this has filtered down into clinical practice, or whether transsexualism has in fact remained diagnostically significant.

My research certainly suggests that ‘gender dysphoria’ has become an important means by which to understand and define those people presenting at gender identity clinics, and this can be seen in the following sets of quotations:

“I use the words ‘gender identity disorder’ or ‘gender dysphoria’ for all patients … so I think the diagnostic term ‘transsexual’ should be seriously questioned.”

(Psychiatrist A)

and,

“Well [transsexualism], it’s a fancy medical word really … I don’t think it’s an attempt to capture … erm … human … distress … using words like ‘isms’ isn’t appropriate I think. But I think it’s [important to] attempt to capture the sense that for some people, that sense of the … biological giveness of the, what the, in terms of the physical apparatus, points in one direction but they feel they’re either wrongly
... they're wrong, that's why I prefer 'gender dysphoria' because that picks up ... the dysphoria part of that profound sense of wrongness which some people experience.”

(Psychoanalyst E).

However, while the term 'gender dysphoria' appears as the favoured descriptive term to label those people presenting to gender identity clinics, it would be a mistake to assume that it has completely consumed the diagnostic term 'transsexualism'. What appears to have taken place is that the term 'transsexualism' is reserved for persons exhibiting 'extreme' gender dysphoria and who as a consequence request the assistance of sex reassignment technology. As one psychiatrist suggested:

“Well, erm ... I don’t accept anyone presenting to me as transsexual until they are a very long way down the pathway. ... I’ll use the word transsexual as a short-hand for somebody who has established a change of social gender role, it appears to be stable and they are progressing with hormones and toward surgery or that they have had surgery, i.e., that they are a long way down the pathway.”

(Psychiatrist A)

The understanding of transsexualism as existing through the demand for surgery is similarly apparent in the words spoken by this surgeon:

“[Transsexualism is] erm, ... I ... suspect a deep unhappiness with their, err, given gender and, err, err, to the extent that they want to explore changing roles ... they’ve ... I mean had a period of time for reflection and absolutely convinced that they are in the wrong role, that they are of the wrong assigned gender and that they therefore want irreversible surgery that will make their lives happier.”

(Surgeon, C)

Here then, my research reveals that transsexualism, as a diagnostic trope continues to structure clinical practice. Even though access to the GIC system has been opened up to include those who are broadly speaking 'gender dysphoric', access to the hormonal and surgical technologies of 'sex change' are reserved for those who identify as trans and who have that identification authenticated by the attending medico-psychiatric 'expert'.
Defining Transsexualism Today: A Trans Perspective

Turning now to look at the ways in which 'trans' women themselves define 'transsexualism', that is, make sense and attach meanings to their experiences in order to form an understanding of their lives and bodies, we find some interesting divergences from the standard medico-psychiatric imposed definition. Comparing the ways in which the two groups – the medico-psychiatric profession and 'trans' women – make sense of 'transsexualism' allows us to begin to address the relationship between medicine and social identity (a discussion which is to be extended within Theme 2).

If we look first of all at the definitions of 'transsexualism' given by 'trans' women, we can begin to see the disparities between the subjective and the medically imposed definitions. One 'trans' woman defined transsexualism as:

“... transsexualism is not being happy with the gender that you were born or with the sex you were born. There’s always this confusion between what’s sex and what’s gender ... which is another reason why you can either call it, say transsexualism or transgender, it’s sort of, ... sex doesn’t come into it, but gender doesn’t either, I know my gender’s alright, I haven’t changed my gender, it’s my sex that I’ve changed, erm, and my appearance that I’ve changed.”

(Janine)

This excerpt, as we can see, problematizes the medical narrative of 'gender dysphoria' suggesting instead that gender remains in many instances possibly the most stable aspect of a trans person’s identity. The problem, then pivots around the body, which is seen as incongruent with the sense of self. Within this articulation, it is the sex that is to be changed and brought in line with the gendered sense of self.

One participant in my research held a view of 'transsexualism' much in line with the 'invention story' (King, 1987, 1993, 1996) whereby medicine has sought to pathologize those men and women whose bodies do not fit the heteronormative sex/gender system that seeks to sustain congruency between mind and body:

“In essence 'transsexualism' does not exist. If it does exist, it exists only in the 'clinical reasoning' of a handful of psychiatrists. There is a
tension that exists in the minds of some psychiatrists between ‘mental
illness’ and men and women.”

(Charlotte)

Here then, Charlotte articulates the idea that the identity of ‘transsexualism’ is borne only through the founding assumption that men have penises and women have vaginas.

As we have seen, throughout the narratives of the medico-psychiatric professionals interviewed as part of this research, ‘transsexualism’ was largely understood as constituting a psychic as opposed to a somatic condition, something which stands in stark contrast with those narratives espoused by those ‘trans’ women interviewed. When asked what they believed transsexualism to be, the great majority of ‘trans’ women expressed a view of ‘transsexualism’ as constituting a somatic condition, originating in the body:

“... yes, it’s a recognized medical condition and it’s something that a patient is born with, erm, there is an awful lot more research needed to find out the cause of it and the fact that it’s very widespread. And I think it’s the fact that foetuses are all supposed to start off as female and change during development, now there must be something latent left in many guys that it’s always in the back of their minds.”

(Sarah)

And as one ‘trans’ woman suggested:

“it’s a natural human condition.”

(Jessica).

The understanding of ‘transsexualism’ as constituting a natural human condition is given further support by Emma, who espouses a view of transsexualism as being the result of the inherent differences between sex and gender, whereby sex is understood as essentially (bio)logical in contrast to gender, which is understood as existing on a social continuum upon which we are all placed:

“I believe it’s a neurological condition ... I mean I have my own theory as to why people are transsexual, and it’s because sex and gender are completely separate. The sex of a child is determined very
early in the pregnancy, the gender of the child, I believe is not decided until much later and differences in whatever, can influence whether it's male or female sex which would be merged together with intersex, but gender's not like that, gender's a sliding scale, from the Stepford wives to Rambo, and everyone's on there somewhere, but it's where you are on that scale, if it goes beyond a certain point, that's when you get problems, but if you think about it, it has to be that way, or every female would be totally female and every male would be totally male, it just wouldn't work. So I think it's a totally natural condition and it's how nature intended, so that's what it is, it's differences in the brain.”

(Emma)

Further to this, and alluding to the social stigmatization and ridicule which leads so many to silence their concerns, Anna defines 'transsexualism' as:

“Transsexualism is a physical birth defect that manifests itself inwardly to the sufferer in the early years of life. The outward symptoms are not visible to others, any mention of the inner feelings of something being wrong are met with, ‘Don’t be silly, you’re a boy’ etc. The constant ridicule of expressing your feelings to others leads the sufferer to not talking about their feelings. In fact, making positive steps to hide how they feel and acting in a way that would make others believe that it was just a phase”.

Further to this, and again in contrast to the medico-psychiatric conceptualization, 'transsexualism' as understood by many of the 'trans' women interviewed constitutes an intersex condition of the brain:

“I suppose it would be an intersex condition of the brain, and there are all sorts of theories, hormonal imbalance, the brain and possibly that could be what’s caused that, that dimorphic, that sexually dimorphic structure that occurs in transsexual people erm, but I certainly do believe that it does have more of a biological basis than anything else.”

(Claire)
Positing a medical view of transsexualism, these views directly contrast and indeed stand in antithesis to the discourses articulated by 'gender specialists' who, as we have seen, vehemently deny such a proposition. Here then, we see the ways in which 'trans' women articulate an essentialist understanding of transsexualism, a strategy which highlights their perception of transsexualism being the result of (bio)logical forces as opposed to psychodynamic processes. In other words, trans is something you are, not something you become. Narrating such a story also serves the function of attaching legitimacy to, and thus transferring blame away from the individual. Moreover, as the extracts above make clear, such a narrative strategy is clearly based upon a detailed scanning of the individual’s history. Thus, many ‘trans’ women could find no evidence for psychodynamic factors playing a role in the construction of their transsexualism, rather, a range of (bio)logical factors are drawn out of their biographies which point to such factors and their exposure to high-levels of the 'female' hormone oestrogen, as playing a crucial role in their development of a trans sense of self.

**Gender Specialists and the Gender Identity Clinic**

In analysing the questionnaire and interview material from both GPs and 'gender specialists' (psychiatrists, psychoanalysts, surgeons and gender counsellors) working within British GICs, we can begin to understand how each group positions itself within the 'treatment' process associated with transsexualism, as well as the ways in which they understand the role of other medical professionals. Furthermore, it provides an insight into the ways in which medico-psychiatric professionals position 'trans' women within the 'treatment' process, necessarily excluding the role of subjective experience and so negating the ability of the trans person to both own and author their own sense of self.

**The Construction of a Specialism**

One of the most significant ways in which we can see the construction of a psychiatric specialism at work is by looking at the ways in which those GPs interviewed saw their role in the ‘treatment’ process associated with transsexualism. Despite often being the first point of contact that so many ‘trans’ women have with the medical profession, those GPs interviewed
held a very narrow conception of their involvement. This point can be evidenced in the following interview extracts:

“So, my role is more like a middle man than you know, treating myself, initiating the treatment, because I don’t have err, much knowledge about it really, so ... I don’t initiate treatment.”

(GP: 24)

And,

“I don’t think I know enough about it, as I say err, I, in general practice I have only seen perhaps, well 3 or 4 in my whole career, in the 27 years, so I don’t feel I know enough about it to instigate treatment.”

(GP: 100)

What came up time and time again was the clear fact that these GPs saw themselves only as acting in the capacity of someone who refers individuals onto those who are ‘experts’ in the field. This is despite the fact that GPs can in fact be crucial to the healthcare of ‘trans’ women, as the following quote demonstrates:

“Very important, well I think sympathy across the board is important, but yes, your GP particularly because you’re looking for people to say ‘you’re not a freak’ you know.”

(Isabel)

Taking such a limited role in the ‘treatment’ process would seem to be confounded then by the lack of knowledge that those GPs interviewed had about transsexualism. Such a lack of knowledge, however, is hardly surprising when we consider that 81% (121/150) of those GPs who responded to my questionnaire revealed that they had received no formal training on the subject matter. As a consequence, 62% of GPs felt that they had little or no familiarity with the area.

This lack of knowledge is coupled with a lack of familiarity, and has, as we shall see later on in this section, had serious consequences for those trans individuals seeking medical assistance. Thus, 42% of GPs questioned believed that they had very little familiarity with the actual ‘treatment’ process and only 6% believed that they had extensive knowledge.
Whilst the majority of GPs believed that they had little familiarity with either transsexualism or its associated ‘treatments’, it was alarming to find that those who felt they had extensive knowledge of transsexualism arrived at that conclusion via rather dubious reasoning. One GP questioned believed that her extensive knowledge of the treatment process was the result of having watched television programmes on transsexualism and that she had read newspaper articles (GP 24). Such a remark was not unique, and similar examples were elucidated, which demonstrate the possible exaggeration of answers: One GP (GP 13) said he had read up about transsexualism from articles in the press or women’s magazines, whilst another claimed to have an extensive knowledge of transsexualism because she had a “transvestite friend” (GP 49).

The idea that those GPs questioned had a detailed knowledge needs to be seriously questioned. However, these statements allude to more than mere exaggeration. Thus, it may not necessarily be that those GPs questioned were lying about the extent of their understandings of transsexualism, but rather, that they feel that an in-depth knowledge is not necessary. Moreover, for some, even partial familiarity actually represents a sound degree of knowledge, thus indicating the lack of seriousness with which the medical profession takes transsexualism, either as a medical condition or something worthy of widespread medical attention.

The ‘Gatekeeping’ Role

The literature pertaining to the relationship between medico-psychiatry and transsexualism abounds with discussions of the ‘gatekeeping’ function assumed by ‘gender specialists’ and in particular, psychiatrists, not just in terms of aetiology and diagnosis, but also in terms of the direction and pace of ‘treatment’. The formalization of a Standards of Care (SoC) by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) has, in many ways, enabled the psychiatric imperialism of trans bodies to become entrenched, thus transforming differing visions as to ‘best practice’ into a standardized document.

Whilst the HBIGDA SoC plays a pivotal role in the clinical ‘management’ of ‘trans’ women, with its dictum spanning the entire ‘treatment’ process, it became apparent throughout my research that various British gender identity clinics have built upon or tailored that which was outlined within the SoC, to suit their own perceptions of ‘best practice’. Nevertheless, what
remains is a rigid protocol that is used to structure clinical practice. The need for a standardized ‘treatment’ protocol was outlined by one psychotherapist interviewed:

“We have err, we have our local protocol, we have the UK protocol as well, we are trying to constantly standardize that so that we’re providing the same kind of service.”

(Psychotherapist G)

The same psychotherapist went on to outline the protocol adopted at the GIC where she worked:

“... what we look at is all the various stages that we go through, from the GP, to be seen by a psychiatrist, coming to us, being designated to the gender clinic, beginning the assessment period, and within that two years assessment period, erm, before they can actually proceed to the next stage, erm, we have gender panel meetings three or four times a year and that gender panel consists of the medical psychotherapist, the, erm, nurse psychotherapist ... we have a lay member, who’s a solicitor, we have a speech therapist and a style counsellor, it’s made up of lots of people and the idea is to try and keep an objective argument as to why someone is ready to proceed to the next stage. So for example there needs to be psychometric testing, erm, we have a minimum of six months before they can actually, err, be seen as eligible for hormones, or certainly three months intensive psychotherapy. But at each stage, when, so if I were actually to present to the panel someone who I thought was ready for hormones, then I would be asked, I would need to justify that, not just because I like that person. We also have criteria for the real-life-experience, so they have to attend speech therapy, they have to be coming to the gender clinic, they have peer group support every month, they have to show they’re doing things like altering documents and working full time for a year or part-time for two years, or if they’re not doing that, they’re doing voluntary work, they have to be socially interacting out there, erm, and also we have to adhere to government guidelines that they say to us ‘here’s some money’, err, we have to be able to justify
someone being ready for surgery, so how have they got to stage nine from stage one?"

The formalization of clinical protocols such as that outlined above necessarily creates a plethora of barriers through which the individual seeking SRS must negotiate. It is with this then, that medico-psychiatric professionals working within GICs have come to assume the role of ‘gatekeeper’ – that is, they construct themselves as the arbiters of access to ‘treatment’, and as such are in a position to cast the ultimate decision as to if, and when, an individual may progress through the ‘treatment’ process. The extract above provides some evidence of the ‘gatekeeping’ function performed by psychiatrists working within GICs. Whilst the essence of this particular clinic’s protocol follows that which is laid down by the HBIGDA, it also reveals an important way in which this specific clinic, along with a number of others within the UK are constructing more barriers through which the trans person must jump. Thus, for example, the retrogressive use of a ‘gender panel’, often consisting of such individuals as vicars, which serves as a patient selection process, further entrenches the rights of ‘moral guardians’ to control the lives of ‘immoral Others’.

By looking at the words spoken by those ‘gender specialists’ interviewed, we are able to see a number of ways in which the trans ‘patient’ is subjected to this very ‘gatekeeping’ function. Each of the hoops through which the trans person has to jump have as their premise a standardized clinical protocol based upon the HBIGDA SoC. The first of these barriers that ‘trans’ women must negotiate during their time at the GIC relates to the actual assessment period, as psychiatrist’s A and D explained:

“... careful interviewing over a period of time and in this clinic two psychiatrists seeing patients early in their presentation and two psychiatrists agreeing that hormone therapy erm seems to be implicated or seems to be worth a trial. I’m not even certain that that’s enough sometimes, or that we actually see patients over a long enough period of time or question their psychology adequately.”

(Psychiatrist A)

“... we have a lot of post-operative transsexuals who attend this, they no longer attend this clinic, but are in therapy and will be in therapy for the rest of their lives, because they’ve either rushed the process and
they've been advised or have gone along in the belief that somehow if I change my sex, I will change myself and be a better person.”

(Psychiatrist D)

What both of these quotes reveal is that rather than try to minimize the length of the assessment process, and thus lessen the number of barriers confronting the trans person within the clinical situation, there instead seems to be a trend towards actually increasing the barriers put in place, whereby the successive movement along the transitional process is further hindered by the construction of a longer assessment process, thus placing ever more power in the hands of the ‘specialists’ and necessarily away from ‘trans’ women.

A second hoop through which ‘trans’ women must jump during their time at the GIC relates to the ability to access hormones. As one psychotherapist explained:

“So in effect, the [real-life] experience starts before they start hormones. Six months in, we would be able to recommend them.”

(Psychotherapist G)

What is significant here is the use of the phrase ‘we would be able to’, because when we look later on, at the ‘trans’ women’s experiences of GICs we will see that, in reality, the prescription of hormones often occurs long after the six month time period has elapsed. Here then, individual clinics adapt ‘best practice’ guidelines by withholding hormones beyond the recommended time frame. This defiance of an already harsh protocol further serves to highlight the control exercised by GICs.

The delaying of hormones until (at least) six months into the real-life-test can however, have detrimental consequences, as one psychiatrist who favours their diagnostic usage, explains:

“But there is a worrying trend among some of the NHS clinics, that they’re trying to make it erm, they’re trying to make hormones, erm, the prescription of hormones wrong, considered bad practice before the person has come out as transsexual and changed over, to start living as a woman. If you start living as a woman, they’re suggesting live as a woman for six or twelve months and then start hormones and err, and live for another two years after that before you have your operation …
which strikes me as a little bit tough … for the patient.”

(Psychiatrist H)

What these two interview extracts also allude to is yet a further barrier constructed by ‘gender specialists’, especially those working within NHS funded GICs, and that is the necessity of undergoing a ‘real-life-test’. Here, the individual is expected to live and work, full time, in the role of their subjectively experienced gender for a minimum of one year, as instructed by the HBIGDA SoC. However, a number of British GICs have extended the length of this test to two years. One simple reason for this extension was provided during an interview with psychiatrist A:

“Well, I don’t think one year’s long enough to establish that confidence in their ability to change.”

The function of the real-life-test would appear to be then a method of collecting ‘evidence’ of a person’s claims to trans ‘authenticity’ via a range of performative markers – that is, they are able to live ‘successfully’ in the subjectively experienced gender. Moreover, the hesitancy in allowing people to access hormones and surgery and thus transition earlier than is laid down in clinical protocol, provides evidence of a ‘hermeneutics of suspicion’ (see Theme 2), whereby rather than take a person’s claims to trans selfhood at face value, concrete proof is needed in order to convince the clinical ‘gatekeeper’ of that person’s suitability and hence ‘authenticity’.

That the real-life-test exists as a measure of success and hence trans ‘authenticity’ can also be evidenced in the assertions made by many ‘gender specialists’ interviewed. During the course of the majority of interviews it became apparent that any time spent living in the role of the subjectively experienced gender prior to a ‘patient’s’ first visit to the GIC would necessarily be discounted by the attending psychiatrist, and thus would not be deducted from the length of the required test. That it was deemed necessary for prior ‘living in role’ to be discounted was explained by psychiatrist D:

“The idea that a real-life-experience is sort of a set length of time is that it stops, hopefully, I mean it should do, in practice it probably doesn’t, it should stop the negotiation at the time, so that the negotiation is forgotten about because it’s a rule and everybody has to do this and therefore you can then go into assessing how well
somebody’s coping with the changes and so forth ... We run the two years from the beginning of the assessment. What we do, I mean it would be nonsense if people just came in and said well I’ve done the two years, can I start today? That wouldn’t allow an assessment and then what happens is that you are negotiating around that constantly, that’s what the meetings become …”

That this psychiatrist believes it to be ‘nonsense’ for a trans person to have their prior experience of ‘living in role’ taken into account provides further evidence of the desire of medico-psychiatric professionals to intensify their control, by dismissing anything that the trans individual says as nonsense.

What we can clearly see from the above interview extracts is the very real existence of barriers to ‘treatment’ which are constructed in order to slow down or hinder the individual from progressing through the transition from assigned gender to subjectively experienced gender. Here then, the decision of who is ‘right’ to pursue ‘treatment’ and when they should be allowed access to it is firmly governed by the medico-psychiatric professional. Whilst this ‘delay’ can be argued to be a pragmatic function of medico-psychiatrists needing to ensure that both they and the individual is certain that transition is the right step, what remains is a situation in which an enormous amount of power is placed in their hands, thus allowing them control over the lives and bodies of ‘trans’ women.

**Negotiating Clinical Protocol: ‘Trans’ Women’s Experiences of the Gender Identity Clinic**

During my conversations with ‘trans’ women, the issue of negotiating clinical protocol came out time and time again. Here the ‘trans’ women interviewed talked at length about their experiences of, and feelings towards the GIC system. The ways in which ‘trans’ women spoke of their experiences of gender identity clinics stands in stark contrast to the supportive role that such clinics should play, and it is from their words that we can begin to unravel the extent to which gatekeeping practices pervade the medico-psychiatric governance of trans-subjectivity. Two themes can be said to have emerged in relation to these experiences. The first concerns ‘the construction of artificial barriers’, and involves such issues as waiting times, access to hormones, the real-life-test, and funding issues. The second theme to emerge
from the research relates to 'a dissatisfaction with the structure and function of meetings' and as such concerns the issues of the inadequacy of meetings, a lack of practical support and a lack of clinical follow up.

The Construction of Artificial Barriers

Before discussing some of the main ways in which barriers are constructed within the GIC, it is worth considering in a more general sense, the ways in which gatekeeping is experienced by 'trans' women. Julie summed up the ways in which constructed barriers have the effect of delaying an individual's transition:

"There are so many hoops to jump through, you know, so many things that could stop you, if you have an adverse reaction to hormones ... psychiatrists didn't like what you were wearing, doesn't like your make-up, your attitude, you know ... if you smoke, yeah ... lost of unnecessary restrictions you know, they'd just make it really impossible for a lot of people ... I've known so many people that went through the NHS and right at the last hurdle they've been stopped .."

Moreover, Ruth explains the unrealistic nature of some of these barriers:

"... cos they set me goalposts ... you know, getting a job, and I'd sought to get a job and I'd done a lot of voluntary work to prove, but there's a lot of prejudice about ... it's very hard to get a job, err, I got a job as a community worker and I went back and they said 'oh, another 2 or 3 years, come back and we might be able to do something for you, so I went down hill quite fast.'"

It would seem that gatekeeping is an inherent feature of the GIC system, and specific instances of gatekeeping, such as those outlined below seem to have been faced by so many of the 'trans' women I interviewed.
Waiting

The length of time that 'trans' women are expected to wait between meetings and consequently the actual length of time spent attending a GIC appeared as one of the key examples of the ways in which the medico-psychiatric profession construct barriers that often have the effect of hindering an individual’s progression through 'treatment'. Jane talked about the delays that she experienced:

“I suppose it’s all a bit demoralizing at the moment because I think theoretically I still have a long time to go because if I actually go in and see them in [X month] and get a second referral, at that point I’ll then be referred to the surgical team, now that will take me 3 months for them actually to write to me and get the appointment, which will probably be 3 months after that ... god that's still [X] years away, which actually feels like a very long time to wait. The way I’m feeling inside at the moment I don’t quite know what I might do ... what quite annoys me is that I’ve had to do those 2 years [real-life-test] and then all I get is this other waiting afterwards, then the surgical waiting list.”

For some, the torment of this constant waiting period proved too much to take and they were forced to take the costly private route to ‘treatment’, as Emma explained:

“...by the time I’d waited to see the psychiatrist I was well down the road to transition and there was no way I was going back say 2 years, which is what would have happened, so I dropped out. And so yes, in a way it was a conscious choice to go private but it was a conscious choice that was forced on me by the NHS.”

What becomes apparent then is that by delaying access to ‘treatment’ the actions of NHS gender identity clinics can have serious consequences. These consequences become apparent when we consider the following issues.
Accessing Hormones

Connected with the lengthy waiting process is the (in)accessibility of hormones. It is general practice within British NHS GICs to only administer hormones after an individual is at least six months into their real-life-test, something which many of the 'trans' women I spoke to saw as ludicrous, and indeed potentially damaging. Emma explains the effects of this practice

“For me, if I’d gone to [X GIC] I could never have done the real-life-experience without hormones, to me that is absolutely ludicrous. If you’re 23 and got a lovely face then it’s not so bad, but if you’re 55 and balding then you need a little help, they do help to give you that little bit more confidence …”

Moreover, that such practices are specific to NHS GICs became abundantly clear throughout my time talking to ‘trans’ women. For clinicians working with NHS clinics, the diagnostic usage of hormones (whereby individuals are administered a small does of ‘opposite’ sex hormones to see if they are happy with the mild affects has upon their body) is regarded as constituting ‘bad practice’. Contrastingly, the diagnostic significance of hormonal therapy is greatly espoused by Britain’s foremost private psychiatrist. It was just such an approach to the administration of hormones that was favoured by many involved in my research. Julie summed up this position when she stated:

“I think, yeah, really important … because it would save a lot of people even starting it, a lot of people they clog up the waiting list at [X GIC] for years and they eventually get hormones and decide it doesn’t suit me … and all that time’s been wasted, whereas [the private psychiatrist] proscribes as soon as you walk in the door … and that’s the best way because most people that go to [him] don’t go back, you know, they go and they get hormones, try them, don’t like them … so I think that’s certainly a change that should be made.”
The Real-Life-Test

Further evidence to suggest that gatekeeping practices are a clear function of the GIC can also be gleaned by the diagnostic significance with which the real-life-test is regarded, as Charlotte explained:

“Arguments in defence of the ‘real-life-test’ as a diagnostic test are intellectually and morally flawed. To say the ‘real-life-test’ is a test is a complete nonsense as the majority of a national minority have already failed in their former real life experience and are compelled to seek to address their gender identity by presenting for ‘treatment’ and also by the time of the official commencement of the ‘test’ have usually been living in their true gender. I repeat, the ‘RLT’ is the official means to elongate the process of treatment rather than the creation of a fast track route. It is evident that the mechanisms of ‘RLT’ is in place to carefully control and regulate a national minimum referral programme for NHS waiting list for surgical intervention. Therefore, the rationale behind the implementation of the ‘RLT’ was an economic rather than a clinical one.”

Here again we find an example of the ways in which GICs draw out the transition process by constructing unnecessary barriers through which the ‘trans’ woman must jump. The result of which is the elongation of the time taken for an individual to access potentially life saving healthcare.

A Question of Funding

Finally, it became apparent throughout my research that it was not only the GIC that served as a gatekeeper to ‘treatment’. The scarcity of funding and resources channelled into the healthcare of trans people creates a final gatekeeping function, placed in the hands of Local Authorities who control access to the funds needed to pay for trans healthcare. The anguish that results from the trivialization of what is for many a life saving operation is made clear in the following narrative extract:
“The NHS took 4 years then my Health Authority wouldn’t pay for 2 years, so I had to get help to force them to pay for the surgery, which was a heinous thing for them to do ... so, when my MP’s letter actually did get results ... well no, the thing was, when my MP did write a letter, cos you know, if they hadn’t reacted to the MP it would have been going to law as some people have to do, but the awful and cowardly thing of the Health Authority was that they actually turned round and said ‘well it’s all been a mistake anyway because as an ongoing outpatient we don’t, we wouldn’t stop treatment anyway ... so basically I’d been kept waiting at the end of 5 years going through the NHS system for no reason at all, erm, well, a very god reason, prejudice from my Health Authority ...”

(Jessica)

With NHS GICs being the principle source of medical support available to trans people, it is alarming, although perhaps not altogether unsurprising, when we consider the continued psychopathologization of transsexualism, that many Health Authorities continue to refuse to pay for sex reassignment surgery, or fund only a small number of operations each year.

Dissatisfaction with the Structure and Function of Meetings

Many ‘trans’ women involved in my research spoke of their dissatisfaction with the support offered to them throughout their time within the GIC system. The first way in which this dissatisfaction was expressed was in relation to the inadequacy of the meetings.

The Inadequacy of GIC Meetings

Looking at the issue of the inadequacy of the meetings provided by GICs, a number of points were made regarding their length, thus for example Zoë expressed the following concerns:

“The thing about [X GIC] is that the interviews, what they were, were pointless. I don’t drive so I have to get the train, it would take me 3 hours plus to get there, 4 hours to get there, get to this [X GIC] appointment, which lasts 7 minutes and then I’d go again, and in those 7
minutes, I mean sometimes I hadn’t slept the night before, or I was ill so I didn’t respond very well to the questions and I came away and thought I’d answered those questions wrong, and as you’ve only got 7 minutes you think ok, I’ve got to try and show them this perfect person sort of stuff…”

Similarly Ruth talked about how she felt about the number of meetings she had with her psychiatrist, as well as their length:

“Once every 6 months and sometimes they’d only last 6 minutes. I’d gone all the way to X, I was fuming, 6 minutes, I thought how can you assess, do anything for me, you know, in that period of time?

Here then, it would appear that the medico-psychiatric professional is in a position to call the shots, thus extending their power over the ‘treatment’ process. That precious little time is given to these meetings leads us to question the level of support that is provided for ‘trans’ women as they enter the GIC system.

Concern was also expressed with regards the content and function of these meetings, which are used primarily as a method of continuous assessment of trans ‘authenticity’. So for example, Zoë talked about her fear to express the things that were of concern to her:

“They never gave me space to discuss this [any concerns]. When I went to [X GIC] I was terrified, I was terrified to express any concerns in case they put me back. And there was no space for, I mean I’m the sort of person who does question everything that I do, erm, but you couldn’t ask any questions because there wasn’t either time, or there was a fear that they wouldn’t take you seriously, and another 2 years would pass.”

That Zoë and many ‘trans’ women like her are often afraid to express any concerns or worries that they might have, through a fear that their access to ‘treatment’ may be put in jeopardy is startling, and as a consequence, they are forced into denying the uniqueness of their subjectivity and present a standard narrative thought to be representative of the ‘truth’ of their trans ‘desires’.
A Lack of Practical Support

It would appear that the support which is offered to ‘trans’ women by GICs and especially NHS GICs is often deemed inadequate and indeed inappropriate for their needs. As we have seen, the medico-psychiatric profession has standardized the ‘treatment’ available to ‘trans’ women and as a consequence, there is often a failure to deliver individualized healthcare packages, as Sue explained:

“No, the protocols don’t appear to offer individualized treatment, not for me anyway. I’m being allowed to meet the minimum requirements, but what if I wished to meet less than that? I have no control.”

Practical support was also something that was deemed to be missing from most people’s experiences with GICs. An example of this can be gleaned from the words of Isabel:

“I would like to have seen a bit more help upfront, before, for example they expect you to pass as a women … you could do with practical support early on and the message I got about [X GIC] was that we’re here to stop you mutilating yourself unless that’s the way you want to go, but things like the voice stuff, it’s not mutilation, it is reversible so we could be getting more support in that area earlier on than there is at the moment, where they just do nothing and they make you wait and if you’re still keen at the end of it then you might get some help.”

Furthermore, Claire makes the point that the decision of GICs to not allow breast augmentation on the NHS is demonstrative of the extent to which there is a lack of concern and practical support with regards some of the most important issues that affect ‘trans’ women:

“... it’s one of the single biggest giveaways for most people or it certainly was for me anyway, and breast augmentation, I don’t see that as being, you know, trans people, they’re never gonna go through their life, with their body producing male hormones for 20-30 years, so they [‘female’ sex hormones] don’t have that great an effect, your self-esteem and your self concept of being a women is hardly gonna be, err,
justified if you don’t actually have breasts and you know, you can take lots of genetic females, all their lives and don’t develop breast tissue, and it’s even harder for a genetic male who’s then taking female hormones, so I see it as being an integral part of the process really, I think it should be available.”

Related to the inadequacy of support available is the fact that despite hormone therapy being an integral part of the somatic change of sex, few ‘trans’ women I spoke to had any contact with endocrinologists. Janine reflects upon the ways in which this affected her:

“... I had so many problems which I think to a certain extent are ... are due to the fact that I’ve never been sent to one [endocrinologist], it’s so vital, erm, that you must have the right hormone level. I still don’t know if I’m taking the correct amount of hormones, I might be overdoing it, I might be under-doing it ... so I think an endocrinologist is important yeah, you should see one. And there’s a good one at X hospital but they won’t refer me to him.”

A Lack of Clinical Follow-Up

Finally, many ‘trans’ women I spoke to talked about their disappointment with the lack of clinical follow up, as Jessica explained:

“... there sure as hell isn’t any follow up in the National Health Service. There is no ongoing care or care into how well people have done, so far as I know, because nobody’s ever asked, nobody’s ever asked and my hormone regime is dictated by psychiatrists who I no longer see which is ludicrous, I mean it’s criminal really. It’s not his fault, it’s just that there are no resources or nobody chooses to make those resources available.”

Meanwhile Ruth reflected upon how the lack of clinical follow-up affected her:

“... even in the private sector there’s no follow up. 4 days after coming home I had chronic diarrhoea and when I went to the toilet I
passed out and woke up lying on the floor and the next morning I was soaked with sweat, but there’s no nurse. I mean if you had a baby someone would come round and check on you, but there was absolutely nothing like that. So I think they should give follow ups for at least 3-4 years, you know, regarding hormones, you know, if you’ve found work, follow up surgery just to make sure it’s going alright. It’s ridiculous you know.”

It would appear then that the sentiment of the GIC is that once sex reassignment has been achieved, ‘trans’ women are forgotten about, cast aside and left to cope on their own without medico-psychiatric concern for their future well-being.

The Involvement of Trans People

In order to overcome the power that medico-psychiatrists have over the ‘treatment’ process, many of the ‘trans’ women I spoke to advocated the involvement of trans people. For example, Janine stated:

“... there is a lack of appreciation, understanding by the gender psychiatrist. They’re not transgendered for a start. Erm, it’s like having a marriage guidance counsellor who’s not married, or a child psychiatrist who hasn’t got children. It doesn’t work, you need someone who’s within ... to understand those who are coming in ... I often left really, really sad, really depressed. I think that if the psycho had been like me I think they probably would have understood a bit better and I think in the early stages I needed to be with other transsexuals rather than going to a gender identity clinic.”

Whilst an advocate of the involvement of trans people within the GIC system, Jessica is also aware that the harsh treatment experienced by some in the past has left them unable to summon the inner strength needed to help others:

“... to spend a year or two living out in society in the other gender without any, any sort of assistance is a very harsh thing to expect of people, so I don’t know what, I mean, I think better therapy and
support would be a great thing, and I think that comes from trans people as well, you know, I'd like to see a lot more community, but people are very inhibited and have been very damaged by being so down trodden."

To involve trans people in the ‘treatment’ process would go some way towards recognizing the value of personal experience over clinical ‘expertise’, and as such would help to diminish the chasm of power that currently exists, thus partially transferring authority and control back to trans people. Furthermore, the involvement of trans people in the ‘treatment’ process, and the consequent shift towards a more egalitarian, and hence paternalistic structure, would potentially reduce the gatekeeping function of the medico-psychiatric profession.

By looking at the experiences that those ‘trans’ women involved in this research have had with gender identity clinics, as well as their experiences with the gatekeeping practices of medico-psychiatric professionals working within this sector, it becomes clear that the ‘treatment’ process continues to favour the decisions made by the medico-psychiatric ‘expert’ over the trans person’s wishes or needs. The continuation of ‘healthcare’ based upon such delineated lines further serves to entrench the medico-psychiatric imperialism of a personal subject position. In so doing, it not only negates the multiplicity of trans-subjectivities, by adhering to rigid protocol and failing to offer individualized healthcare packages, but it also continues to contain ‘trans’ women safely within the recognized norms of medico-psychiatric discourses of pathology.

Conclusions

It becomes evident, when looking at the ways in which ‘transsexualism’ is understood by both medico-psychiatric professionals and ‘trans’ women that the relationship between medicine and social identity is not as clear-cut as is often believed. It is no longer possible to simply state that ‘trans’ women uncritically accept the medico-psychiatric definition of their lives and bodies as suggested by writers such as Raymond (1979), Shapiro (1991) and Hausman (1995), but instead we must understand the extent to which ‘trans’ women are reclaiming autonomy over the definitional process, and in so doing, ‘transsexualism’ is moving away from being a medico-psychiatric condition and back to a form of individual narrative. It is important however, that when understanding transsexualism in its current context, we do not
continue to espouse a homogenous portrait of the ‘trans’ woman, but instead recognize that each person makes sense of their experiences in different ways and attaches different meanings to them.

As we have seen, the ways in which those ‘trans’ women involved in this research understand and hence define ‘transsexualism’ stands in stark contrast to the ways in it understood by those medico-psychiatric professionals interviewed. The differences are most apparent in relation to the whether ‘transsexualism’ is to be understood as being of the body or of the mind, and the extent to which it can be understood as constituting an intersex condition of the brain. While, as we have seen, a number of the ‘trans’ women espoused a medically orientated definition of ‘transsexualism’, the ways in which they did so varied enormously from its medico-psychiatric categorization.

Moreover, I hope I have demonstrated the complex ways in which the medico-psychiatric profession have assumed a position of ‘expert’ over the trans phenomenon, and as such exact a position of authority and control over the lives and healthcare of ‘trans’ women. Connected with this is the way in which the medico-psychiatric profession have constructed themselves as the ‘experts’ of transsexualism. The effects of which are two-fold: in the first instance, the construction of a specialism, governed by medico-psychiatric professionals, acts in such a way so as to effect a limited and inappropriate healthcare system, whereby other medical professionals are removed from an authoritative position within the care structure. Thus, for example, the prescription and administration of hormones is governed by the psychiatrist rather than an endocrinologist. Moreover, GPs remain distanced from the delivery of healthcare, and as such their knowledge and understanding of transsexualism remains peripheral despite the potentially crucial role they play in the provision of healthcare for ‘trans’ women. Finally, the construction of transsexualism as a psychiatric specialism serves to maintain and promote a psychopathological depiction of the trans phenomenon.

Concordant with the construction of transsexualism as a psychiatric specialism is the ability of such professionals to assume the role of ‘expert’ and hence gatekeeper to the access of often life saving healthcare. As long as psychiatric imperialism continues to go unchallenged, British GICs, and those psychiatrists working within them, will continue to be able to dictate the ways in which ‘treatment’ is to be structured, as well as who is to be granted access to such ‘treatments’ in the first place. Rather alarmingly, my research also revealed that many British GICs are failing to follow a set protocol for the ‘treatment’ of transsexualism as laid out by the HBIGDA in their ‘Standards of Care.’ Thus, even whilst such protocols may be
considered to impinge upon the autonomy of trans individuals, British GICs make further impingements upon an individual's subjectivity by elongating the time periods before which an individual is able to progress to the next stage of 'treatment', and by constructing more and more barriers to an individual being able to gain access to these 'treatments' in the first place.
The intention of this last chapter in the theme of 'definitions and pathology' is to provide a summary of the key debates and findings of the research into this theme, as well as make any necessary connections between the literature and my research into the ways in which transsexualism has been, and is currently defined within medico-psychiatry and by 'trans' women, as well as the role and function of gender identity clinics. Finally, the chapter concludes by highlighting the ways in which my findings can be used to move debates on, and as such provides a bridge between this theme and the next.

During the interviews conducted with GPs and 'gender specialists', each were asked what they understood transsexualism to be. The answers given were revealing of the extent to which those working within the field of medicine are informed by the wider medico-psychiatric discourses of transsexualism. Needless to say the responses to the question of clinical definition varied according to the level of expertise held by the clinician, with GPs espousing a more social or populist conception, informed to varying degrees by the relevant clinical literature, or through contact with trans individuals. Not surprisingly, the responses elicited by those professionals working within the field of transsexualism - whether they be psychiatrists, psychoanalysts, gender counsellors or surgeons - articulated a view of transsexualism much more akin to medico-psychiatric discourses as they exist at the present moment. Interestingly, there were some disparities between discourse and practice evidenced through my research, which highlighted the need to move away from view medico-psychiatric discourses within the clinical setting as unitary and unambiguous. While it is true that a psychopathological view of transsexualism predominates, clinical understandings are in fact far more diverse and draw upon and combine in a variety of ways those discourses that abound within the literature.
Moreover, by looking at the ways in which those ‘trans’ women involved in my research define transsexualism we find some interesting divergences from the standard medico-psychiatric imposed definitions. Here then, the ‘trans’ women that I spoke to did not conceive of transsexualism as a psychopathology, as it is often scripted within medico-psychiatry, but instead favoured a view of transsexualism as a naturally occurring human condition, or as a legitimate medical condition, not a psychiatric disorder. Comparing the ways in which these two groups – the medico-psychiatric profession and ‘trans’ women – make sense of transsexualism allows us to begin to address the complex relationship between medicine and social identity. As we shall see in Theme 2, ‘trans’ women have at times been charged with accepting the medicalized definitions of their identities and bodies (see for example, Raymond, 1979). Yet such an analysis negates the role of subjective agency on the part of the ‘trans’ woman, casting them instead as medicine’s ‘dupes’. Moreover, such an analysis fails to take into account the extent to which medico-psychiatry and the broader medical profession have come to assume the position of a ‘total institution’ (Goffman, 1961) in contemporary western society, and as such often constrains the ability of ‘trans’ women to narrativize a coherent sense of self, other than through that which has been medically constructed. In this way then, we would expect there to be a large degree of overlap between medicalized definition and personal understanding. The increased presence and growing autonomy of trans communities, fuelled and sustained by the rise in trans activism since the 1990s has created a situation whereby the communities themselves are becoming increasingly vocal in the telling of their stories, and many are moving beyond the former definitions imposed on their ‘being’ by medico-psychiatry. What I hope the interview excerpts from my conversations with ‘trans’ women reveals is the extent to which many ‘trans’ women are beginning to verbalize their own narrative, one which, while at times pivoting around a view of transsexualism as constituting a medical condition, does, and important ways contradicts the definitions of medico-psychiatry (for a fuller discussion of the ways in which trans and medico-psychiatric accounts of transsexualism diverge see Theme 2).

What becomes evident when looking at the ways in which transsexualism is understood both by medico-psychiatric professionals and ‘trans’ women is that the relationship between medicine and social identity is not as clear-cut as is often believed. It is therefore, no longer possible to simply state that ‘trans’ women uncritically accept the medicalized definitions of their lives and bodies. Instead, we must understand the extent to which ‘trans’ women are reclaiming autonomy over self-definition, and in so doing, ‘transsexualism’ is again becoming a self-narrated phenomenon. It is important however (and as we shall see in Theme 3) that when understanding transsexualism we do not continue to espouse a homogeneous portrait of
the 'trans' woman, but recognize that each individual makes sense of their experiences in different ways and attach different meanings to them.

Much of the sociological and trans literature relating to the medicalization of transsexualism addresses the ways in which medico-psychiatry has constructed a role for itself as the 'experts' of transsexualism, and as such are able to enact the role of gatekeeper. It became apparent that not only did the construction of transsexualism as a medico-psychiatric specialism curtail the individual's ability to enact an autonomous position within the 'treatment' process, but that it also served to exclude other medical professionals, who are perhaps more suitable, from the decision process as to how exactly trans healthcare should be organized and delivered.

The narrative extracts contained in the previous chapter, from GPs and medico-psychiatric professionals as well as 'trans' women provide an important glimpse into the ways in which each group negotiates the complex issues of authorship and ownership. By understanding the stories that each group tells we can begin to understand how each sees themselves in the 'treatment' process associated with transsexualism, together with the ways in which they position others in relation to it. What becomes clear is the way in which medico-psychiatric professionals working within British GICs have constructed a role for themselves as 'gender specialists', and as such have excluded other professional bodies from being more involved in many of the important decisions regarding 'treatment' as well as what constitutes 'best practice', together with acting in such a way so as to assume authority over and ownership of a personal subject position.

Within Britain, the psychiatric profession have been charged with, or more accurately assumed power and authority over the healthcare of trans people. This psychiatric imperialism demonstrates itself both in terms of its enactment of a gatekeeping function, deciding who can and cannot legitimately access 'treatments', as well as when these 'treatments' should be given, but also in terms of its control over the 'treatment' process. Here then, important decisions about 'treatment' are governed by those psychiatrists working within gender identity clinics, as opposed to trans people themselves, as well as other medical professionals who might be better placed to discuss and make decisions about relevant 'treatment' issues. As such, the profession's claims to a 'special kind' of knowledge have lead to the construction of transsexualism as a medico-psychiatric specialism. It is as a result of this that those psychiatrists working within GICs are able to set themselves up as the 'experts' of transsexualism. A consequence of this is that other medical professionals, who
could potentially play a crucial role in trans healthcare, are insufficiently knowledgeable of, and experienced in trans issues. But more than this, the construction of transsexualism as a medico-psychiatric ‘specialism’ has further entrenched the subjugated position of trans people. By overriding the significance of the personal narrative and of experiential knowledge the medico-psychiatric profession has been able to negate the subjectivity and autonomy of the speaking subject, viewing narratives as suspicious and incoherent texts that require decoding by the psychiatric ‘expert’. Here then, personal experience or subjectivity looses ground to self-assumed clinical ‘expertise.’

The extent to which the medico-psychiatric profession have assumed an imperialistic position over the healthcare available to trans people can be evidence through the profession’s formalization of rigid protocols such as that which has been laid down in the HBIGDA’s ‘Standards of Care’. The material discussed within such protocols as to the appropriate ‘treatment’ regime for trans people, makes apparent psychiatrist’s claims to the ownership of and authority over trans-subjectivity. Again, however, such claims to authority and ownership are not only exercised over trans people, but also over other medical professionals. When thinking of this, it is important that we are reminded of the fact that in places such as the Netherlands, and during other periods of trans history, other professional bodies, and principally endocrinologists have, and do play a more prominent role (the ‘founding father’ of trans medicine, Dr. Harry Benjamin was himself an endocrinologist. See also the work of Gooren and Swabb, 1995).

The colonization of transsexualism and its construction as a medico-psychiatric specialization, to the exclusion of other medical professionals such as endocrinologists and general practitioners, can also be evidenced by the findings of my own research. What became apparent then was the lack of involvement that GPs saw themselves as needing with regards to trans healthcare, let alone an awareness that their involvement could be crucial, especially from the point of view of some of the ‘trans’ women that I spoke to. Here then, it would appear that those GPs interviewed for this thesis were happy to pass over the role of ‘expert’ and officiator of ‘treatment’ to those who are self-proclaimed ‘gender specialists’, thus further perpetuating medico-psychiatric power over transsexualism and trans subjectivity.

What I hope to have been able to have shown throughout this theme is the way in which medico-psychiatric professionals have constructed transsexualism as a clinical specialization over which they and only they have control. By understanding transsexualism as a ‘condition’ which ‘affects’ only a minority of British citizens, it has been deemed necessary
for only a small number of ‘specialists’ to have any detailed knowledge of the subject matter, a hypothesis perpetuated throughout GICs. Thus, those specializing in this field are able to claim a ‘special kind’ of ‘expertise’, and as such, their claims to authority cannot easily be challenged by others from within the medical community, who, as a consequence of this constructed specialism, receive little or no formal training on, and consequently have limited knowledge of transsexualism.

The interview material from the research conducted with the medical profession, and in particular those psychiatrists working within British gender identity clinics provides a great deal of evidence for the extent to which this group enacts a gatekeeping function, whereby barriers are constructed with the effect, it would seem, of hindering the transition process. Here then, a clinical judgement is made: those who can surmount such hurdles are considered ‘authentic’ in their ‘desires’ and are thus successful in their pursuit of ‘treatment’, and those who are unsuccessful in their attempts to negotiate clinical protocol, have their ‘failure’ read as a mark of their ‘inauthenticity’. That such gatekeeping is a prominent feature of ‘expert/patient’ relationships within GICs was reiterated volumously throughout the words spoken by those ‘trans’ women involved in this research. From the perspective of these ‘trans’ women, the existence of barriers put up to control their movement through the GIC system provides clear evidence of the sheer disparity of power that exists between ‘expert’ and ‘patient’, whereby the former enacts a controlling function over the subjectivity of the latter.

By constructing a number of barriers that trans people must negotiate – the real-life-test, the delaying of hormones and the insistence upon divorce – and which are standardized and inflexible, psychiatrists working within British GICs are able to assume the role of gatekeeper, able to decide if and when an individual is able to progress onto the next stage of the ‘treatment’ process. The result of this gatekeeping is that power is placed firmly in the hands of the psychiatrist rather than the trans person. This controlling function is also evidenced by the failure to provide an individualized healthcare package, whereby past experience and an individual’s circumstances are taken into account when deciding how the question of ‘treatment’ should be approached. Finally, that the goal of the meetings held at the GICs, is from the perspective of the medico-psychiatric profession, to gather a detailed life history and check the individual’s ‘authenticity’, the actual length of these meetings calls into question the extent to which this can ever be achieved. Perhaps then, the greater function of these meetings is to make decisions about to somatic and performative ‘authenticity’ of the trans person’s desires (see also Theme 2). Moreover, the extreme shortness of these meetings
can only serve to contradict the supportive role that GICs should perform, and is required by those ‘trans’ women involved in the research.

What this theme has achieved is an insight into the historical emergence of transsexualism and its relationship to medico-psychiatry, as well as teasing out the disparities and continuities between the ways in which transsexualism is defined with medico-psychiatric discourses, clinical practice and by ‘trans’ women themselves. As such, we have begun to see the ways in which we can rethink the relationship between medico-psychiatry and trans-subjectivity. Thus evidence of the disparate ways in which transsexualism is defined within the domain of medico-psychiatry and within the words of ‘trans’ women suggests that the latter do not simply reproduce the discourses and assumptions of the former. It is such a position that also enables us to move beyond the feminist interpretations of the relationship between trans-subjectivity and medico-psychiatry which are discussed in Theme 2. Moreover, it makes suggestions to a relationship between transsexualism and sex/gender, which enables us to problematize the literalizing/deliteralizing binary suggested in Theme 3.

Finally, by assessing the historical relationship between medico-psychiatry and trans-subjectivity, as well as looking at the differing ways in which transsexualism is defined, and using that to contextualize the current workings and structure of the gender identity clinic, we are led neatly into Theme 2 and the discussion of the ways in which trans becoming has been scripted within the domains of medico-psychiatric discourse, clinical ‘expertise’ and personal experience.
Theme 2

Telling Stories, Creating Histories: The Politics of Trans Becoming.
"[A]t certain moment the great men grew too complacent, they forgot that they could not really fly, they believed their own propaganda too completely. In these moments new possibilities arose. The whispered voices of dissent carried a little further, the rest of the world started to doubt a little more. After a while, no matter how loudly the great men shouted, everyone realized that there were other stories to tell and hear. And it was in these moments that the rest of the world chose to change all the endings."

(Bhattacharyya, 1998: 36)

As we saw in Chapter One, contrary to much gay and lesbian histiography (Katz, 1976; Wheelright, 1989; Hirschauer, 1996), the contemporary narrative plot of transsexualism can be traced back to the sexological period of the late nineteenth century, as evidenced in the words spoken of and about those individuals categorized as ‘inverts’. Such a re-conceptualization of trans histiography has, in its turn, had major ramifications for the ways in which we are to understand trans becoming. Theorists such as Hausman (1995), Billings and Urban (1996), and others writing from within the medicalization school of thought, influenced largely by labelling and discursive approaches, contend that transsexualism only becomes meaningful once the technological means by which the subject could ‘change sex’ became possible, and once the category ‘transsexual’ came to be named as such, through its entry into language in the 1950s. However, by recognizing the sexological period of the late nineteenth century as the moment at which a trans identity emerged, as well as the active role played by trans people in the construction of that identity, we can begin to problematize the assumption that transsexualism was constructed in and through medico-psychiatric thought about it, and that a trans identity only became meaningful once it was named as such. It is from this that we can begin to rethink the relationship between medico-psychiatry and trans-subjectivity,
whereby 'trans' women do not simply reproduce or reify medicalized conceptions of their identity, but are instead speaking from a subject position that 'trans' women of the late nineteenth century were active in constructing; a subject position which subsequently came to be named and colonized by the more powerful voice of medico-psychiatry.

This chapter seeks then to look at the two diametrically opposing ways of understanding trans becoming – as a product of 'demand' (Hausman, 1995) or a process of 'narratology' (Prosser, 1998) - as a means by which we can begin to problematize and indeed rethink the relationship between medicine and social identity, and which in turn will throw light on those debates discussed at the close of the chapter, which concern the extent to which 'trans' women can be understood as being either the dupes of medico-psychiatry, or duplicitous in their supposed manipulation and reiteration of the standard medico-psychiatric discourses of transsexualism. The chapter also looks at the ways in which trans stories of becoming are told within the medico-psychiatric profession, as a means by which we can begin to trace their journey into clinical practice.

**Telling Stories, Creating Communities: Understanding the Story–Telling Process**

As discussed in the introduction to the thesis, I am interested in the ways in which we tell stories about our lives, and especially our gendered lives. These stories of selfhood are important because they enable us to make sense of our lives and experiences and as such, help us to position ourselves in the social world. Connected to this, I am also interested in the ways in which stories are told about Others, and how these ‘Othering’ stories often come to assume a position of power and authority over the stories of those being talked about. It is in this way then that my approach to trans becoming and its consequent relationship to medico-psychiatry is informed by the works of Plummer (1995, 1996a) and Bhattacharyya (1998).

**Incidents in the Telling of a Successful Story**

Following Plummer (1996a) we can suggest that when a personal story is shared by many, and has a receptive audience it is able to enter into the public domain, moving outside of the
realm of the private and into discourse. It is at this moment that the story has been successfully told.

According to Plummer, a number of themes are necessary for a story to be successfully told and so enter discourse. Arranged into a sequence, these “generic process[es] of telling” (Plummer, 1996a: 41) indicate the necessary conditions for the successful telling of a story. Plummer (1996a: 42-44) describes these generic processes as: (1) 'Imagining – Visualizing – Empathizing'; (2) ‘Articulating – Vocalizing – Announcing’; (3) 'Inventing Identities and Becoming Story-Tellers'; (4) 'Creating Social Worlds'; (5) 'Creating a Culture of Public Problems.'

The first process, ‘Imagining – Visualizing – Empathizing’ concerns unconscious experiences. Here then, stories are unable to be told. As Plummer suggests, these stories are “culturally insignificant” and will remain so “as long as they fail to enter into the more public domain” that is, “as long as they are silent” (1996a: 42). Within the second process of ‘Articulating – Vocalizing – Announcing’ “[a] space needs to be found where languages can be invented, words can be applied, a voice can be found, and a story told” (Plummer, 1996a: 43). From the early descriptive case studies of people who express a sense of ‘gendered difference’, written by a few isolated clinicians, to the early autobiographies of those who experience such a ‘difference’, people began to talk about, albeit in no particularly uniform way, a particular phenomenon.

Next is the process of ‘Inventing Identities and Becoming Story-Tellers’. This occurs when stories move out of the limited world of private thought and into language. That is, when a story is not merely being talked about, but is being discussed. For this stage to come to fruition the stories told must be those of community – providing a chance for people to be able to see themselves and relate to. The penultimate process, Plummer calls ‘Creating Social Worlds’. This process emerges when the story has transcended the private mode of individualized telling and has found an audience willing to hear its tale, and accept it as their own. “The critical take-off point comes when social worlds come together”, forming an “interpretive community” (Plummer, 1996a: 44). Within this it is important to recognize the ways in which stories become arranged in a hierarchical manner, which serves to give power to some, whilst silencing others.

The final process is described as ‘Creating a Culture of Public Problems.’ “Here the story moves out of the limited social world and enters an array of arenas of public discourse”
For this stage to have been reached, there will have to be, "(a) a large number of people willing to claim it as their own; (b), a willingness to tell the story very visibly so that others can identify with it, and (c) the presence of alliances who while not claiming it as their own, are keen to give it credibility and support" (Plummer, 1996a: 44-5).

These processes of successfully telling a story can be understood as both a historical process as well as a more personal process of becoming, and as such enables us to understand not only the entry of transsexualism into language, and its ensuing construction as both a social and a cultural issue, but also the process by which individual ‘trans’ women begin to make sense of their ‘gendered difference’, from a feeling that something is ‘wrong’, to the articulation of a trans identity, as well as their entry into trans politics.

Understanding Trans Story-Telling

According to Plummer "Stories have recently moved centre-stage in social thought: as pathways to understanding culture; as the basis of identity; as tropes of making sense of the past; and as ‘narrative truths’" (e.g. Spence, 1982; Bruner, 1987; Maines, 1993), and as such, "a ‘narrative moment’ has now been sensed" (Plummer, 1996a: 34). Story-telling, as I understand it refers to the internalized means by which individuals make sense of their self, as well as the selves of Others, and as such they are private stories that each and everyone of us tell in order to make sense of our lives and the lives of others. At times however, some of these stories break out of the private world and enter into public discourse, and it is at that moment that following Plummer (1996a) we can say that such stories have been ‘successfully told’. This happens at a specific historical moment when an audience to that telling is willing to hear and accept that particular story being told.

When we consider the stories that we as individuals narrate as a vehicle through which to understand the self, especially when that self confronts socially sanctioned ways of ‘being’ (i.e. transsexual, Transgendered, gay, lesbian, bisexual) it is useful to make reference to what Plummer (1995, 1996a) terms ‘coming out’ narratives. These ‘coming out’ narratives have arguably played a crucial role in the development of a trans and a Transgendered politics. However, it is not until the time is right, that is, when groups of people are willing to hear these stories that ‘alternative’ ways of ‘being’ can enter into the realms of public discourse.
As we shall see, many of the ‘trans’ women involved in this research have at times felt constrained in their ability to narrate the ‘truth’ of their subjectivity, fearing that it did not replicate the official story of transsexualism as it is scripted within medico-psychiatry. With an audience not ready to hear those stories that speak against that which is scripted within medico-psychiatric discourses, many of these ‘trans’ women could do little more than reproduce this ‘official’ and standardized narrative, which constructed the ‘trans’ woman as an ‘Other’ to sanctioned ways of being ‘female’. Following Bhattacharyya (1998), we can reason that this is so because historically, ‘trans’ women often had, and at times continue to have little faith in their own narratives and story-telling capability, and as such have looked to medico-psychiatry for approval, judging themselves through ‘the great men’s imagined eyes’ (Bhattacharyya, 1998: Chapter 1), thus perpetuating the scientists’ ‘truth’ claims. Here then, we can begin to understand the ways in which those stories used to make sense of personal experiences are often constrained by wider and more dominant stories that have successfully gained entry to the public world of discourse. However, as we shall see in the following chapter, many ‘trans’ women are beginning to (re)tell a story of their lives, which while contained within the rubric of medicine, differs in significant ways from that which is constructed of and for them by medico-psychiatry.

In a similar vein to Plummer, Bhattacharyya (1998) believes that story-telling is important in facilitating both social and political change. For Bhattacharyya, stories are told not only by the subjugated to affect their own empowerment, but also by the holders of social power, the result of which is the perpetuation and maintenance of their control over the story-telling ability of those whom they speak.

As with Plummer, Bhattacharyya believes that specific cultural climates create a space whereby the stories of the oppressed can be heard and given authority. According to Bhattacharyya these are the only real and ‘true’ stories. We are beginning to witness the (re)emergence of different ways of telling trans stories. The emergence and growth of trans movements, like that of the gay liberation movements that rejected the ‘disease’ model of homosexuality, sees trans and Transgendered individuals rejecting the psychopathological model of ‘sex changing’. These new story-tellers are telling the stories of their becoming, in a way far removed from the medico-psychiatric stories told for so long. Related to this is the reclaiming of power back from the hands of medico-psychiatry. However, the telling of these ‘new’ stories is no easy task, as the stories told within medico-psychiatric discourses on transsexualism, once thought to represent the ‘truth’ of trans-subjectivity, in many ways actually serve to restrict possible means of gendered expression.
The telling of 'new' stories of 'being', told by those once Othered calls for a change in narrative. This changing of narrative is about reinventing possibility, "so new stories look on the bright side and stress achievement, beauty, potential. Once they were told we all worked hard at believing them, against our learned-long-ago habitus" (Bhattacharyya, 1998: 37). The 'new' stories, of both trans and Transgender emerge then as a challenge to the hegemony of medico-psychiatric understandings of transsexualism and trans-subjectivity, in that they move away from a story of perversion, to the story of the 'sufferer' to the 'normal' to the 'radical'.

Significantly, changing the world also involves changing one's beliefs about oneself, something which involves the restructuring of knowledge. This goes to someway explain why, as we shall see in Theme 3, the subversive politics of Transgender has not become the principle organizing force for all trans-subjectivities. Moreover, since so many 'new' trans stories have (re)emerged, 'trans' women are beginning to find a story that fits from a whole gamut of possibilities, rather than being constrained into telling one tale of their lives. However, we also need to consider that the reason why so many 'trans' women position their subjectivities within a medical domain, has much to do with the fact that 'trans' women of the late nineteenth century were active in the construction of a trans identity which subsequently came to be co-opted and standardized by medico-psychiatry.

The framework for the successful telling of a story as outlined by Plummer (1996a), together with Bhattacharyya's (1998) vision of the power of stories for empowerment, allows us to articulate the shift from the privatized world of story-telling to the public world of discourse, through a constant interplay of power relations which arrange stories hierarchically, thus enabling some stories to be heard, whilst silencing others. Such a framework also gives us an insight into why stories and subsequently discourses emanating from within medico-psychiatry have for so long, dominated our understandings of transsexualism, together with why it is now that the various trans discourses are becoming both more vocal and more powerful.

Where however we must proceed with caution when following this approach, and especially when considering the work of Bhattacharyya, is that from such a perspective, the stories told by 'colonizers' and those told by 'Others' are radically distinct from and stand apart from one another and it is in this way that such a conception fails to account for the intricate ways in which the construction of stories and identities is achieved through a subtle process of negotiating with the self and the Other. Thus, it becomes important to stress that trans stories are constructed in relation to a whole host of other stories, including those told within medico-
psychiatry. Likewise, it is important to remember that sexological stories, and to a lesser extent, medico-psychiatric stories, especially when transferred into the clinical practice, and as we saw in Theme 1, are constructed in relation to ‘trans’ women’s own stories. Sometimes this relational process creates a synthesis, and other times it acts as a basis for ‘resistance’, nevertheless, it is important that we do not think of stories as static, existing in isolation, or as mutually exclusive.

Trans Becoming: A Product of ‘Demand’ or a Process of ‘Narratology’?

In her book Changing Sex, Hausman (1995) proffers a theory of trans becoming centred upon the concept of ‘demand’. That is, that people could only be meaningfully known as ‘transsexual’ once that term had entered the medico-psychiatric lexicon. This discursive naming of the ‘transsexual’ as a medico-surgical entity occurred, according to Hausman, during the 1950s, as a result of the developments being made in endocrinology and plastic surgery, which made realizable the somatic ‘change of sex’. Here then, technology is the marker of trans-subjectivity, and as such, the ‘transsexual’ as a coherent subject position could not, and indeed did not exist until after the technological apparatus of ‘sex change’ emerged.

It is Hausman’s contention then, that there could be little or no demand for such surgeries if the medical technologies needed to exact a somatic change were not in existence. Endocrinology and plastic surgery – the medical specialities that form the foundation of sex reassignment – became widely available in the latter half of the twentieth century. Endocrinology, Hausman argues, provided “medicine with the tools to enforce sexual dimorphism” (1995: 284). As a result of these medical advancements, those who expressed a trans desire, could “be made to hormonally conform to medically/socially agreed upon norms” (Devor, 1997: 40). Moreover, the increased prevalence of plastic surgery from around the latter half of the twentieth century gave further support for the construction of transsexualism as both a diagnostic category and an identity.

By making available the medical means to alter the body and the somatic markers of sex, plastic surgery and endocrinology came to be recognized as ‘solutions’ to the feelings of ‘wrong’ embodiment. Moreover, as the public became increasingly aware of the technologies and the ‘solutions’ available “persons who felt the need for these services learned what to call
themselves ('transsexual') and how to describe their psychological state ('gender dysphoric') in order to gain access to the desired transformative medical procedures” (Hausman, 1995: 284). From this perspective, transsexualism needs to be understood as a “communicable disease” (Prince, 1976), whereby the more publicity that surrounded transsexualism and sex reassignment surgeries, the more people came to identify with its associated desires and practices.

The trans person, according to Hausman, emerges through the demand for ‘sex change’, a demand which exists as a direct response to the existence of a specific diagnosis and the technological ability to alter the somatics of the body:

“the demand for sex change is an enunciation that designates a desired action and identifies the speaker as the appropriate subject of that action. ... [T]he demand for sex change was instantiated as the primary symptom (and sign) of the transsexual”

(Hausman, 1995: 110)

In Hausman’s description, one becomes transsexual because one says one is. Thus, the claim to trans-subjectivity is for Hausman, performative:

“in the demand for sex change, the transsexual stakes a claim [...] that determines, indeed, founds, subjectivity as ‘the other sex.’ [...] The demand itself, however, inaugurates in the subject a desire that cannot be met through the specific surgeries and endocrinological interventions that serve to relocate him or her in the opposite sex category”

(Hausman, 1995: 136-7)

However, because Hausman also reads ‘demand’ via a Lacanian understanding, the demand for sex reassignment made by the trans person “paradoxically undermines this subjectivity” (Prosser, 1998: 105).

If we follow Hausman’s hypothesis, the diagnosis of transsexualism (and gender dysphoria) inaugurates demand for sex reassignment surgery as the defining characteristic of the phenomenon. Such a ‘demand’ is couched in a language which assumes that a person’s gender identity may take precedence over the evidence of their bodies as the basis for sex
reassignment. In other words, for both trans people and their physicians, gender identities, which exist at odds with seemingly ‘normal’ bodies can act as a sufficient cause for trans identities, the diagnosis of transsexualism and the application of the technologies of sex reassignment. For Hausman then, it is technology that makes the ‘transsexual’, whereby trans individuals are “authored by medical technologies of plastic surgery, endocrinology and the ‘idea of gender’” (Prosser, 1998: 133).

Critical of Hausman’s theory of ‘demand’, Prosser charges Hausman with failing to read the narratives that trans subjects have historically told as a means by which to author themselves prior to the emergence of an official diagnosis. Preceding the discursive naming of ‘transsexualism’ and the creation of an officially sanctioned discourse, Prosser argues that the narratives or “plot lines” (1998: 133) of trans people, told in the nineteenth and early twentieth century share remarkable similarities with the autobiographies and personal narratives of contemporary trans subject positions. It is then, according to Prosser, the very “consistence and continuity of this narrative” (1998: 143) that produced medico-psychiatric discourses of transsexualism.

Hausman is clearly informed by the work of both Foucault and the discursive construction of identities, and labelling approaches, but in doing this, she fails to consider the realm of subjectivity. That is, she fails to pay attention to the ways in which ‘trans’ women can be said to have been actively involved, through a complex negotiation of power dynamics, in the construction of a trans identity. Moreover, Hausman fails to consider the ways in which trans conceptions of self play with, are informed by, and in turn inform those discourses that are written of and for them. It is not helpful then to think of ‘trans’ women as involved in reifying medical understanding. Instead, taking a more interactionist stance, we are able to see the ways in which medico-psychiatric discourses and subjective experiences continually interact with and inform one another.

Prosser’s concern in his seminal 1998 publication Second Skins is with the ways in which transsexualism is produced both in and through autobiographical narrative. His reading of autobiography begins “where the transsexual begins its telling: The clinician’s office” (Prosser, 1998: 103). For Prosser, it is because transsexualism cannot be read off bodies that the subject’s narrative is required to speak in the clinical setting. Thus, and in contrast to Hausman, Prosser contends that narrativization as a transsexual precedes its official diagnosis. Through the use of the term ‘body narrative’, it is Prosser’s intention to reflect “the ways in which body and narrative work together in the production of transsexual subjectivity”
Here then, the trans person’s narrative actually enables the realization of a somatic change of sex.

Prosser’s ‘narratology’ is distinguishable from Hausman’s ‘demand’ in three principal ways: Firstly, unlike demand, narrative is not performative, but is instead organized through the repeated telling of episodes over time; secondly, narrative is “bound up with realization” thereby developing its own telos rather than signifying “lack” and, finally, more obviously than demand, narrative indicates a complex dialogue between author and reader, trans person and clinician (Prosser, 1998: 105).

In presenting at gender identity clinics as transsexual, Prosser contends that subjects are the original (self) authors of their transsexualism. In this way then, we can understand the narrative tropes of transsexualism – having felt as such since their earliest memory, together with a strong and persistent wish to live as the ‘other’ gender – as being plot lines originally told to clinicians by trans people themselves. However, as Prosser recognizes, in order to receive or indeed begin ‘treatment’ the trans person must receive an appropriate reading by the attending clinician, which in turn, serves to authorize the trans person’s personal history. In other words, it is only through the critical reading of the trans person’s narrative by the clinician, that their story, and thus their sense of self, can be legitimated. In this way then, the entry of ‘transsexualism’ into the DSM-III (1980) represents the medical formalization of transsexualism into a coherent plot. This standardization of the trans narrative by the clinician has the consequent effect of homogenizing the trans experience, rendering some stories intelligible while inhibiting the plethora of possible subject positions from which trans people can speak.

In a similar vein to Prosser, Epstein (1995) addresses the transformation of a personal story into a medical type. Epstein explains that in order to understand the ways in which becoming trans is understood within clinical practice, we “need to begin with the clinical case history itself as a form of institutional writing” (1995: 25). Through the process of clinical interviewing, psychiatrists are able to produce a narrative of a patient’s history, which they then write up in the form of a case history. It is in this way that psychiatrists can be understood as storytellers – listening to a ‘patient’s’ autobiography and conferring upon it the ‘appropriate’ diagnosis. In so doing, they work to “contain human beings safely within recognized social norms” (Epstein, 1995: 4).
It is through the production of the case history that Epstein argues the psychiatrist is able to translate the 'patient's' experience into a clinical 'text', and in so doing become the official authors of transsexualism, a process which bestows upon them the power not only to legitimate or deny the individual's self diagnosis, but also to define what is to be understood as an 'authentic' or 'true' trans narrative. The result is that the trans person's private story is transformed into the public discourses of medico-psychiatry. It is in this way that the case history can be said to represent "a key aspect of the diagnostic process" (Epstein, 1995: 25).

The function of the case history for Epstein, in terms of it being a process of storytelling, is to subject the 'patient' to the 'medical gaze' whereby the body and the subject become detached from one another, and as a consequence the 'patient' becomes a special type of person; a medical type distinguishable and codifiable only through medico-psychiatric diagnosis, thus loosing the uniqueness of their personal story.

The turn to psychoanalysis coincided with the shift in authorship and authorization, which Epstein argues "explains in part professional statements about patient's, in which authority has moved from private experience to the public expertise of a medical discourse written by an 'authorized' medical practitioner" (Epstein, 1995: 29). What must not be forgotten is that these case histories not only record what they observe, but play a role in its very production. Medico-psychiatric case histories thus demonstrate the extent to which official discourses are able to regulate the ways in which people think about themselves and their identity. As a result, the trans person's success in obtaining the medical 'treatments' that they often seek depends upon their ability to convince doctors that their personal history matches the officially sanctioned aetiology (Bolin, 1998; Green, 1987). However, as we shall see in the final section of this chapter, to see such negotiations as simply evidence of duplicity, is dubious at least.

The use in understanding trans becoming as a narratological process vis-à-vis Prosser, over Hausman's 'demand' thesis is that it enables us to conceive of trans people as active in their own becoming, that is, it allows us to attribute trans people with the degree of agency that the concept of demand necessarily negates. Moreover, it allows us to understand the complexity of the situation as it exists between author and authorization. So, while it is important to see transsexualism as a coherent subject position with a historically consistent plot structure, and over which the individual has a degree of agency, Prosser's narratology allows us to understand the medico-psychiatric standardization and colonization of a self-authored subject position, whilst, and importantly, not falling into the trap of viewing the trans person as either
the dupe of the medico-psychiatric profession, or duplicitous in their relationship to it, thus enabling us to critically engage in the debates over the relationship between medicine and social identity that are to be discussed later on in this chapter.

**Becoming Trans: A Clinical Concern with Aetiology**

By the middle of the twentieth century, two prevailing clinical accounts of trans becoming, framed within the context of aetiology had come into existence. Scientists favouring a (bio)logical explanation espoused a theory of human bisexuality. Such a view represented a direct challenge to the belief that two diametrically opposed sexes existed. Instead, following on from the ground breaking scientific discovery of the 1920s and 30s, which demonstrated the existence of ‘opposite’ sex hormones within both men and women, a theory of human bisexuality emerged. Here then, “with hormones as the measure, sex was quantitative, literally fluid, and all humans were, to greater or lesser degrees, mixtures of male and female” (Meyerowitz, 2001: 82). The theory of bisexuality appeared in the medical texts by the 1920s and in popular sexology by the 1930s (see Weininger, 1906; Thorek, 1924; Frank, 1929; Hampton-Young, 1937), and was later to be publicized by Harry Benjamin, one of the founding fathers of medicalized transsexualism, in his book *Transvestism and Transsexualism* (1953).

Psychiatrists and especially psychoanalysts on the other hand, rejected the theory of human bisexuality and proffered instead a theory of perversion. In contrast to (bio)logical approaches, theories espoused by the psychiatric/psychoanalytic profession emphasized a psychodynamic process of gender differentiation over that of (bio)logical explanations of ‘femininity’ and ‘masculinity’.

**(Bio)logical Accounts of Transsexualism**

One perspective on the aetiology of transsexualism that can be found amongst the medical literature is that which considers biogenic variables as paramount to the formation of a trans identity (i.e., genetic, parental hormonal, and/or foetal metabolic factors). Research taking this perspective “elevates biological variables or ‘nature’ to a more important position than a merely supporting role” (Bolin, 1988: 44).
Benjamin’s 1966 study of 122 trans individuals revealed that socialization factors could not be found in 56% of his research population (1966: 84). Advancing the theory of human bisexuality Benjamin wrote that: “sex is never 100% male or female [...] there may be more or less pronounced irregularities in genetic and endocrine development with resultant ‘intersexes’ of varying character, degree and intensity” (Benjamin, 1953: 12). Thus, both here and in later works, Benjamin acknowledged psychological influences, but continued to stress organic causes in the development of transsexualism.

Benjamin, a great advocate of sex reassignment surgery (SRS) felt that trans people were “the most neglected sexual [sic] minority”, viewing trans surgery as a “salvation to poor [...] pitiful [...] unhappy [...] abnormal transsexuals” (Green and Money, 1969: 14). In examining Benjamin’s theory about trans people, we can quite clearly see the ways in which sex and gender values and beliefs were transmitted along with their scientific theories. Benjamin, believing that hormonal and surgical ‘treatment’ was therapeutic and life saving, maintained that withholding hormones and SRS was like withholding insulin from diabetics. He argued that cross-sex hormones functioned like “transsexual tranquilizers” to calm the trans person down (MacKenzie, 1994: 73). This tranquilizing effect, Benjamin believed, was due to the promise that oestrogen would feminize the ‘trans’ woman by redistributing body fat, softening skin, reducing body hair and creating some breast development.

Brain Sex

Research emanating from the Netherlands (Gooren, Swabb, Zhou, et al, 1995) has compared the size of the central subdivision of the bed nuclei of the stria terminalis region of the hypothalami, taken from the brains of deceased heterosexual men and women, gay men, and ‘trans’ women of different sexual orientations. The findings claimed to have revealed that the brains of ‘trans’ women “fell within the female range rather than the male range” (Martin, 2002). A similar project, with related results was conducted by Kruivjer et al (2000). Increasingly, and in line with this research, transsexualism, from a (bio)logical perspective is said to be the result of a neuro-developmental condition of the brain, which “induces an innate gender identity that is incongruent with the apparent physical sex” (Martin, 2002). As we shall see in the next chapter, the theory of brain sex, which articulates as view of
transsexualism as constituting an intersex condition of the brain, has become the preferred explanation for the majority of those ‘trans’ women involved in my research.

Psychological Accounts of Transsexualism

During the early 1950s, and perhaps as a result of the surge of publicity surrounding the ‘sex change’ of Christine Jorgensen, a number of psychoanalysts began to take a renewed interest in transsexualism, taking as their premise the repudiation of (bio)logical theories, together with an ardent abjection to sex reassignment surgery. Instead, scientists form within this tradition sought to provide an alternative aetiology for transsexualism, one which positioned transsexualism firmly within the domain of sexual perversions. Thus, for example, Gutheil (1954: 233) proposed that transsexualism always included: “six psychopathological factors: 1) homosexuality “with unresolved castration complex”; 2) sadomasochism; 3) narcissism; 4) scopophilia; 5) exhibitionism, and; 6) fetishism”.

Money

The dominant psychological/psychiatric clinical position with regards the aetiology of transsexualism is an interactionist one of ‘nature’ and ‘nurture’, with socialization variables accorded greater importance in the formation of gender identity. Money, with Erhardt (1972) and Tucker (1975) consider socialization variables as the most prominent factor in the development of a ‘cross sex’ identity, with biology acting as a backstage coach. Whilst Money and his colleagues did not rule out the possibility of some “undiscovered foetal metabolic or hormonal component responsible for transsexualism” (1972: 21) he did acknowledge that prenatal factors alone could not explain the development of transsexualism (1972).

Money developed his theories by working with hermaphrodites. Here he observed that in some instances, the gender of rearing contradicted secondary sex characteristics, which developed at puberty. It was Money’s belief that gender identity became fixed at an early age, and so such individuals must be surgically reassigned in accordance with their gender identity (see the infamous case of the ‘castrated twin’ Money and Tucker, 1975).
By reporting dramatic instances among hermaphrodites or chromosomal men who have been successfully socialized as women, and *vise versa*, they claimed to have demonstrated the independence of (bio)logical sex and social gender. Money, Hampson and Hampson (1955: 290) claimed however, that gender "is so well established in most children by the age of 2 ½ years that it is then too late to make a change of sex with impunity." However, they acknowledged that sex reassignment could be made in later years if hermaphrodites themselves felt some error had been made in their assigned sex – a concession that whilst proving itself to be theoretically important for the ‘treatment’ of trans people (Billings and Urban, 1996: 101), had, in a practical sense, very little bearing. For the concession to be successfully used by trans people, they must be able to prove that they had been assigned to the wrong sex for their gender identity, something which holds very little weight in a court of law.

*Stoller*

Stoller, like Money *et al* (1969, 1972), favoured an approach that emphasized the relationship between infant and parent (and especially the mother), although he too did not deny the possibility of ‘some biological force’ as a contributing factor (1968: 139). Stoller’s conception of aetiology can be expressed in his (in)famous axiom “too little mother made possible by too little father” (Stoller, 1968: 264). In effect, the ‘little boy’ does not separate or individuate from a mother who is excessively (emotionally or physically) close to her child. Meanwhile, the fathers are phantoms in the family, actually and psychologically absent. The mothers, who are overly protective and involved with their ‘sons’, have their own problems with gender identity and marital relationships (1968: 94-6, 279). As a consequence of maternal overprotection and excessive contact, the child does not separate from ‘his’ mother’s femininity, nor identify with the father as a role model, and develops into an ‘effeminate boy’. Significant here is the fact that neither parent discourages this behaviour.

What becomes apparent then when looking at the various aetiological explanations of trans becoming provided within the clinical literature and medico-psychiatric texts, is the extent to which, rather than a coherent picture emerging, a more messy set of explanations abound, which pivot to varying degrees around the two central (bio)logical and psycho-dynamic approaches. That the psycho-dynamic approach has been accorded more explanatory weight can in part be explained by the dominance of medico-psychiatry in the governance of transsexualism as a clinical subject position. However, and somewhat regardless of whether
transsexualism is conceived of in either (bio)logic or psycho-dynamic terms, there is the continued transmittance of sex/gender values and beliefs that are propagated along with supposedly ‘neutral’ scientific theories. Moreover, and in line with this, we see the total devaluation of women, regardless of perspective. Thus whether the explanation be (bio)logical or psycho-dynamic, women and especially mothers are blamed for their child’s transsexualism, either as a result of ‘inappropriate’ secretions of ‘cross-sexed’ hormones in utero, or because of ‘harmful’ mother-child interactions.

Finally, and as we shall see in the following chapter, a disparity exists between the ways in which trans becoming (as understood within aetiological accounts) is both articulated and conceived from the perspectives of medico-psychiatric discourse and indeed clinical practice, and by many ‘trans’ women. Such a disparity can be explained by reference to a becoming/being dyad. Thus, from the perspective of medico-psychiatry, transsexualism is something that happens to an individual, something that they become, a process, whilst for a great many ‘trans’ women, transsexualism is something innate, not something that they became, but something they are. Here then, a review of medico-psychiatric discourses of transsexualism makes evident the extent to which, not only do medico-psychiatric professionals dismiss the narratives told to them by their ‘patients’, but also promote themselves and the legitimate authors of trans becoming, and hence trans ‘authenticity’. Moreover, the disparity between the ways in which trans becoming is scripted by medico-psychiatry and ‘trans’ women provides further evidence of the need to move beyond characterizing this relationship within a duped/duplicitous dyad.

**The Politics of Diagnosis**

In order to find candidates for sex reassignment surgery, clinicians working within the field of gender identity undertook the task of defining ‘ideal candidates’. Most agreed that Benjamin’s concept of the ‘primary’ transsexual - people for whom, from their earliest memories recalled feeling like members of the ‘opposite’ sex and as such desired sex reassignment surgery – were ideal candidates. This opened up in the 1970s (as we saw in Theme 1) with the shift in understanding toward a model of ‘gender dysphoria’. During this period, the ‘secondary’ transsexual – the closest to primary transsexuals – who, according to Benjamin, became aware of their cross-sex identity at a later age, also came to be considered as potential candidates for SRS. According to the medico-psychiatric literature, “most
applicants for SRS are considered to be secondary transsexuals, as primary transsexuals are thought to be exceedingly rare” (MacKenzie, 1994: 59). Yet, as the literature suggests, ‘primary’ transsexuals continue to be idealized as the best candidates for surgery. This search for the ‘ideal candidate’ is however problematic in that it focuses only upon that one trans narrative which came to be colonized and standardized by medico-psychiatry. The result is that many who seek the assistance of gender identity clinics find themselves in a precarious situation. To speak the ‘truth’ of their subjectivity, when that very sense of self contradicts the constructions of the phenomenon, more often than not leads to the dismissal of that individual’s ‘desires’. Duplicity then becomes the ally of so many trans people who sense of self does not match that which has been officially sanctioned. However, as we shall see towards the end of this chapter, that the charge of duplicity is more complex than many writers often assume, and as such requires both detailed deconstruction and re-conceptualization. Moreover, when we look at those critiques of a clinical diagnostic politics as proffered by trans writers, we begin to witness a more complex relationship at work with regards the relationship between medicine and social identity as well as that between author and authorization.

A Clinical Account

This section aims to review that literature pertaining to the politics of diagnosis as proffered by those working within the clinical field of ‘gender identity disorder’. Thus, it is through looking into the literature concerned with finding ‘ideal candidates’ for sex reassignment surgery that a series of key tropes become apparent. By looking at the ways in which a diagnostic politics is contained within medico-psychiatric discourses on transsexualism, we are able to assess the extent to which clinical practice is informed by wider theoretical discourses emerging from within medico-psychiatry, when we come to look at the ways in which diagnosis works within clinical practice (see Chapter 6).

Employing a Hermeneutics of Suspicion

Clinical concern to distinguish between ‘primary’ and ‘secondary’ transsexualism gained in significance as the number of persons requesting such procedures continued to grow, and the medico-psychiatric literature relating to post-surgical outcomes revealed significant levels of dissatisfaction with surgical procedures and ‘poor adjustment’ (see, Lundström, Pauly &
Wälander, 1984; Lindemalm, Körlin & Uddenberg, 1986). Lundström et al concluded therefore that surgery should be available only for “carefully evaluated transsexuals” and should not be offered to “secondary gender dysphoric patients” (1984: 293). This concern has lead some clinicians to employ a ‘hermeneutics of suspicion’ when evaluating the suitability of candidates for surgery. According to Green (1987: 7-8):

“In the circular universe of transsexual autobiographies and clinical evaluations, patients convince physicians of their transsexual nature by repeating the published developmental histories of transsexuals who precede them. History has a habit of repeating itself.”

In this vein, Tully (1992: 24) calls for the use of detailed ‘authenticity checks’ with regards to trans autobiographies.

A Concern with Sexuality

A further key diagnostic trope used to distinguish between the ‘primary’ and the ‘secondary’ ‘transsexual’ is that of sexuality (Pauly, 1990). In order to assist in the diagnosis of individuals presenting to gender identity clinics, the DSM-III (1980) specified three subtypes of transsexualism, which correspond to the “predominant sexual history prior to the request for sex reassignment” (Sharpe, 2002: 32).

First, the ‘asexual’ subtype is described as “typically never having had strong sexual feelings, sexual activity or genital pleasure” (American Psychological Association [APA], 1980: 262) and as such corresponds closely to those accounts of ‘primary’ transsexualism as described by Benjamin (1953, 1966) and Stoller (1968). Second is the ‘homosexual’ subtype, who is portrayed as an individual who is, “pre-surgically, erotically attracted to members of his or her own anatomical sex” (APA, 1980: 262). The final subtype is that of the ‘heterosexual’ transsexual. Persons falling into this category are represented as being “almost exclusively male, and who are sexually attracted to females, at least until their gender ‘disorder’ is well established” (APA, 1980: 262). It is members of this sub-type who are diagnosed as being ‘secondary’ transsexuals, and have been described in the literature as cases of “transvestic (secondary) transsexualism” (Person & Ovesey, 1974a, 1974b) and “heterosexual fetishistic transsexualism” (Blanchard, 1985: 229). A more simplistic typology was also offered by Blanchard (1989), who divided ‘gender dysphoric’ ‘trans’ women into ‘homosexual’
('primary') and 'non-homosexual ('secondary') transsexuals. The terms 'homosexuality' and 'heterosexuality' came to be replaced in the DSM-IV by that of ‘sexually attracted to males’ and ‘sexually attracted to females’ (APA, 1994: 547).

A number of medico-psychiatric writers have posed that the need to conform to the heterosexual imperative, together with an intense internalized homophobia, acts as the key motivating factor behind transsexualism:

"[t]he clearest motivation for transsexualism is both sexes has always been a displaced homosexuality which caused men and women to believe they could not love their own sex without mutilating their bodies and professing to a new sexual identity which would make them really 'heterosexual'"

(Lothstein, 1983: 34)

According to the literature, within many gender identity clinics heterosexual orientation (in the psychological sense) is said to function as a criteria for surgery (Denny, 1992: 14; Lewins, 1995: 94; Califia, 1997: 209) whilst past ‘heterosexual’ practice (in the (bio)logical sense) is said to contraindicate surgery (Wålinder, Lundström & Thuwe, 1978; Denny, 1992: 13). Concordant with this, lesbian desire or anticipated future lesbian practice for the ‘trans’ woman is viewed as antithetical to an ‘authentic’ trans ‘desire’ (Kando, 1973; Pomeroy, 1975; Blanchard, Steiner, Clemmensen & Dickey, 1989). The inappropriateness of lesbian desire finds further expression in the medical reluctance to refer persons who are still married on for surgery (King, 1993: 83; Bolin, 1996: 454). The abjection to transsexualism and homosexuality residing within one body is consistent with the aetiological picture of transsexualism as advanced by the likes of Benjamin (1953, 1966) and Stoller (1968). Whilst more contemporary accounts provided by a number of clinicians have begun to recognize lesbian identified ‘trans’ women, they continue to be coded as ‘rare’ and ‘unusual’ (Feinbloom, Fleming, Kijewski & Schulter, 1976; Blanchard, Clemmensen and Steiner, 1987).

Early Onset

A further trope of ‘primary’ transsexualism concerns “early onset of gender identity in childhood or early adolescence” (APA, 1994: 549). Consistent with this is the articulation of
heterosexual desire, whereby the late onset of 'feminine' gender identity is linked to 'lesbian' desire (Pauly, 1992: 7-9), thereby functioning as a sign of 'secondary' transsexualism (APA, 1994: 549; Blanchard, 1989), and as such, serves to problematize requests for sex reassignment. The mutually reinforcing relationship between late onset of 'feminine' gender identity and lesbian desire, further puts into question the 'authenticity' of sexual desire and trans identity.

**The Proof of Success**

Finally, the medico-psychiatric literature suggests that a range of somatic and performative markers determine 'good' prognosis. Thus, the offer of SRS is conditional upon the 'patient' living in the role of the subjectively experienced gender for a designated period of time. The time set by the governing organization, the Harry Benjamin International Gender Dysphoria Association (HBIGDA), is one year. However, most British gender identity clinics (GICs) insist upon a period of two years. The requirement to 'live in role' has generally been referred to as "the real-life-test" (Money and Walker, 1977: 1292), in which performance is directed toward the ability to 'pass', thus demonstrating to the medico-psychiatric professional that the individual can live 'successfully' in role of their subjectively experienced gender.

Although not officially part of the psychological profile of 'primary' transsexualism, the ability to 'pass' in the subjectively experienced gender has been viewed as one of the most prominent factors in the determination of eligibility for SRS (Randell, 1971; Stoller, 1973; Fisk, 1974). Moreover, for the likes of Benjamin (1971), too many 'masculine' features, such as heavy beard, deep voice, height over six-feet tall, and heavy frame, were seen to constitute contraindications to the suitability of SRS, whilst the best candidates were those whose physical build and general appearance were so 'feminine' so as to be of constant torment. The 1982 (re-printed in 1996) study conducted by Billings and Urban makes abundantly clear the extent to which "discrepant appearances are taken as alarming signs", with one physician interviewed claiming that: "we're not taking Puerto Rican's anymore, they don't look like transsexuals. They look like fags." (1996: 111). 'Feminine' behaviour and manner of dress have also been used in the selection of 'patients' for SRS (Benjamin, 1971: Stoller, 1973; Lothstein, 1979). In this vein, Randell (1971) proposed that ideal female candidates should be weak, submissive, timid and shy.
Here then we see a number of ways in which the medico-psychiatric profession has sought to both control and authorize trans people's desires and experiences via reference to white, middle class, heterosexual discourses of 'being'. Thus, that a number of performative and somatic assumptions govern clinical judgements of trans 'authenticity', as well as proscriptions for sexual orientation, makes clear the medico-psychiatric desire to reduce social anxiety by transforming 'gender deviant men' into 'gender conforming women', who both look and act the part, but desire in an appropriately female way also.

By constructing a rigid protocol for the diagnosis of transsexualism, medico-psychiatry has further entrenched the assumption of one 'true' trans identity, whereby those who do not meet these criteria have their authenticity questioned, and are often scripted as something other than transsexual. However, rather than this diagnostic criteria being reflective of trans 'authenticity' for all 'trans' women, I would suggest that it is only a reflection of, or more reflective of one trans subject position – that is, that trans subject position whose narrative came to be co-opted and standardized by medico-psychiatry. The result then is that medico-psychiatry fails to account for the range of trans-subjectivities. Moreover, by constructing diagnostic criteria which is perhaps more reflective of one subject position, the voices and subjectivities of others became lost or silenced, and scripted as evidence of 'inauthenticity'. Whilst as we shall see in Theme 3 other trans-subjectivities are beginning to become more visible and indeed more vocal, the continuation of such a rigid diagnostic script continues to homogenize the trans experience to one set narrative.

A Critique of Medicine

Such diagnostic factors, as contained within the medico-psychiatric literature relating to 'gender identity disorders' have, to varying degrees, been critiqued by scholars working within the fields of sociology and trans theory, as serving to both further entrench the medico-psychiatric control over trans bodies, as well as to reinforce rigid binaries around sex/gender and sexuality. It is to those debates that I now turn.

Autobiography and Suspicion

In his critique of the politics of diagnosis, Prosser (1998) outlines the ways in which medico-psychiatry has produced a standardized narrative out of a plethora of trans situated
experiences and identities, creating a situation whereby all trans individuals must tailor their narrative to fit that which has been constructed by medico-psychiatry. Following Prosser then, we can see how the primary working diagnostic criteria for ‘gender identity disorder’ in the DSM-IV (1994) under which transsexualism is now subsumed, a “strong and persistent cross-gender identification” and a “persistent discomfort with ... sex or sense of inappropriateness in the gender role of that sex,” (DSM-IV, 1994: 537) must be substantiated through the subject’s life history. Thus, the recounting of various episodes such as:

“[B]oys playing with Barbie, wrapping their heads in clothes to simulate long hair, and hiding their penises between their legs; girls asking to be called boys’ names, refusing to urinate sitting down, wanting to be Batman or Superman, and asserting that they will grow up to be men.”

(Prosser, 1998: 104)

all find themselves contained within the diagnostic features of ‘gender identity disorder’ as it transforms itself into transsexualism’s classic plot. This standardized narrative, produced by medico-psychiatry, whilst reiterating the experiences of ‘gendered difference’ of some trans people, cannot account for all trans subject positions, which have become silenced through this standardization, making it appear that they never existed in the first place. Moreover, that those speaking from a trans subject position that does not reiterate that narrative which has come to be colonized by medico-psychiatry, does not provide evidence of their ‘inauthenticity’ and hence deserving of clinical suspicion over the reading of their life history, but rather, their existence is evidence of the multiplicity of trans subject positions, the existence of which has been ignored in the construction and promotion of the ‘primary’ or ‘true’ transsexual category.

The ‘policing model’ (Prosser, 1998: 111) of reading trans autobiographical accounts employed by Green (1987) and Tully (1992) highlights the clinician’s concern over the fraudulent nature of the trans autobiography. It also brings to the fore the unspoken violence that such concerns may structure into diagnosis, for as Prosser contends:

“the patient’s position is to confess, the professional’s – half priest, holding the key to the patient’s salvation, half detective, decoding this
The trans autobiography is treated then as a 'suspicious text', which has led some clinician’s to question the necessity of transition (Lothstein, 1983; Tully, 1992). The degradation of the trans autobiography as ‘suspicious’ is indeed unfair, and as Schaefer and Wheeler observe: “it is in part this tendency among some clinicians to approach the transsexual as a suspicious text – a lack of understanding from the medical establishment of the difficulty in rendering transsexuality as a story – that may provoke transsexual’s to ‘falsify’ histories in the first place” (cited in Prosser, 1998: 111). As Prosser concludes, it is at the moment of epistemological ‘change’ towards a model of gender dysphoria that a privileged trans narrative acquires a premium in the services of the legitimation of medical practice.

Enforcing Heterosexuality

As we have seen, the language used to distinguish between the various subtypes of transsexualism according to sexuality changed from the ‘asexual’, the ‘homosexual’ and the ‘heterosexual’ subtypes as described in the DSM-III (1980) to ‘sexually attracted to men’ and ‘sexually attracted to women’ in the DSM-IV (1994). However, according to Sharpe (2002: 32), while this ‘change’ in language represents an improvement, “it holds in place the coupling of primary transsexualism with heterosexual desire (in the psychological sense) on the one hand, and secondary transsexualism with homosexual desire (in the psychological sense) on the other.” As scripted within medico-psychiatry, the ‘trans’ woman is required to desire a (bio)logical man. The attempt then is to distinguish the ‘trans’ woman from that of the homosexual man who, it is thought, might also seek SRS as a means of escaping the stigma of homosexual identification. However, the scripting of ‘primary’ transsexualism has the consequent effect of erasing homosexuality. Moreover, by viewing both ‘trans’ men (Fleming, MacGowan and Costas, 1985: 47-8) and ‘trans’ women (Green, 1974: 129) as almost exclusively desiring (bio)logical women, those stereotypes about gay men and lesbian women are reproduced and applied to trans people. A further effect of this change in language is, according to Rosario that the “specific erotic identification of ‘gay male’ and the attraction to ‘gay men’ [...] are lost in this new descriptive typology” (1996: 45, fn. 13). Moreover, the medico-psychiatric depiction of trans people as being heterosexual in
orientation is contradicted by research emanating from the trans community itself. Thus, Stephen Whittle concluded that:

“My research showed that of the FTMs that responded, 33% identified as bisexual, 40% as homosexual, 2% as asexual and 25% as gay men. So it’s a much larger percentage than in the general population. In relation to MTF transsexuals, 50% identified as lesbian women. It’s laughable that MTF transsexuals present stereotypes of women, when in fact the stereotype of women they’re representing is a butch dyke. Only 10% identified as bisexual and 40% as heterosexual.”

(Whittle, [no year provided], cited in Nataf, 1996:32)

For Sharpe (2002), what becomes apparent is that medico-psychiatry deploys a (bio)logical and psychological understanding of sexuality which differs across the homo/hetero divide.

By reinventing heterosexuality so that it can no longer signify the desire for ‘opposite’ (bio)logical sexed persons, transsexualism is made intelligible through reference to a psychological conception of sexuality. It in this way then, that the good prognosis demanded by clinicians “implies a particular gendered relationship between the re-sexed body and sexual preference” (Sharpe, 2002: 34).

Following in the vein of Sharpe, Rosario (1996) also presents a critique of the heterosexualization of transsexualism as understood within the clinical literature. According to Rosario, the paradoxically designated ‘heterosexual’ trans person – the gay ‘trans’ guy and the lesbian ‘trans’ woman – is hugely problematic to the heterosexual paradigm: “[a]s several psychiatrists perplexedly exclaimed to me; ‘if a woman is attracted to men, as normal, why should she want to become male in order to be homosexual? (Rosario,1996: 39-40). As Rosario argues, the gay or lesbian identified trans person “violates the clinician’s imaginary balance of sexual psychopathologies which weighs the stigma of transsexualism against that of homosexuality” (1996: 40).

According to these critics of medico-psychiatric epistemology, the stories told by such professionals about transsexualism are all potentially dangerous stories, which have a major impact on the lives and identities of trans people whose identities become subsumed by a story that does not belong to them. With all this constant searching for a possible ‘cause’ and clues as to diagnostic markers, we need to follow King’s (1982: 352) lead in questioning whether “this area of medical knowledge [is] a product or reflection, not of the ‘reality’ of
transsexualism itself, but of social processes and relations which shape the nature of medical thought and practice.”.

It becomes evident then that the medico-psychiatric standardization of just one trans narrative, and the exclusion of other trans subject positions has created a situation in which those whose narrative does not fit with this classic plot are forced into a situation whereby they can do nothing but present a life history and a sexual identity which will allow them access to the ‘treatments’ that they seek. Whilst as we shall see in the ensuing section, such actions have, for some scholars, provided evidence for the fact that the relationship between medico-psychiatry and trans-subjectivity can be understood by making reference to a duped/duplicity dyad, I would suggest that such a conceptualization negates the complex power relations at work, whereby those silenced are often forced into a situation whereby the only means of escape is to reiterate the great scientists ‘truth’ claims.

**Medico-Psychiatry and Trans-Subjectivity: A Contentious Relationship**

As we have seen, the medico-psychiatrically formulated diagnosis of transsexualism is not without its critics. However, writers have long postulated as to why there appears, to varying degrees, to be an overlap between the standardized medico-psychiatric narrative of transsexualism and both the public (in the form of published autobiographies) and the private (stories that trans individuals tell to themselves and others) writings of ‘trans’ women. In a study aimed to investigate the ‘ideologic relationship’ between the medico-psychiatric establishment and the trans ‘community’, as evidence in the private writings of ‘trans’ women, Nakamura (1997) discusses three different explanations for the similarity between the official discourses and personal stories of trans becoming: the first explanation relates to medical discovery and ‘truth’, second is the view of ‘trans’ women as the dupes of the medico-psychiatric profession. The final explanation regards ‘trans’ women as involved in a duplicitous relationship with the medico-psychiatric profession. Here then, the intention of this section is to provide a critical contextualization of the relationship between medico-psychiatric discourse and trans-subjectivity within a feminist framework, which conceives of ‘trans’ women as involved in a dyadic relationship of dupe/duplicity. This proves a useful standpoint for a discussion of my research findings, thus in the following chapter and in Chapter 7, I suggest ways in which my research contradicts and encourages us to move
beyond such assumptions as to the relationship between medico-psychiatry and trans-subjectivity.

Medical Diagnosis and ‘Truth’

The first explanation provided by Nakamura as to why there appears to be a congruence between medico-psychiatric discourses of transsexualism and both the private, but especially the public stories of trans-subjectivity, centres around the idea of medical ‘discovery’ and ‘truth’. According to this position, the congruence between the two positions cannot be seen as surprising if we assume that the medical diagnosis of transsexualism, as formulated in and through the DSM, was, and indeed is, correct in its description of trans-subjectivity. In line with the ‘discovery story’ (King, 1987, 1993, 1996), this perspective assumes that the medico-psychiatric profession simply revealed the ‘truth’ of trans existence. That medico-psychiatry insists upon such tropes as heterosexual orientation, childhood onset, and the existence of performative and somatic markers associated with the subjectively experienced gender, is simply a reflection of how ‘trans’ women themselves formulate and make sense of their desires and experiences.

Trans People as the Dupes of the Medico-Psychiatric Profession

A second explanation for the apparent congruence between medical diagnosis and trans-subjectivity pivots around the idea of ‘trans’ women as the dupes of the medical profession, or its ‘unconscious victims’ (Raymond, 1979). Contained within this argument is the assumption that medical doctors – as part of our general cultural discourses on sex and gender – promote a particular sex/gender ideology. It is this ideology that emphasizes such things as the ‘natural’ and inevitable state of sex/gender congruence. Following this perspective, it is argued that while we all suffer from the ‘false consciousness’ of gender, ‘trans’ women in particular, are said to succumb to and reify this ideology by going through with sex reassignment, thus making them the dupes of the western sex/gender system and the medico-psychiatric profession that blithely insists upon adherence to its dictum.

The idea that ‘trans’ women exist as the dupes of the medico-psychiatric profession is reaffirmed in Hausman’s (1995) discussion of the published autobiographies of trans people. Hausman discusses the often avid collection of published autobiographies by trans people,
early on in their self-realization. The collection of autobiographies of trans people who have already successfully transitioned, according to Hausman plays a crucial role in the construction of a trans sense of self, by providing the individual with a “guide book” (Hausman, 1995: 143) of how to negotiate the strict protocols of the gender identity clinic. According to Hausman, this suggests that the authors of trans autobiographies serve to encourage and enable trans subjects to “conform to the parameters of an ‘established personal history’ in order to obtain the desired medical treatment” (Hausman, 1995: 143)

Trans Duplicity

The final explanation expounded by Nakamura is that of the trans person as duplicitous. Theorists supporting this view regard trans people as intentionally fooling clinicians into giving them the diagnosis and ‘treatment’ which they seek by presenting a narrative plot that they know will convince the gatekeepers of their ‘authenticity’. Billings and Urban call this “the con” (1996: 108-110). However, the necessity of this duplicity needs to be recognized. As Nataf makes evident, the necessity of producing a well-rehearsed and standardized narrative that alluded to the medicalized diagnosis is due to the fact that trans people are often well aware that any deviation from this medicalized script could seriously jeopardize their access to hormones and surgery. In this way then, “reproduction of the standard story superseded truth” (Nataf, 1996: 20). Whilst the necessity of this apparent duplicity is understood, writers such as Bolin (1988) and Stone (1991) firmly believe that alleviating the silence around certain aspects of the trans experience will result in a measurable change in current conceptions of transsexualism and the ‘authenticity’ of trans peoples’ lives.

In a combination of the above two explanations Shapiro (1991) proffers an explanation that views ‘trans’ women as both duped and duplicitous. This model of understanding describes how, ‘trans’ women, through a process of historical reconstruction, deceive both themselves and their doctors. Shapiro argues that ‘trans’ women, rather than challenging the gender ideology, either simply accept it and reiterate the standardized medico-psychiatric script of their ‘being’, or use the ideology of the doctors against them – that is, the manipulate them into performing surgery for them. In either case, ‘trans’ women are said to be caught up in the ideologies of our western sex/gender system, and as such reify and reinscribe the boundaries of gender. It is in this way that Shapiro understands ‘trans’ women as both duped and duplicitous. By assuming that ‘trans’ women are not aware of the narrative tropes that define their ‘condition’, Shapiro’s view suggests that they are involved in the process of ‘repressing’ information.
Each of the explanations for the relationship between medico-psychiatry and trans-subjectivity are fraught with problems, most notable of all is their negation of trans as both a self authored subject position, as well as their seeming insistence upon the existence of a standard and unitary trans-subjectivity. Turning to that explanation which supports a view of medico-psychiatric ‘discovery’; I would suggest that this explanation be reformulated rather than cast aside as medico-psychiatric propaganda. Here, rather than medico-psychiatry ‘discovering’ transsexualism, we need to think of it as having listened to and interpreted those stories told by ‘trans’ women about their gendered selfhood, which served to construct the trans identity. Thus, a process of colonization rather than discovery is at work. It is from this perspective that it becomes possible to state that congruence between medico-psychiatric discourses and the subjective experiences of some ‘trans’ women is more than mere coincidence. This is not because medico-psychiatry discovered a thus far hidden ‘truth’, but because it colonized and subsequently standardized one such trans subject position. Unfortunately, in doing so, medico-psychiatry cast aside, or failed to take into account the whole host of other trans subject positions, which have consequently come to be ignored or interpreted as an ‘inauthentic’ account of trans becoming.

Furthermore, to level either charges of ‘trans’ women as the dupes of, or duplicitous in their relationship to the medico-psychiatric profession is naïve. The re-conceptualization of trans histoigraphy, together with an understanding of trans becoming as a process of narratology (Prosser, 1998) allows us to understand trans people as their original authors of transsexualism. Thus, rather than ‘trans’ women being the dupes of the medico-psychiatric profession, and as such reifying medico-psychiatric discourses regarding the principal tropes of transsexualism, the reverse is actually at work. The apparent reproduction of medico-psychiatric discourses of trans becoming can instead be explained by reference to the medico-psychiatric colonization of the voices spoken from within one trans subject position. A similar understanding can be employed to critique the condemnation of ‘trans’ women as duplicitous. Again, that a similarity exists between the two accounts can be explained by medico-psychiatry’s colonization of one trans subject position. That others are forced into a position of having to present a concordant life story, testifies merely to the negation of other trans-subjectivities by the medico-psychiatric imaginary. The result is then, that those ‘trans’ women who are ‘unfortunate’ enough not to have had the narratives of their existence co-opted by medico-psychiatry, and thus, have their lives and experiences cast as ‘inauthentic’ are forced into a position of having to, publicly at least, tell that story which will grant them access to the healthcare that they seek. However, as we shall see in the following chapters, an understanding of trans complicity is further contradicted by the extent to which those ‘trans’
women involved in my research tell a story of their becoming which, in important ways contradict the medico-psychiatric scripting of trans becoming.

Conclusions

Contained within the medico-psychiatric literature on transsexualism we see the suggestion of two principle aetiological accounts at work – the psychological and the (bio)logical – which appear to exist in a mutually exclusive relationship to one another. However, as we shall see in the chapter that follows, such a clear-cut typology is necessarily contradicted by the findings of my own research, which suggest a far messier picture at play, whereby the two positions overlap with one another to create a more blurred account of transsexualism’s aetiology as it is worked through in clinical practice.

As we have seen, the ways in which transsexualism is scripted within medico-psychiatry and the attendant critique provided by trans theorists, diverge considerably. However, according to the sociological literature, there is much overlap between the two camps. The three explanations as to the apparent complicity between ‘trans’ women and the accounts produced of, and for them by the medico-psychiatric profession seek to understand the complex relationship between medico-psychiatry and trans-subjectivity. Through the next two chapters I shall use my research material to attempt to provide answers for the nature of this complex relationship and begin to offer some tentative conclusions, which I believe are able to provide us with a more cohesive picture of the relationship between the two domains of knowing, which, whilst recognizing the current necessity of ‘trans’ women, to present a carefully delineated life history, does not seek to cast the individual as duplicitous, and at the same time allows the ‘trans’ woman a legitimate position from which to speak, without proffering an accusation of the ‘trans’ woman as the dupes of the medical profession. Rather, by truly listening to the words spoken by individuals who are involved in the process of self-narration, we can understand the subtle, yet nonetheless empowering differences in the words spoken from within trans situated subject positions, from the words written of and for them by the medico-psychiatric profession.

Finally, the literature concerned with assessing the ‘authenticity’ of transsexualism, and the attendant scripting of a diagnostic politics suggests that a somewhat rigid and standardized
conception is at play. As we shall see in the chapter that follows, this set of criteria was echoed during the interviews conducted with general practitioners and 'gender specialists'. Here then, there would appear to be a great deal of overlap between medico-psychiatric discourses and clinical practice in terms of the criteria used to diagnose someone as transsexual. Linking this to the concern of the thesis – an inquiry into trans becoming as it is scripted within medico-psychiatry and trans-subjectivity – we are able to begin to suggest a number of significant issues. By constructing a rigid and standardized diagnostic classificatory system, medico-psychiatry has sought to homogenize the trans experience, the result of which is the maintenance and perpetuation of the assumption of one 'true' trans narrative, and thus one 'authentic' trans experience. By failing to incorporate the range of trans subject positions, as well as recognize the ways in which they diverge from one another, medico-psychiatry has effectively silenced the voices and identities of those subject positions which do not correspond to the medico-psychiatry imaginary.
The aim of this chapter is to explore in detail, the understandings of both medico-psychiatric professionals and ‘trans’ women which can be used to shed light on the complex relationship between medicine and trans-subjectivity, together with the relationship between medico-psychiatric discourses and clinical practice. Through an analysis of the words spoken by, and stories told about trans becoming – in the form of aetiological accounts, diagnostic practices and experientially derived understandings – by the general practitioners, ‘gender specialists’ and ‘trans’ women involved in this research, the chapter seeks to trace the differences and continuities in the medico-psychiatric accounts and ‘trans’ women’s stories of becoming.

Aetiology: A Clinical Account

When analysing the words spoken by GPs and ‘gender specialists’, four discourses, or stories as to the aetiology of transsexualism became apparent: the ‘wholly (bio)logical’ approach; the ‘psycho-social/developmental’ approach; the ‘fusion’ approach; and interestingly, an increasingly prevalent approach which tends toward the ‘rejection of causality’. Unsurprisingly, and in line with the results of Chapter 3, the explanations given by GPs were of a more limited nature than those given by ‘gender specialists’, yet can still be incorporated within the four discourses.

By looking at the ways in which aetiology is scripted within clinical practice, we are able to draw some interesting comparisons to both its scripting within medico-psychiatric discourses (see Chapter 5) as well as the ways in which aetiology is understood by ‘trans’ women (see below). This allows us firstly, to assess the extent to which clinical practice and understanding is informed by wider medico-psychiatric discourses on the aetiology of
transsexualism. Secondly, it enables us to assess the extent to which ‘trans’ women’s accounts of transsexualism’s aetiology differ from or are informed by medico-psychiatric discourses and clinical understandings.

The Wholly (Bio)logical Approach

When analysing the words spoken by those medico-psychiatric professionals working within the field of transsexualism a number of accounts were given which pertain to a (bio)logical explanation of transsexualism. However, only one ‘specialist’ advocated a wholly (bio)logical understanding of transsexualism, which in many ways echoed many of the accounts given by those ‘trans’ women involved in this research. Here then, Gender Counsellor (I) articulated the following understanding of transsexualism:

“... erm, I believe it to be a state, a biological condition, erm, I’m one of the biological camp who believe that we are all neutral up until 6-8 weeks and that it’s a chemical/hormonal response. I believe the result of which, that erm, our brain pattern does not necessarily match our body pattern. I believe that there are possibly a lot of people that this applies to in a continuum, to a small degree, to a very large degree.”

Further evidence for (bio)logical understandings of transsexualism is seen in the words of the following psychiatrist. However, it is interesting to note that he only viewed this pattern to be of relevance to ‘trans’ men, and in so doing, believed them to be qualitatively different in type from ‘trans’ women,

“... the biological field, there’s not much evidence except for ... female to male transsexuals, where I think there is a significant suspicion that something might have androgonized the brains of these girls [sic] and the association with polycystic ovaries and polycystic ovary syndrome or other disorders of hormones. So approximately 80% of females [sic] who come to our clinic probably have what some of us call primary or core transsexualism, the other 20% I don’t admit to understand very well but I guess there’s some sort of developmental disorder of masculine and lesbianism. I’m not saying the other group
don't have some developmental disorder input as well, but I think in a significant number there's a biological force.”

(Psychiatrist A)

One surgeon interviewed also agreed that (bio)logical factors were a dominant factor in the formation of a trans identity, stating that:

“... there is clearly some evidence of biological differences in transsexuals and people who aren’t transsexuals, err, and you know that the scientific studies which have shown an anatomical difference in the brain, the business about right and left handedness, and so there may be, err, genetic components to cause transsexualism, there may be congenital problems, inappropriate or abnormal exposure to the opposite hormones and err, and you know there are interesting examples ... in err, intersex worlds, where people are given the opposite gender to their genetic gender but they can be unhappy or ambivalent about it so it, so there do clearly seem to be important biological influences and I would say that in my experience that’s the dominant factor.”

(Surgeon C)

Concordant with the understanding of transsexualism as a wholly (bio)logical phenomenon, is the rejection of socialization as a factor in the formation of a trans identity. Reiterating her understanding of transsexualism as a biological phenomenon, Gender Counsellor (I) made the following point in relation to the idea that socialization could be a potential causal factor:

“... I don’t see any relevance to socialization as a concept in transsexualism, in that we can all be brought up with a kind of tomboy attitude but that doesn’t make us suppressed transgendered males err, so, and I think that most of my clients would be horrified to think that they were mentally damaged by some socialization process that encourages them to believe that they are a different gender. I think that most of my clients all believe that there must have been some biological mishap to, for them to be in the state that they are in.”
Further rejection of the idea that processes of socialization plays a role in the formation of a trans identity can be found in the words of one psychotherapist interviewed:

"... you could argue that someone who has lived as a male erm, and accepted, erm, the role that’s chosen for them ... would be happy, because of the social pressures, but if that’s the case, why have we seen so many clients who come in to us that have married, had children, and gone out and sought a male orientated job, and yet they still come to us saying ‘well, I’ve done that and I can’t, I can’t bear it any longer?’ So that kind of sways against the argument of the social.”

(Psychotherapist G)

What became apparent throughout my research was that the idea of transsexualism as a wholly (bio)logical phenomenon received only scant support from within the clinical field, with only one ‘gender specialist’ (Gender Counsellor I) advocating unequivocally the (bio)logical causes of transsexualism and the total rejection of socialization variables as being in any way significant.

Psycho-Social/Developmental Approaches

A second explanatory model of transsexualism contained within the words spoken by my clinical respondents followed a psycho-social/developmental trajectory. Those GPs interviewed who understood aetiological theories of transsexualism generally favoured this approach:

“I suspect it’s acquired, erm, but that’s as far as I’d put it, erm. We know they are genetically, err, genetically ... assigned in the proper way ... but genetically, they’re genetically normal males or females, whatever the case may be, erm. For some reason their upbringing or their life, or their experience makes them feel that they are in the wrong gender ...”

(GP 100)
"I think it's to do with their psyche. I don't believe it's an anatomical problem or a hormonal problem, I think it's to do with their self image and err, their sense of identity and who they are identifying with."

(GP: 13)

One psychiatrist fully ascribed to the psycho-social/developmental approach. From this perspective then, transsexualism is thought to be caused by the same developmental patterns outlined by Stoller (1968), as psychiatrist (A) contends:

"...there's an incongruity that needs a description, erm, and I'm certainly not happy to call it an intersex condition, and I ... I suppose I'm happier to keep it as a psychological disorder, certainly for most of the men [sic]. I think it is, it's a psychological, developmental disorder for the majority of males [sic]."

Which he then qualified by saying,

"... I certainly believe that the ones who have a significant heterosexual interest and a transvestic fetishism have a developmental disorder, this is the disorder of the development of the sense of gender, it is to do with separation/individuation problems for the male child tangled up with the use of comforters and transitional objects which then become sexualized and addictive. I also think that we have a ... we develop a sense of gender and sex slowly, therefore the first year or so of life we seem to have a hermaphrodite sense in that we've got biological brains that probably direct us in err, the usual, correct pathways. But sometimes that isn't so. The first person that the male child [identifies with], and this is true of all children, is the mother, and Stoller talked about dis-identifying from the mother as a necessary step in male gender identity formation. I think that it's a difficult or contentious step, perhaps for all males, for some more than others and this leads to disorders in separation and individuation and I think, identification with the mother, with the mother, with the female and the use of female clothing, identifying objects and comforters, transitional objects. That's my approach to the development, and I think that's true for the majority of males [sic]."
This scripting of trans becoming as a result of disordered developmental processes is one which finds enormous support from within the medico-psychiatric literature, and was first advanced by Stoller (1968), who attributed transsexualism to a pathological relationship between parent (principally the mother) and child. That this theory has received notoriety is not surprising given that the ‘treatment’ associated with transsexualism within the UK is placed firmly in the hands of psychiatrists. However, with the large increase in numbers presenting at gender identity clinics, a third explanatory model has increased in popularity.

The Fusion Approach

This third approach combines the (bio)logical and psychoanalytical accounts of trans aetiology in two main ways. The first means by which the two theories are united is through the view that a combination of psychodynamic processes planted in a fertile soil of biological predisposition is needed for an individual to develop a trans identity; a perspective prevalent in much of the medico-psychiatric literature. The second combines the two models across the trans phenomenon, whereby that which leads to the development of a trans identity in one person is different from that which ‘creates’ transsexualism in another. This perspective leads ultimately then to the fragmentation of the trans phenomenon along an aetiological divide, which seeks to reproduce the ‘primary’/’secondary’ distinction, and it is this perspective that was attributed most weight by those clinicians involved in my research, which the following excerpts make clear:

"... it would be too simplistic to say there’s a cause, that there is one cause. ... There are a whole variety of reasons why people become transgendered, a whole variety, from all sorts of psychological to ... reasons, to possible physical reasons, to combinations, in fact I suspect it’s more a combination of reasons rather than any single thing for any one person."

(Psychiatrist D)

"Erm, I’m glad you’ve said causes because I think there are several, erm, for a proportion of the patients, quite a small proportion I’m dead sure it’s a consequence of what their mothers were given when they were pregnant with them, I’ve got one or two where I know that’s true. Another one where I’ve got a sneaking suspicion that it’s to do with
the endogenous secretions of particular hormones as a consequence of physical illness, and then there’s another bunch where one wonders whether there’s something genetic going on because their family tree is absolutely laden with individuals where that sort of looks as if it might be the case. And there’s another bunch where I’m pretty sure that’s not true and it seems to sort of erm, be a vaguely environmental thing and you can’t quite see why and then there’s another chunk where I think there’s a pretty good psychodynamic cause, you know, if somebody pitches up three months after their sister’s died wearing her clothes and saying they want to be her, then you don’t have to be Mr. Freud to figure that, that one out. And then there’s another chunk of individuals where erm, this is just a gender dysphoria with a whole lot of other stuff going on. But that’s the causes of people who are transsexual. All I can think of now, bearing in mind that I’m, that if you gave me time and everything I could probably think of a few more.”

(Psychiatrist B)

An elaboration of the kinds of dynamics that are thought to ‘cause’ transsexualism was espoused by the following psychiatrist:

“Well, I think that it’s, it’s no one, no one knows for sure, but I think it’s, the theory that’s suggested that there is some ... influence on, at a critical period of development, sometimes, you know in the mother’s womb, but, but, you know, the, the, the brain can be influenced by opposite sex hormones ... as the baby is developing ... as the foetus is developing, the embryo, so that’s one suggestion that makes, that makes sense to me, that as long as these people can have some sort of feminization of their brain during, you know, foetal development, which makes them potentially transsexual, depending on their environment as they’re growing up, so they become feminine, you know, feminine, girlish boys and mother’s boys, and develop a female identity at an early age ... and I, err, I think that, that there’s, the suggestion is that, err, a hormonal influence on the developing brain according to this. The same way with girls who become boys,
tomboyish girls. ... But I think that’s only one possible explanation. ... Erm, you know, during the growing up period, during development.”

(Psychiatrist H)

The same psychiatrist went on to proffer a further theory, akin to the understanding of transsexualism as an ‘obsessional/behavioural’ condition,

“I think there’s other ... possible, erm, reasons as well, erm, I mean, for many transsexuals it’s almost as if their libido, their sex drive has been hijacked by what I call their gender drive. The need to become women has taken over from any need to have ... sex, so that they, they keep their, they’re preoccupied all day and night by, about being a girl, whereas most normal fellas, straight or gay, will think about sex [laughs] all the time, and so I think there’s that, there’s links there to, err, a libido driven condition ... an obsessional type, erm, behaviour, err, where they, it obsesses them to get what they want by way of treatment and living in role, changing over role, living as, as the person, as the person they think they are. In the gender they think they should be. So that’s, that’s another possible, I suppose, explanation of how things develop.”

That sex/gender congruence is considered ‘natural’ and inevitable, and thus, that trans ‘desire’ is as a consequence ‘unnatural’ due to it’s deviation from the assumed ‘norm’ of mind/body harmony, is clearly evident here.

That we find a number of examples of the ‘fusion’ approach to the aetiology of transsexualism within the words of those ‘gender specialists’ interviewed can perhaps be explained by the growth in numbers presenting to GICs and is also concordant with the paradigm shift within medico-psychiatry towards a model of ‘gender dysphoria’, the literature for which suggests that ‘good prognosis’ be assessed in terms of future success as opposed to looking for clues as to the ‘authenticity’ of trans desires.
A Rejection of Causality

One surprising finding from my inquiry into the stories told by the medico-psychiatric professions on the aetiology of transsexualism, was that a number of clinicians expressed a view that the desire to find a 'cause' and the espousal of a particular aetiology of a condition as being an outdated process, with which we should no longer be concerned. These clinicians theorizing as such explained their beliefs in the following ways:

"Causes? ... I can’t say that I actually could really answer that one. I think if it was that simple as it was caused by, we’d have found a solution [gestures with inverted commas] if you like, and in a way I think professionals have tried to medicalized and haven’t been able to. I think that’s too simplistic really. I don’t think I could actually say there’s a cause.”

(Psychotherapist G)

Similarly, psychotherapist E explained that:

I know there are people who want to look at, err, the kind of, err, physiology or, err, neurophysiology and that’s fine. As a psychoanalytic psychotherapist I’m not particularly ... knowledgeable or ... I am interested in, but it’s the lived experience of the person that’s more important to me, than I think the aetiology, such as the causes, it’s very much a nineteenth century scientific idea ... that again, I find incredibly unhelpful, if people try and find out the causes of homosexuality or the causes of transsexuality, and I think well, it’s very interesting [laughs] but it doesn’t kind of, except of course, I think there may be civil rights campaign reasons ... for it, but from a people point of view I don’t know. I’m not interested, I just think yes well that’s very interesting but let’s move on.

This movement away from medicalized explanations of type can in part be explained by the growth and socio-political effectiveness of trans-activism, whereby trans people are beginning to be more vociferous and public in the telling of their stories and life experiences. Significantly, this is coupled with the creation, or expansion of an environment in which the 'medicine men' are willing to hear, and accept these re-emerging stories and acknowledge
trans people as the true authors of their lives and experiences. Moreover, by rejecting a
standard, unitary cause of transsexualism we can perhaps begin to argue that the medico-
psychiatric profession are beginning to open up a conceptual space in which an understanding
of a coherent trans subject is rejected in favour of recognition of multiple temporalities of
trans-subjectivities.

**Aetiology: A Trans Perspective**

In contrast to those storied explanations provided by medico-psychiatric professionals, and in
particular 'gender specialists', which paid only scant credence to a wholly (bio)logical
account of trans aetiology, the stories of aetiological becoming provided by those 'trans'
women speaking in this research, talked of (bio)logical factors as being predominant in the
formation of a trans sense of self. As we saw in Chapter 3, such a view is concordant with an
understanding of transsexualism as constituting an intersexed condition; a view vehemently
rejected by the overwhelming majority of those 'specialists' interviewed. In the explanatory
narratives provided by the 'trans' women involved in this research, we can clearly see that
transsexualism is overwhelmingly considered to be the result of (bio)logical factors such as
prenatal hormonal imbalances, which result in the sexually differentiated brain. Here then,
the dissonance between body and mind is believed to constitute an intersex condition of the
brain. The following extracts taken from the life stories of my respondents clearly
demonstrate such an understanding:

\[\text{For Jane, her understanding of what both constitutes and creates transsexualism is deeply imbedded her mother's experiences during pregnancy:}\]

\[\text{"I'd be quite an advocate of the issue with development. Essentially, when all children are first conceived and developing in the first early weeks, everyone is ... with the blueprint of female, it's only the hormone levels that, then things change and I believe it's those balances being slightly out of sync that could cause problems and then resulting in someone being transsexual, err ... I'm quite a strong advocate of that down to my mother's circumstances, that when she actually had me, I think it caused here hormone problems, err, between me and my sister, err, who is five years my junior, she actually lost a}\]


child, had a miscarriage, and to keep my sister, so that she didn’t lose her she actually had to take hormone supplements, which is to me suggestive that her hormone levels were all over the place and I think, I attribute that to being the root cause.”

Similarly, Julie also understood hormonal imbalances as constituting the origins of transsexualism. Such a view also suggests that contrary to the predominant psychiatric position, transsexualism is a natural state, not a developmental process:

“... I think it’s ... quite likely to be sort of a hormone wash that goes wrong in the womb, I mean, I read that and I think that sounds plausible ... so ... I think it’s something that happens, I think there’s a physical cause for it, I don’t think it’s something that’s happened to me, it’s just the way I was.”

Linking ideas of hormonal imbalances to brain development, Sue argued that:

“It will probably turn out to be an endocrinological reason. Perhaps a hormone imbalance during foetal development causing the creation of a female brain type in an apparent male body.”

The scripting of transsexualism as caused by an intersex condition of the brain is something widely discussed in trans-academic and trans-theoretical literature, and is something that my respondents also talked at length about:

“The problem is ... the trouble is ... insufficient research has been done on this, so exactly what it is nobody knows, but I believe it’s something innate, that I was born with, it’s not something that developed ... erm ... whether it’s a question of ... incorrect brain hormones, or what ... or should we say, inappropriate brain sex? Erm, that’s probably the most likely explanation.”

(Cerridwen)

Likewise, Claire explained that:
"... for me, my belief of where I actually think it originates from ... and I believe it's actually, you know, a biological basis for it, like, err, Swabb, his research has shown that there's an area in the brain that is sexually dimorphic in males and females, and transsexual people, the number of transsexual people he has looked at, and then they have a physical structure, I think it is in, I can't remember, I think it's in the bio-stratus, the stria-terminus, or something in the brain that's sexually dimorphic and the same in transsexual people as what it is in genetically female people and it would be my experience ... I think it, there's certainly a biological basis there for it, so that would be my belief anyway."

Here then, we see that from these 'trans' women, the causes of transsexualism are understood as being a product of an intense hormonal imbalance. Drawing upon scientific reasoning as to (bio)logical sex and foetal development, these women clearly articulate a sense of the physical 'causes' of transsexualism as it relates to them and their becoming.

Concordant with this scripting of transsexualism as an innate, intersex condition of the brain, is the rejection of any psycho-social/developmental processes at work. With regards to transsexualism being a product of nurture, a number of respondents made the following remarks:

"I mean I don't believe it's nurture, that, that plays a great part, you often have people who say that it's because maybe someone's had a feminine upbringing and I certainly don't believe that 'cos I certainly didn't have a feminine upbringing, and if anything my upbringing would have been completely opposite really, you know, it was always kind of sport orientated, with my two brothers, and my sister, well had left home at an early age but I mean, but I certainly don't see it as being nurture."

(Claire)

"... because I can't think that at any time it's been nurture, I can't think of any time ... you know, where I've been sort of put in a position that it might make me turn that way if you like, I've just
It becomes clear then, that transsexualism, as understood by those ‘trans’ women involved in this research, is articulated through reference to (bio)logical factors, culminating in the sexually differentiated brain. Whilst this theory receives support from within certain sections of the clinical community (Gooren, Swabb, Zhou, et al, 1995; Kruivjer et al, 2000), it is antithetical to the views held by the vast majority of ‘specialists’ working within British gender identity clinics also interviewed for this research.

The Politics of Diagnosis: A Clinical Account of Trans ‘Authenticity’

Looking behind the ways in which a diagnostic politics works within clinical practice enables us to assess the degree of overlap within wider medico-psychiatric discourses on the subject (see Chapter 5). Moreover, by once again looking at the ways in which this diagnostic politics is experienced by ‘trans’ women, together with their feelings about and criticisms of such politics, we can begin to suggest alternative ways of thinking about the relationship between medico-psychiatry and trans-subjectivity, as well as problematizing the assumption of one ‘authentic’ trans narrative.

Answers to what constitutes the diagnostic criteria for transsexualism as it is understood within clinical practice can be found in those interviews conducted with ‘gender specialists’. Moreover, when we look at specific factors involved in the construction of a diagnostic politics, the answers given by those GPs interviewed can also be used to understand the ways in which medico-psychiatric discourses have filtered down into clinical practice.

Turning to the actual diagnostic criteria used to assess the ‘authenticity’ of trans ‘desire’, there would appear to be a great many links with the ways in which the diagnosis of transsexualism is described in the medico-psychiatric literature. The following quotations taken from interviews with ‘gender specialists’, demonstrates this clearly. Thus, referring to what they would expect to be contained within a ‘trans’ woman’s life history, those ‘gender specialists’ interviewed made the following statements:
“Erm, if somebody’s likely to go down that pathway I am looking for ... evidence of childhood gender identity disturbance, manifested behaviour or peer group relations, perhaps cross-dressing continuing through puberty into adolescence, with or without fetishism or sexual arousal, erm, prolonged ... a life-long sense of one’s, of his [sic] social/sexual roles, therefore social gender identity and sufficient discomfort to, err, consult about it with a view to seeking gender change.”

(Psychiatrist A)

“Factors? Erm, how long they’ve felt like that, erm, what lifestyle they’ve had, erm, erm, how do they think people see them?”

(Psychotherapist G)

The above quotes would seem to suggest that when assessing a person for sex reassignment surgery, clinicians are, to a great extent, drawing upon classic depictions of the ‘primary’/‘secondary’ trans dichotomy, whilst simultaneously drawing upon the concept of ‘good prognosis’ found within the ‘gender dysphoria’ paradigm. Further evidence for this comes from one clinician’s elaboration of the prognosis associated with both ‘primary’ and ‘secondary’ transsexualism:

“I mean, the very good prognosis of transsexual patients usually presents early with a very established social gender role almost without the help of hormones, those core, or primary group do extremely well in my experience. There are some, but not many women [‘trans’ men] present beyond the age of 40, there’s the occasional one, erm, actually men [‘trans’ women] present in their 40s or 50s and had gender dysphoria of a moderate to severe degree, have had marriages, have had children, have had transvestism, they’ve kept it, what I call compartmentalized for many years, then it breaks out with either divorce or death of a spouse or something, children growing up or some other external change so, that group, that’s I’d call the secondary transsexual group, I do think they come from the dysphoric, fetishistic group, have their sex drive which is quite low, so that again, that’s one of the pathways into a transsexual outcome. But research shows that
good prognostic patients come earlier in their lives.”

(Psychiatrist A)

What starts to become clear then is that clinicians working within the ‘gender dysphoria’ perspective are willing to accept that there is more than one narrative line (nonetheless contained within a medico-psychiatric script) told by people seeking sex reassignment surgery – that is the ‘dysphoric’ patient/’secondary’ transsexual, and the ‘true’/’primary’ transsexual. However, what also becomes apparent, and concordant with the literature (see King, 1993) is that the label ‘transsexual’ is reserved for a ‘special’ kind of person:

“Well, erm ... I don’t accept anyone presenting to me as transsexual until they are a very long way down the pathway ... I’ll use the word transsexual as a short-hand for somebody who has established a change of social gender role, it appears to be stable and they are progressing with hormones and toward surgery, or that they have had surgery, i.e., that they are a long way down the pathway ...”

(Psychiatrist A)

Here then, it would appear that not everybody can claim a trans identity, and while presenting as, or being attached the label of ‘secondary gender dysphoric’ is not necessarily a bar to ‘treatment’, there continues to be, in the medico-psychiatric imaginary, a clear distinction to be made between ‘authentic’ or ‘true’ trans ‘desire’ and ‘secondary gender dysphoric’ practice. This becomes even more apparent when we look at the main factors that go to make up a politics of diagnosis.

Compulsory Heterosexuality

Both GPs and ‘gender specialists’ were asked in the form of a semi-structured questionnaire as well as a series of semantic differential scales (see Appendix 1b and 2a) to grade the extent to which they considered a number of factors to be important in order for a diagnosis of transsexualism to be made. Here, a number of responses relating to sexual orientation were elicited. The need for trans people to enter into a heterosexual relationship, or to identify as such post-surgically, (and hence identify as homosexual in the (bio)logical sense) is cited within so much of the clinical literature as being of great significance in terms of making an ‘appropriate’ diagnosis. However, this concept was not widely supported within my own
research, with only 24 per cent (8) of general practitioners believing heterosexual orientation to be important for ‘trans’ women, and 21 per cent (4) believing it to be important for ‘trans’ men. Meanwhile, of those ‘gender specialists’ questioned, only 10 per cent (2) believed heterosexual orientation to be an important diagnostic factor for both ‘trans’ men and women.

When analysing the material obtained from those semi-structured interviews with ‘gender specialists’, a number of significant references were made, which relate to the sexuality of their ‘patients’. Firstly, the use of sexual sub-typing was discussed by a Psychiatrist A:

“Well, the primary, core group, if we believe there is such a group, are by definition, homosexual, or hetero-gendered, which they call themselves, erm, there’s a group ... of males [sic] who are quite inhibited and asexual, then there’s another, erm, the homosexual people, those who are sexually attracted towards men, are probably on my reading and experience, there’s only 30% I suppose, I mean 50% or more are heterosexual in orientation, they may become bisexual or homosexual as their gender dysphoria moves in a transsexual, and that certainly is the case, although some stay or become asexual or they stay attracted to women, or certainly emotionally and practically, and some stay in their marriages. The female [sic] group ... just about all of them, I think are bisexually orientated towards other [sic] females, on very rare occasions ... It’s the occasional one that’s got married and had a child, by accident or by depression to have a child or be a parent.”

Further suggestion that ‘trans’ women both identify and practice predominantly an asexual sense of self came from the words of one psychiatrist:

“... actually most of them don’t have sex afterwards, only about a third or a quarter ever get round to having penetrative sex after surgery ... most of them ... most transsexuals that I come across are feeling relatively asexual or hyposexual ... Well, because their, their libido has been hijacked by their gender drive, they think about being a woman more than they think about having sex, so they get out of the habit.”

(Psychiatrist H)
Moreover, one surgeon expressed concern over the possibility of an individual enjoying a healthy sex life prior to surgery:

"... if someone's having an active penetrative sexual relationship, erm, you've got to question that they've thought through clearly that that's going to be absent and I would therefore probably refuse [surgery]."

(Surgeon C)

Concerns over an active sexual desire, or rather an insistence that 'trans' women should identify as asexual can be attributed in part to the assumption that all 'trans' women experience severe bodily hatred, as two clinicians stated:

"There's often a sense of distaste for the physical sort of body that the person has ..."

(Psychiatrist F)

And,

"... but, erm, certainly in the male-to-female transsexuals, the, erm ... strident features are that of total abhorrence of the penis, they really do hate it, and to a lesser extent the testes and the scrotum, and so the dominant wish is to be rid of it."

(Surgeon C)

Interestingly, whilst 'appropriate' (read heterosexual) practice and/or desire continues to structure much of the contemporary clinical practice within British GICs, it is also one area where to an extent, clinical practice seems to be breaking away from medico-psychiatric discourses, thus comments such as the following were made:

"I have to say, sexual orientation doesn't swat me diagnostically one way or the other, and neither does it particularly affect therapeutic outcomes in that I really couldn't give a toss whether people are heterosexually or homosexually orientated and so consequently it doesn't make any difference."

(Psychiatrist B)
"No, I think what's important is the quality of the relationship not the genital organization, the object of their affection."

(Psychotherapist E)

Whilst much of the medico-psychiatric literature and clinical practice codes homosexual identification (in the psychological sense) as a sign of 'inauthenticity', it would seem that a number of the clinicians interviewed are in fact moving away from such a retrogressive understanding and thus did not regard it as an important indicator of trans identification.

Performative and Somatic Markers of an 'Authentic' Desire

Both GPs and 'gender specialists' were asked whether they believed such factors as the ability to 'pass', the willingness to dress, to adopt the name, and the behavioural mannerisms of the subjectively experienced gender to be important for a diagnosis of transsexualism to be made. The first sign that 'trans' women are assessed in relation to a series of performative and somatic assumptions about their entitlement to 'gendered realness' can be found amongst the questionnaire results of both GPs and 'gender specialists' and was subsequently reaffirmed during interview discussions.

An Ability to 'Pass'

The first sign that trans people are assessed in relation to a range of performative and somatic assumptions about their entitlement to 'gendered realness' can be found among the questionnaire results of both GPs and 'gender specialists'. Seventeen (51%) of the GPs who responded to Questionnaire 2 (see Appendix 1b) believed that it was important for 'trans' women to be able to 'pass' in the role of their subjectively experienced gender. Slightly less, (48%/16) believed the same to be true for 'trans' men. The configuration of assumptions elucidated by those 'gender specialists' questioned (see Appendix 2a) differed somewhat. Whilst again, half (10) of the respondents believed that it was important for 'trans' women to be able to 'pass', 60 per cent (12) believed it to be an important issue in the case of 'trans' men.

In relation to the significance of an individuals' ability to 'pass', those 'gender specialists' interviewed elicited the following responses:
“So, it’s not necessarily to do with how a person looks on a still photograph, it’s as soon as they sort of come alive and become animated and what they become animated with. It begins to make a significant difference and I have seen patients who on still photographs who would flatten horses but nonetheless have no difficulty whatever sailing through life with people treating them as if they were female.”

(Psychiatrist B)

For this particular psychiatrist, the ability to affect a ‘female’ persona is incredibly significant in his judgement as to whether a person will be ‘successful’ in their trans identity, a success which transfers itself into the appropriate diagnosis being made and hence ‘treatment’ being offered.

Commenting on the importance of ‘looking the part’ and indulging in necessarily ‘feminine’ pursuits, Psychiatrist H commented:

“... I’ve had people who are blind, not even able to put their mascara on ... and I’ve tried to persuade them not to proceed because it’ll be too difficult and compound the problem ...”

Yet he did admit that:

“... they’ve always proved me wrong ... so you know there’s erm, appearance doesn’t, doesn’t really, doesn’t necessarily come into it.”

Finally, the same clinician talked about the role that ‘passing’ has traditionally played in the diagnosis of transsexualism at other clinics:

“Well, I know that one of the old professors, Professor X used to do this. He used to get his nurse or receptionist or something, you know, and he would say, ‘does this one pass muster? Do you think we can give this one treatment or is it hopeless?’ and the nurses would say ‘err, err, no I think it’s going to be difficult, we, we really ought to erm ... pass this one over for treatment because he’s, she’s so masculine looking and ugly, she’d never pass as a woman in a hundred years’, so he wouldn’t treat them and they’d go and kill themselves.”
Whilst it would seem that there is some reflexivity with regards to an individuals’ ability to ‘pass’, the same cannot be said when we consider other factors of a performative and somatic nature.

Wearing the ‘Right’ Clothes

Evidence from the questionnaires given to GPs and ‘gender specialists’ as to the importance attached to ‘patients’ wearing ‘appropriately gendered clothes’, suggests that just 27 per cent (9) of those GPs questioned believed that it was important for ‘trans’ women to dress in the role of their subjectively experienced gender in order that they receive a diagnosis of transsexualism. A slightly higher proportion (33%/11) believed that the same factor was important in order to confer a diagnosis of transsexualism among ‘trans’ men. In regards to the results produced from those questionnaires completed by ‘gender specialists’ we are able to see that the wearing of the clothes associated with the individual’s subjectively experienced gender was considered to be of equal importance (40%/8) for both ‘trans’ men and ‘trans’ women.

Further to this, those ‘specialists’ interviewed often regarded the wearing of ‘unisex’ clothes as a sign of ambiguity over the ‘reality’ of an individual’s trans ‘ambitions’, and in line with this, the wearing of the ‘wrong’ clothes when coming to the clinic is also viewed with immense trepidation. Thus, those ‘specialists’ interviewed made a number of remarks about the clothing they expect their ‘patients’ to wear:

“I, I suppose ... how ... I mean how they’re turning up at the clinic is of course also important at that stage because if they’re coming very androgynously sort of dressed ... but if people come in a, very ambiguous clothing then I guess you’ve got to consider that they’re ambivalent about the whole thing, that they haven’t, maybe, they don’t feel comfortable facing the world in their chosen gender.”

(Psychiatrist F)

And,

“... we follow a protocol and we also adhere to the International Harry Benjamin, erm, and the protocol sets out very clearly about making
that transition and living in their chosen gender, but I’ve had one particular client who dressed very unisexed, had male pattern balding and did not want to wear a wig, wouldn’t wear make-up, and it caused lots of discussion in our clinic.”

(Psychotherapist G)

As we can see then, in order to receive a diagnosis of transsexualism, ‘patient’s’ must demonstrate that they are prepared to ‘dress the part’, and as we shall see, behave in a manner appropriate to their subjectively experienced gender. For to do so serves, in the medico-psychiatric imaginary, the dual function of indicating the ‘authenticity’ of a trans ‘desire’, as well as serving as a sound indicator of ‘good prognosis’.

**Acting the Part**

Again, beginning with those questionnaire responses given in relation to the diagnostic importance of the ability to behave in a manner ‘appropriate’ to an individual’s subjectively experienced gender, we can see that 54 per cent (18) of those GPs questioned believed that it was important for ‘trans’ women to adopt the mannerisms or behavioural characteristics associated with their subjectively experienced gender, whilst only 45 per cent (15) believed that the same need apply to ‘trans’ men. Whilst the percentage of ‘gender specialists’ who believed the same needs to be true in the case of ‘trans’ women was less (40%/8), 45 per cent (9) believed the ability to adopt the ‘appropriate’ behavioural characteristics was important for ‘trans’ men.

As with the need to dress in a manner ‘appropriate’ to the subjectively experienced gender, ‘gender specialists’ also placed a great deal of emphasis upon the adoption of those mannerisms and behavioural characteristics considered to be concordant with their sense of self. Once again, my interview work gleaned a number of significant responses:

“Pretty important … erm, it’s much more convincing if it’s there right from the beginning, but I certainly have a number of patients who develop … feminine body language and mannerisms, speech language helps them etc. Erm, I have the view that if their feminine mannerisms or body language isn’t there, or their, or their … I have doubts about the correctness of their transsexual ambitions. I can accept that they
might have a deep voice and that might need help, but, err ... anyone with masculine body language is to me a dysphoric transvestite who needs careful evaluation."

(Psychiatrist A)

And,

"I suppose you could have any number of non-typical ... behaviours as long, but if you wanted to become convincing in the sex you’ve chosen, you’d have to have a certain, you’d have to have a certain percentage of behaviours which were of that sex."

(Psychiatrist F)

Contained within the need to determine ‘good prognosis’ in terms of performative and somatic markers of ‘authenticity’ comes the requirement that ‘patient’s’ adopt a suitable name, as psychiatrist A commented:

"Again, if they’re using unisex names, you wonder about what it means, are they going to be unisexed or between sexes, or are they going the whole way? Yes, I think the choice of name indicates something about the person’s mental state."

By adopting a range of ‘appropriate’ gender markers, the trans person’s claims to a trans identity can be legitimated by the medico-psychiatric professional. However, and more than this, it also serves to assure the clinician that the individual no longer poses a ‘disruption’ to the sex/gender dichotomy.

Further Evidence or Proof

Concordant with the use of performative and somatic assumptions to determine ‘good prognosis’ for those requesting sex reassignment, which seeks to find proof for the ‘authenticity’ of an individuals’ trans identity can be evidenced by the standardized use of the real-life-test (RLT) by British gender identity clinics. The significance of the RLT was espoused by a number of ‘specialists’ interviewed:
"Well, I'm convinced that's [RLT] one of the most reliable indicators we have of stable outcome for the transsexual change, then if someone has established a two-year role indicating one year of work or studies, integrating, then that's evidence of their determination, and I suppose the stability of their transsexual ambitions."

(Psychiatrist A)

And,

"I think it's erm, I think it's the sensible, it's sensible for most people to do this, because ... I think there's more likelihood of a person being successful long-term if they're sort of given a trial run by living in the role they feel they are beforehand ... erm, so I think if you, if you, if you give surgery on demand, if you give surgery on demand without any sort of real-life-test ... erm, I think the, the likelihood of a poor outcome increases ..."

(Psychiatrist H)

The real-life-test is regarded as so significant in terms of ensuring a 'good prognosis' that, as one psychiatrist explained:

"If there's no, or a lack of corroborating evidence that the patient will live successfully in the female role [treatment will be refused]."

(Psychiatrist A)

The assumption then is that by requiring 'patient's' to live for a period of time in their subjectively experienced gender, clinicians can be assured that in allowing 'treatment' to be continued, we won't end up with a world which accepts mind/body incongruence.

**Authenticity Checks and the Hermeneutics of Suspicion**

A further diagnostic trope that became apparent from the words spoken by those 'gender specialists' interviewed can be described as a deployment of a hermeneutics of suspicion, as evidenced through the careful utilization of detailed 'authenticity' checks. The notion of the deployment of a 'hermeneutics of suspicion' was discussed in Chapter 5, and the assumption is that the personal narrative of the 'trans' women's becoming is treated as an unreliable
indicator of trans ‘desire’. Rather, the ‘truth’ of one’s identity can only become apparent through careful psychiatric reading and interpretation. The result is that the trans narrative is treated as suspicious, and an individuals’ claim to a trans identity fails to be taken at face-value. The value of taking a detailed life history was espoused by a number of ‘gender specialists’ interviewed:

“The most important thing is that there’s a good history collection, you know, a good history of how the person developed, their background, what factors influenced their development both psychologically, physically, erm, and what are the factors that pertain now, so it’s, it’s a ... a prolonged history taking exercise to get an evaluation.”

(Psychiatrist D)

And,

“Well, the first thing I do with all patients is take a detailed history, particularly concentrating on transsexual behaviours and I think the history is 90% of the story. What I’m looking for is patients able to tell me what their experience of transsexualism has been in detail and I think that shouts at me.”

(Psychotherapist E)

Moreover, for psychiatrist B, there appeared to be an inherent danger in accepting the self-diagnosis of transsexualism. What his words reveal is a perceived need for the clinical deconstruction, reconstruction and interpretation of personal histories:

“...If you follow the line of it doesn’t matter if you do or you don’t, you see what you do is you end up saying ‘well I feel I am female/male or whatever, and so consequently that’s enough and I don’t actually need to behave in a traditional manner, why should I be bound by traditional rules’ and so forth. If that’s true what it boils down to is saying what people pronounce out of their mouths is going to be the be all and end all, if one simply takes them at their worth, and makes the assumption that that’s all that’s required for diagnosis and then sort of goes ahead on that, at which case I could sit here in front of you now and say well I feel female and accordingly you ought to give me a shit
load of oestrogens and undertake some surgery on me and that will be fine.”

(Psychiatrist B)

Despite the significance of this detailed history gathering as a means of assessing the ‘truth’ of trans identity, many of those clinicians interviewed viewed it as a problematic exercise, in need of careful evaluation. When discussing the histories given by ‘patients’, clinicians continually employed a hermeneutics of suspicion, thus regarding the individual’s own narrative as unreliable and suspicious, the value of which can only be decoded by the medico-psychiatric ‘expert’. The following account makes this clear:

“Erm, well we make considerable efforts to verify what they actually say and if people maintain that they lived all their life in the female role for the last 15 years and so forth, and so therefore they ought to have surgery right now, we usually make some attempt to verify this and, err, and often it’s interesting that the whole thing turns out to be a tissue of lies or more often sort of a distortion of events and they say everybody takes me as female, actually everybody takes them as how they present themselves, but they’re not taken for female, because they may call them Vanessa, but when they’re talking about them they refer to them as he and they say ‘that funny bloke who calls himself Vanessa’ … Yes, they do, often they have a rather characteristic phrase, which I think they’ve got out of whatever book it is that the public library service stocks about this, and that they have to sort of trot this phrase out and you usually come to recognize it … yes, yes, I did not come down with the last shower! … it does mean that anything the patient utters thereafter is always viewed with the utmost of caution and, erm, anything they say which is substantive will automatically be checked. If they say, ‘no, no it is true, erm, and I’m going to stick to this story and I insist that you treat me on the basis of it’ then I think they really are scuppered because I have no confidence in them, and it’s a two-way thing this doctor-patient lark, if I don’t have any confidence in them, I’m not going to treat them. Most patients get one chance at lying to me and, erm, then they get a warning, when they lie a second time they’re out.”

(Psychiatrist B)
Similarly, another clinician remarked:

“[I] don’t make assumptions because patients will always tell clinicians what they want to hear.”

(Psychotherapist E)

One way that clinicians attempt to overcome the possibility of lying on the part of the ‘patient’ is through a process of detailed interviewing:

“Erm … I’m certainly aware that some patients lie; some of them have been detected here. I guess I think if one takes one’s time with interviewing. Patients often forget their lies and don’t know what they’ve said, so in a sense by prolonged assessment and asking for external evidence, references and being certain that their references are genuine, or hopefully are, one does, I think, increase the level of confidence when one is not being lied to.”

(Psychiatrist A)

A further strategy employed is that of using more than one clinician in the diagnostic process, as one psychotherapist explained:

“Err, well, I think one of the values with two clinicians being on the job is often you can get a sense that you are being conned, but if it’s just you, if it’s just one clinician I think it’s much harder.”

(Psychotherapist E)

What these interview extracts make apparent is the extent to which clinicians exert a high degree of suspicion over the individual’s life history. The deployment of such a hermeneutics of suspicion not only serves to discredit a person’s sense of self, but also places the power of legitimation firmly in the hands of the medico-psychiatric ‘expert’.
The Surgical Demand

A penultimate way in which diagnosis is determined is in relation to the 'patient's' articulation of a need to undergo surgery, and as such this demand is often regarded as the clearest marker of trans 'authenticity'. Failing to articulate such a demand results, more often than not in the deployment of a differential diagnosis, and the refusal of further 'treatments'. Those responses gleaned from my questionnaire work revealed that, in terms of the demand to 'change sex', 69 per cent (23) of GPs believed that it was important for 'trans' women, while slightly less (57%/19) believed the same to be true for 'trans' men. 55 per cent (11) of those 'gender specialists' questioned believed demand for surgical intervention to be an important diagnostic requirement for both 'trans' men and 'trans' women. There would seem then, to be little recognition of the often unsuccessful outcomes associated with SRS for 'trans' men, which makes surgery a non viable option for many.

The importance attached to surgical demand was espoused by the following two psychiatrists:

"Well it's a bit critical. If I have no desire to have my body surgically or hormonally altered then accordingly it would be extremely hard to give me a diagnosis of transsexual. Without such a desire such a diagnosis would be very hard to make."

(Psychiatrist B)

"... well it appears to be a necessary final step, it appears as a final step in the process of gender reassignment, erm, so that the person's psychological and social identity can be made congruent with the body."

(Psychiatrist B)

However, one might be tempted to ask, for whom does surgery appear to be a necessary final step, the clinician or the individual?

Two further ways in which individuals are assessed in terms of their suitability for SRS are first, the use of panel meetings by some gender identity clinics, as one surgeon explained:
"At X we have panel meetings where individual psychiatrists may have difficulties with individual patients in terms of the diagnosis or, erm, surgery or the ability to pass."

(Surgeon C)

Second, there is the use of physical examinations:

"He [the psychiatrist] will do physical examinations [as part of the diagnostic process]"

(Psychotherapist G)

Both of these methods of assessment have come in for close scrutiny by many within the trans communities. Panel meetings are often regarded as superfluous and indeed outright damaging, constituted as they are by such people as vicars and lawyers. The role of such lay members in the diagnosis of transsexualism needs to be questioned in terms of their exact contribution other than as a moral judgement. Moreover, the pre-requisite that an individual must undergo a physical, internal examination before the administration of hormones is seriously questionable – not least in terms of the precise function that such an internal examination has in what is supposed to be a psychological assessment. Moreover, it seems somewhat paradoxical that while psychiatrists espouse a ‘narrative’ truth that trans people must abhor their genitalia, the same clinicians subject the very same trans people to the often humiliating experience of this psychological game-play. While physical examinations are justified on the grounds that it is necessary to ascertain whether or not the genital area is devoid of any signifiers of intersex and/or that there is sufficient suitable tissue for SRS. However, this is a matter of concern for surgeons and should not constitute a factor in the diagnosis of transsexualism.

The Importance of Age

A final diagnostic trope utilized within the assessment of transsexualism, as evidenced in the responses to my questionnaire work, concern the age at which trans people realize their gendered ‘difference’. Childhood onset and/or realization are cited as an important pre-requisite for the diagnosis of transsexualism within the medico-psychiatric literature. This was confirmed by the questionnaire results of both GPs and ‘gender specialists’. Here, 63 per cent (21) of GPs questioned believed childhood onset to be important for both ‘trans’ men and ‘trans’ women. However, whilst 65 per cent (13) of ‘gender specialists’ believed age to be an
important diagnostic criterion in the case of ‘trans’ women, only 55 per cent (11) believed the same to be true for ‘trans’ men. This would seem to suggest then that ‘trans’ men and ‘trans’ women are treated and understood as constituting somewhat distinct phenomena in terms of both their aetiological and diagnostic features. This differentiation can perhaps be explained by the continued conflation of ‘trans’ men with butch lesbians. Moreover, because the ‘desire’ to live as a man is often considered ‘natural’ and unsurprising given the greater degree of social power afforded to men in western culture, there is often a perceived need to insist upon more markers of ‘authenticity’ for the ‘trans’ man in order to ensure that their quest is more than a desire to usurp the social power of men.

A Question of Refusal

As we can see, there are a number of strict criteria that the trans person must adhere to and reiterate in the telling of their life history if they wish to have that narrative legitimated by medico-psychiatric ‘experts’, and thus gain access to the ‘treatments’ that they seek. In order to provide further support for the existence, and indeed relevance of such criteria in the assessment and diagnosis of transsexualism, clinicians were asked on what grounds they would refuse to confer a diagnosis of transsexualism. Despite a somewhat messy picture of trans aetiology within the medico-psychiatric imaginary, the answers given to the question of refusal did seem to provide support for the existence of a standardized medico-psychiatric portrait of the ‘true’ transsexual as it is scripted within formalized medico-psychiatric and clinical protocol (see Theme 1) and the significance of the diagnostic tropes discussed above. Thus grounds for the refusal to legitimate a trans narrative of self were seen as:

“[Refusal] simple, if they don’t meet the criteria …”

(Psychiatrist D)

“I mean the factors that would go against [diagnosis] would be patients who had an inability to physically pass in the chosen sex and the inability to have the appropriate mannerisms, body language with their psychology, as it appears to me.”

(Psychiatrist A)

Here, we see a reliance upon subjective criteria by psychiatrist A - ‘as it appears to me’ – as a means by which clinicians can evaluate the ‘truth’ of trans ‘desire’. 

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Whose Line is it Anyway?

Finally, a revealing insight can be gleaned when assessing the question of who is perceived to be the legitimate author of transsexualism. Evidence that transsexualism is not considered to be a self-diagnosable, and hence self-authored identity can be found in the words of a number of my clinical respondents:

“I think there's a lot of false self-diagnosis and it's important to question that self-diagnosis.”

(Psychiatrist A)

And,

“Also, I won't make such a diagnosis if I don't think it's the case even if the patient fancies that it is ... a very poor indicator of how people will do after surgery is their own opinion of how well they will do after surgery.”

(Psychiatrist B)

However, there is some evidence that a number of 'specialists' working within the field are beginning to employ a more reflective approach to the question of authorship, with one psychiatrist insisting that:

“Oh, I think it has to come from the patient, the patient diagnoses themselves.”

(Psychiatrist H)

Further evidence in support of such reflectivity on the behalf of the clinician as to the orthodoxy of the psychiatrist as gatekeeper can be gleaned from the following quotation:

“I know that if ... if I felt that somebody else held, if I really wanted something in life, erm, and yet somebody else held the decision-making, whether I should have that or not, I think I would feel outraged with it 'cos I think, I, for many people, erm, they are their own experts, and I'm talking about patients as experts in any other field, and I think trans people as well is also true ...”

(Psychiatrist F)
Interestingly however, one GP interviewed, when responding to the question of whether transsexualism was either a self-authored subject position, or a medically diagnosable condition, intonated that it was their role to be the first person to authenticate the trans experience into something more tangible:

"I mean, I, err, I feel it's up to me to try, erm, properly decide whether this is a true transsexual or not ... I believe that to be the case."

(GP 100)

That this GP believed himself to be a key figure in the diagnostic process is somewhat troubling, given, as we saw in Chapter 3, GPs often limited understanding of, and inexperience with transsexualism.

As we have seen, concordant with the paradigm shift towards psychoanalysis, psychiatrists began, more so than in previous historical moments (especially the period of sexology from around the late nineteenth century) to regard themselves as the authors of the trans experience.

**Telling the 'Right' Tale: A Trans Perspective on the Politics of Diagnosis**

Looking at the words spoken by those ‘trans’ women involved in this research, and by understanding how they feel about the use of rigid diagnostic criteria such as those outlined above, we can add depth to our understanding and can build upon what we have already seen with regards to the relationship between medico-psychiatry and social identity; that is, we are able to question the extent to which trans people are either the dupes of the medico-psychiatric profession, or alternatively, are duplicitous in their relationship to it. A number of my respondents talked at length about their feelings and experiences of the diagnostic process, in terms of the extent to which they felt, or actually experienced a pressure to conform to white, middle class, male, medical practitioner’s understandings of ‘femininity’. The narratives relayed throughout this research also shed an informative light on the complex identity-negotiation process that faces so many ‘trans’ women as they attempt to stay true to themselves in the face of irrevocable dismissal. Connected to the themes relating to the diagnostic politics as discussed by those ‘gender specialists’ interviewed the three main themes that came out of my research with ‘trans’ women as to their feelings of and
experiences with the diagnostic process can be understood as: performative and somatic markers of ‘authenticity’; an enforced heterosexuality, and a hermeneutics of suspicion.

Performative and Somatic Markers of ‘Authenticity’

As we have seen, much of the diagnostic process involves the clinician making a number of performative and somatic assumptions as to the ‘authenticity’ of the individual’s ‘desire’. That this process is overtly present within the clinical relationship was made clear throughout the words spoken by those ‘gender specialists’ interviewed, and was something which they made apparent to their ‘patients’. In this vein then, a number of the ‘trans’ women involved in the research clearly articulated a sense of experiencing a pressure to perform their ‘femininity’ to such a degree that they would suitably convince the while, male psychiatrist of their ‘authenticity’.

Beginning with the pressure to dress in ‘feminine’ clothing, a number of ‘trans’ women I spoke to explained how this affected them:

“... there’s always sort of an underlying thing with [X GIC] that if you turn up in trousers or jeans they won’t be happy and if they weren’t particularly feminine trousers, bootleg or with embroidery up the side, their idea was that you shouldn’t be wearing that, we can’t take you seriously ... So I don’t know about the trouser thing with X. If you look down the street how many women are wearing trousers and jeans? probably 90%. I think they could be a little more flexible on that. Originally it was quite a strong mind set that if you didn’t turn up in a skirt then they wouldn’t take you seriously. I think they do have some weird perceptions on some things.”

(Jane)

And;

“That was an overreaction because they don’t realize that a lot of stuff I wear is male and female, but back then it was that insistence again at [X GIC], you had to wear a skirt, it’s so daft you know. They have a sort of old-fashioned, antiquated idea of what a woman should be like, and dress, you know, so you ended up turning up there like Miss Jean
Brodie, flowery blouse on. I did get sent home for wearing leggings ... back in the 80s it was all leggings and leg warmers, that was the thing and I used to wear that a lot and I went there once and got sent home ... Oh yeah, it was like that at X GIC, I don’t think it’s quite so bad now, but it was definitely. You had to dress to be the ideal of what a women should be and look like, and it was hard because at that time I was working ... I’d actually got a job as a female, err, and I was the only person actually dressing like that, their idea of a girl. I was really out of place.”

(Julie)

For Charlotte, the pressures that GICs place upon ‘trans’ women to perform an archetypal ‘feminine’ persona, can only be regarded as an outrage, and something which both perpetuated and maintained the social stigmatization of ‘trans’ women:

“‘Trans’ women are expected to present at clinics in a strict stereotyped dress code perhaps on more than one occasion to receive ‘provisional diagnosis’ – ‘transsexualism’: if they refuse to wear a dress or skirt and blouse, wear make-up and if necessary wear a wig they would almost certainly be denied access to healthcare. This gross form of stereotyping was to have consequences for the women of a national minority, it inspired a social backlash and the culture of ‘men in frocks’ snap shots of in the media or at social gatherings before and as a pre-requirement to the commencement of hormone therapy, looking effectively like the clinical creation of the transvestite which substantially degraded their public image as well as including a culture of fear in many who often in social spaces stood out in the crowd and invited the acrimony of the general public and the media.”

Similar sentiments were expressed with regards to the diagnostic significance of ‘passing’ as ‘non-transsexual’, as one respondent explained:

“... they are a bit short sighted and think that you’re more likely to be transsexual if you look good. Erm, and they probably feel a certain amount of, at ease at allowing you to go through hormones and GRS
Another 'trans' woman involved in the research made a similar comment in relation to what she had read about, and heard expounded within the communities:

"... I do get the impression from reading books and hearing about other people's experiences that it [the ability to 'pass'] is one of their criteria and that ability to function properly in role. But I think for somebody maybe who is 6 feet tall, broad shouldered, whatever, you know? the feelings of being transsexual are not any less than they are for anyone else ... We live in a very judgemental society where people do judge people by the way they look, and any woman gets that kind of thing, and you know, if you're a trans person who doesn't pass particularly well then psychiatrists, who are surely going to be as judgemental towards transsexual people as everyone else even if they say they're not. I think that element probably does go on."

(Claire)

Enforced Heterosexuality

Combined with the significance of performative and somatic markers of 'authenticity' as cited within both medico-psychiatric literature and clinical practice, is an equally strong concern over the sexual identity of the 'trans' woman. Whilst my clinical respondents talked about this as being less important than the literature would seem to suggest, the responses elicited by those ‘trans’ women involved in the research somewhat contradicted this, especially as many of those who expressed a concern to conceal the ‘truth’ of the sexual desire transitioned only a matter of years ago. The following fears or concerns over talking about sexual identification, or the ways in which it would affect their ability to transition can be seen in the following set of quotes:

“Yeah, it was mentioned yeah. I think everyone is a bit less likely to mention it now but back then they were looking for reasons and I was reluctant to mention that I didn’t do anything homosexual because I had an idea that they would pounce on it, so I was very reluctant to
The reality would seem to be then, that the mention of homosexual practice, to some clinicians would create a situation whereby the diagnosis of transsexualism is placed in jeopardy.

Claire also talked about the clinical misconception of the relationship between (trans)gender and (homo)sexuality:

“I think it was one of the questions that everyone asks, not just the psychiatrist and it’s one of the great misconceptions really about transsexuality, is its relation to sexuality, err, so people, psychiatrists particularly, they do ask if you’ve had homosexual experiences, if you feel yourself to be a gay man or whatever, and you know, they do ask you these questions ... to me there’s a kinda irrelevancy there, you know? Sexuality and gender are not the same thing.”

That a number of ‘trans’ women speaking within this research felt a pressure to hide their sexuality suggests that concerns over sexual identification continue to structure the diagnostic process, thus providing further evidence for the continued conflation of (trans)gender identity and (homo)sexuality.

A Hermeneutics of Suspicion

Much is made in both the medico-psychiatric literature and within clinical practice of the need to treat the trans narrative as a ‘suspicious text’. Here then, the ‘truth’ of one’s trans ‘desire’ is something which can not be taken at face value, but needs to be decoded and legitimated by the medico-psychiatric ‘expert’. However, it is only through talking with ‘trans’ women themselves that we can begin to uncover the true extent of this practice.

The need to conceal certain parts of a person’s history, or to re-tell that which the clinician expects/wants to hear, through a fear that to do otherwise would jeopardize access to ‘treatment’, was discussed at length by some of my respondents:
"I think a lot of it’s complicated because a lot of people go and say what they [clinicians] want to hear, because you know they lie because we talk to each other and we know, you know? You expect every question, you know what to say, whether it’s exactly how you feel or not, you know that’s the answer they’re looking for so they can tick the box. There’s very few you can actually be honest with, you know.”

(Julie)

For Jane, the apprehension over ‘coming clean’ is apparent. Her fears centred on not being taken seriously, or being labelled inappropriately:

“I suppose to start off with I felt very apprehensive about saying certain things to them because it was very important to get where I needed to be, I didn’t want to say anything that would jeopardize, err, the assessment of me. I wish, I wish I’d been totally honest with them and sort of truthful, err, but there was a lot of things that sort of played on my mind, thinking well, if I turn round and say that to them, will they look at that as being really bad and as saying you’re not transsexual. My world was falling apart, I could not go back and live as I was before and deal with that, but I suppose over a period of time, you’re speaking to a psychiatrist and you’re speaking to other people, how I actually felt, not making out anything was the case and lying to them … I did become very worried because of what they might actually do in terms of ‘OK no treatment for you and we think you’re a transvestite or something.”

For Emma, while she presented the ‘truth’ of her identity, she was aware that this was to a great extent a luxury afforded to her by her decision to access private healthcare:

“I didn’t lie by the way: I mean I just told the truth. I think if I’d gone through X [GIC] and told the truth then I’d still be in transition, so the route I took was the right route.”

As we can see from the above two quotes, there is much evidence which goes against the depiction of ‘trans’ women as duplicitous, and that their words should be treated with suspicion. This point is reiterated in the following quote:
“I was really open with them, because I kinda felt early on that if I start telling them maybe what they want to hear, well there’s no point really, that’s going to be a self-defeating exercise really. So I genuinely thought myself to be a transsexual person so I didn’t feel the need to go and tell them anything that wasn’t true, so really, that’s just me being me.”

(Julie)

However, further statements were made regarding the suspicion held by the psychiatrists and the extent to which they hold the power over the diagnostic process:

“They don’t trust anyone, even if, you know, even if I went in, say on my first date and said you know I am a woman and I actually showed that I’d got ovaries and the whole lot, they still wouldn’t believe me.”

(Janine)

Similarly;

“I remember once X [psychiatrist] saying to me ‘sure analyse yourself, but you should always ask yourself how good your analyst is’ …”

(Jessica)

The structure and content of the ‘assessment’ meetings is such that many ‘trans’ women do not feel at ease, and thus are not confident in their ability to ‘convince’ a medico-psychiatric ‘expert’ of their ‘authenticity’. The cumulative effect then is the continuation of medico-psychiatric imperialism and control.

Conclusions

My research sought to address the extent to which medico-psychiatric discourses (as contained within a plethora of research papers, scientific studies and clinical textbooks, which seek to outline and describe what constitutes an aetiology of transsexualism, and what factors are considered important for a diagnosis of transsexualism to be made) transfer themselves into, and play a crucial role in the clinical practice of British gender identity clinics. Further
to this is an analysis of the impact of this for the ways in which ‘trans’ women make sense of themselves and their transsexualism. By conducting both semi-structured questionnaires and in-depth interviews with general practitioners and ‘gender specialists’, as well as narrative interviews with ‘trans’ women, I hope to have been able to provide some insights into the extent to which both clinical practice and trans-subjectivity are informed by wider medico-psychiatric discourses on transsexualism.

This chapter revealed in the first instance the ways in which a number of explanations of the aetiology of transsexualism abound within clinical practice and that they combine those discourses propagated within wider medico-psychiatric discourse with varying degrees and intensities. Moreover, by talking to ‘trans’ women I hope to have been able to demonstrate the sometimes subtle ways that a trans aetiology is conceived within this domain, which, as I shall seek to show in the chapter that follows, call into question the assumption that ‘trans’ women blindly reproduce those discourses constructed of and for them by the medico-psychiatric profession. That is, my research reveals ‘trans’ women’s active role in the construction of a transsexual identity.

My investigations into the range of diagnostic criteria that abound within both the medico-psychiatric discourses as well as within clinical practice have revealed a number of key tropes that are shared between the two domains. Thus we see the perpetuation of such tropes as: a concern over sexuality; the age of onset; the role and significance of performative and somatic markers of ‘authenticity’; and the treatment of the trans narrative as a suspicious text. What this reveals then is the extent to which the medico-psychiatric professional remains in a position of relative power and control over the ability of the ‘trans’ woman to affect her own becoming. However, by looking at the ways in which those ‘trans’ women have experienced such a rigid diagnostic politics, as well as the ways in which they script their own becoming, we are able to bear witness to the ways in which ‘trans’ women are negotiating their becoming in relation to medico-psychiatric discourses, and at times seeking to stand outside of them as a means by which they can begin to narrativize in a way which more closely approximates their own experiences and subjectivities.
The purpose of this chapter is to bring together the theoretical and medico-psychiatric debates on trans becoming (Chapter 5) and my own empirical research (Chapter 6). Having documented the words spoken about transsexualism, its aetiology and its associated diagnostic politics, we are in a position to rethink the ways in which we understand the relationship between medico-psychiatry and trans-subjectivity, as well as to problematize the medico-psychiatric and clinical assumption of one ‘true’ and ‘authentic’ trans narrative. By bringing the findings of chapters 5 and 6 together we are also in a position to extend the inquiry of the first Theme, that is, to discuss the medico-psychiatric discourses on transsexualism and the way in which those discourses are worked through in clinical practice.

One of my main concerns throughout this theme has been to look at the ways in which the aetiology of transsexualism is understood within medico-psychiatric discourses, clinical practice, as well as by ‘trans’ women. It is from this that we can begin to think about the nature of the relationship between medico-psychiatry and trans-subjectivity, together with the extent to which they are informed by and interact with one another. It has also been my concern to look at the extent to which medico-psychiatric discourses are transferred uncritically into clinical practice.

Within the medical literature, there is a suggestion of two, somewhat mutually exclusive explanations at play – the (bio)logical and the psychological – which stress opposing ways of thinking about the aetiology of transsexualism. However, my own inquiries have lead me to suggest that aetiological understandings, as they exist within clinical practice, are far more varied and messy than medico-psychiatric discourses would seem to suggest.
The four thematic explanations (as discussed within Chapter 6) of the aetiology of transsexualism as it is understood within clinical practice: the 'wholly (bio)logical'; the 'psycho-social/developmental'; the 'fusion' approach, and the 'increasing trend towards the rejection of causality', are not however, as clear-cut as they might at first appear. It is my contention that these themes should not be treated as self-contained explanations, but instead, can be used to highlight the messiness of explanatory narratives surrounding transsexualism, as they exist within clinical practice. What needs to be recognized then, are the ways in which these stories combine and overlap with one another to produce a somewhat messy account of aetiology, which draws to varying degrees upon the (bio)logical and psychoanalytical paradigms discussed within the literature. Importantly, where overlap exists between medico-psychiatric discourses and clinical practices is in relation to the fact that those ‘gender specialists’ interviewed continued to rely on (although combined in different ways) the more traditional aetiological assumptions of Benjamin (1953, 1966) and Stoller (1968) as opposed to the more recent research which seeks to present transsexualism as an intersex condition of the brain (Gooren et al., 1995; Kruivjer et al., 2000). What becomes apparent is that the two principle accounts of trans aetiology found within the medico-psychiatric literature – the (bio)logical and the psychological – are taken up, synthesized or rejected by the individuals ‘gender specialist’ depending on her/his theoretical proclivities, rather than there necessarily being a strict adherence to one single explanatory account.

When comparing the ways in which the aetiology of transsexualism is scripted in both the accounts provided by ‘gender specialists’ and by ‘trans’ women we can clearly see the ways in which they diverge from one another, with ‘gender specialists’ preferring to think of transsexualism as resulting from a combination of psycho-social/developmental processes planted in a fertile soil of biology, or as a more heterogeneous process whereby what constitutes transsexualism in one person is different from that which creates transsexualism in another. In contrast, the ‘trans’ women I spoke to proffered a purely (bio)logical account of transsexualism which, as we saw in Theme 1, leads to their scripting of transsexualism as an intersex condition of the brain. In this telling of (bio)logical innateness, transsexualism is understood as constituting a legitimate medical condition.

Here then, we see an interesting juxtaposition between medico-psychiatric ‘becoming’ and trans-situated ‘being’. Stories of trans becoming as told by clinicians talk about aetiology, attributing it to a culmination of (bio)logical and psycho-social/developmental processes. However, when we look at those stories of ‘becoming’ as told by the ‘trans’ women involved in this research, we find a (bio)logical story at play, which talks more about ‘being’ than
'becoming', that is not a product of psycho-social/developmental processes, but the result of (bio)logical/developmental factors, which these 'trans' women have used to situate their being. From their perspective transsexualism exists prior to birth, rather than resulting from life experiences. In short, one is (born) trans, one does not become trans. Where a sense of 'becoming' is evident in the words of the 'trans' women I spoke to is in relation to 'becoming' comfortable with oneself; '(be)coming home – a journey of self-realization and eventual acceptance, and where surgery is sought, 'becoming' whole. It is through reading trans narratives as distinct from medico-psychiatric accounts, or at least the hegemonic discourses, that we can begin to rethink the relationship between medicine and social identity, whereby trans-subjectivity can be understood as challenging, in important ways, the standard medico-psychiatric accounts of trans becoming.

The findings of my research into the divergent ways in which trans becoming and aetiology are understood within medico-psychiatric discourses and clinical practice and by those 'trans' women involved in the research, allows us to problematize the sociological debates regarding the relationship between medico-psychiatry and trans-subjectivity. As we saw in Chapter 5, a number of scholars from feminism and medicalization theory, have sought to characterize the relationship as one of either duplicity (Shapiro, 1991; Hausman, 1995; Billings and Urban, 1996) or of blind conformity (Raymond, 1979; Shapiro, 1991). However, I would suggest, and as is borne out in my research, such a view must be considered problematic. To regard 'trans' women as dupes, the handmaidens of the medico-psychiatric profession is to negate the extent to which 'trans' women have historically been (as we saw in Theme 1) and indeed continue to be active in the construction of a trans identity, viewing them instead as passive receptors of cultural and medico-psychiatric messages and stories. Moreover, to level the charge of duplicity is to be somewhat patronizing, whereby the possession of knowledge renders the 'trans' woman fraudulent. Moreover, again it fails to recognize the active role that 'trans' women play in the construction of a trans sense of self, and the subsequent colonization and homogenization of that self which was discussed in Theme 1.

By moving beyond thinking of 'trans' women as being involved in a duped/duplicitous relationship with medico-psychiatry, the arguments presented here enable us to begin to problematize some of the assumptions presented within Transgender theory which are discussed in detail in Theme 3. Within much Transgender theorizing we see the call to reject the medicalization of trans bodies, as well as the suggestion that by surgically 'changing sex' many 'trans' women continue to espouse a medicalized narrative of their identity, which serves to reify sex/gender as 'naturally' and inevitably congruent. However, such
propositions only serve to homogenize the trans experience, and thus fail to pay attention to the range of trans subject positions. Moreover, it further serves to negate the extent to which ‘trans’ women have played an active role in the construction of a trans identity, which whilst subsequently colonized by medico-psychiatry, nonetheless exists as a valid trans subject position. Once again then, we see the homogenization of trans experience, and the reduction of that experience to one ‘true’ narrative, this time, not from within medico-psychiatry, but from those situated within Transgender.

We need then to re-conceptualize the way in which we understand the relationship and to understand the complexities and subtle differences between medico-psychiatric discourses on transsexualism and trans-subjectivity. My research reveals that whilst those ‘trans’ women interviewed articulated a sense of self framed within a medical framework – understood as constituting an intersex condition of the brain – that sense of self is diametrically opposed to those views currently espoused within British gender identity clinics, which as we saw in the previous theme, vehemently reject such a proposition. Thus, the failure of my trans respondents to articulate a sense of self within a Transgender border, whereby sex and gender become meaningless constructs, and the body fluid, does not thereby suggest that they are the dupes of the medico-psychiatric profession.

A final way in which my research provides fresh insights into, as well as confronts some of the literature with regards trans becoming, concerns the construction of a diagnostic politics. In Chapter 5 we saw the ways in which a rigid and standardized diagnostic politics has been constructed within medico-psychiatric discourses on transsexualism, which serves to perpetuate a belief in the existence of one ‘true’ trans narrative, which in turn accords with the typology of transsexualism discussed in Theme 1 – the ‘primary’ or ‘true’ transsexual (Stoller, 1968) who displays a certain pattern of behaviours or characteristics that have been taken as representative of the trans experience. This scripting of a ‘true’ trans narrative and its attendant diagnostic tropes (discussed in Chapter 5 and 6) – age of onset, sexual identification, performative and somatic markers and a desire for surgery – in many ways serves to extend the medico-psychiatric sphere of control over the bodies and lives of ‘trans’ women. This is especially pertinent given the clinician’s deployment of a hermeneutics of suspicion and the devaluation of personal experience and/or understanding, both within medico-psychiatric discourse and clinical practice. The construction of a sphere of influence on behalf of the ‘gender specialist’ serves to extend their realm of influence over trans-subjectivity, from as we saw in Theme 1, being able to define what transsexualism is, to being able to discuss who transsexuals are.
Furthermore, and in contrast to the previous discussion of the divergence between the ways in which the aetiology of transsexualism is scripted within medico-psychiatric discourse and worked through in clinical practice, there does appear to be far more overlap between the ways in which key diagnostic tropes are constructed within medico-psychiatric discourse and transferred into clinical practice. Again, we can make connections back to Theme 1 with regard to the ways in which medico-psychiatry has constructed transsexualism as a specialization over which it has 'expertise', together with the ways in which this 'expertise' has been formalized into clinical protocol as evidenced in the writing of the HBIGDA's Standards of Care.

The rigid standardization of a diagnostic politics, and thus the construction of an 'authentic' trans narrative, as it is scripted both within medico-psychiatric discourse and clinical practice has implications for the ways in which we are to understand trans becoming, in that it leaves little room for an individual to tell a story that does not comply within the medico-psychiatric scripting of 'authenticity'. As previously stated, in constructing and perpetuating the idea of one 'true' trans narrative, the medico-psychiatric profession have served to homogenize the trans experience, as well as the range of trans-subjectivities. It needs to be recognized that the fear of dismissal, or the fear of having one's 'desires' scripted as 'inauthentic' often propels those who do not articulate a sense of their self, or whose personal story does not accord with medico-psychiatry's scripting of the 'truth' of transsexualism, to conform to this medical type and thus silence the 'truth' of their subjectivity. Where then, it is possible to talk of trans duplicity is in relation to the needs of some 'trans' women to present a life history which will be accepted by the 'gender specialist' as evidence of their 'authenticity', even when that history does not necessarily match their personal experiences. Thus, the ability to live one's life often means that conformity (at least in the short-term) is a small price to pay, especially when the alternative does not bear thinking about. Moreover, and to reflect upon the discussions evident within Theme 1, a recognition of the active role played by 'trans' women in the construction of a trans identity, once again calls for us to problematize those assumptions of 'trans' women as medico-psychiatry's dupes.

By understanding the ways in which a trans sense of self existed prior to its medico-psychiatric naming, and thus conceiving of trans people as the original authors of transsexualism, together with a recognition of the ways in which that story has come to be co-opted by medico-psychiatry, we can again rethink the assumption that 'trans' women are simply involved in a process of reiterating a standard medico-psychiatric script. Rather, we are able to see the situation as one in which those 'trans' women whose sense of self was co-
opted by medico-psychiatry, through its formalization of one 'true' or authentic trans narrative, are instead narrating their own existence, and a sense of self which has remained consistent since it's formalization in the late nineteenth century.

By understanding 'trans' women as apart from the duped/duplicitous dyad, but as active agents in the construction of a subject position that came to be colonized by medico-psychiatry, and by recognizing the multiplicity of trans-subjectivities, we are in a position to move on to critically discuss some of the issues concerned with thinking in terms of an inclusive Transgender politics (Theme 3) that seeks to stand outside of the sex/gender binary as well as medico-psychiatric scriptings of 'trans' women’s identities. Thus, it is my contention throughout Theme 3, that whilst Transgender has made enormous strides in liberating transsexualism from a range of stigmatizing judgments, it unproblematically assumes that all 'trans' women should want to stand outside of such parameters of 'being'. Yet again, such a position potentially serves to homogenize the trans experience. Moreover, by calling for all 'trans' women to reject medico-psychiatric definitions, Transgender fails to pay attention to the ways in which, for some 'trans' women, that was their story, not a story purely constructed by medico-psychiatry. Furthermore, by calling for a queer approach to the destabilization of sex/gender categories, Transgender fails to recognize the ways in which 'trans' women, such as those involved in this research, do in fact, and in spite of their 'less queer' expressions of self, open up a conceptual space between 'female' and 'male', and as such problematize the 'naturalness' of a sex/gender binary more effectively than can a theory which, as we shall see, continues to have so much investment in the binaries that it seeks to overturn.
Theme 3

Resisting the Binaries?
The Politics of Trans.
"Why is it that we hand over to a group of psychiatrists and psychologists (a group of grey suited men who might have been cloned from the same Sussex stockbroker) the right to define OUR condition and pontificate on the complexities of OUR feelings about gender?"

(Hennessey, 1990-91. cited in Whittle, 2002: 19)

There is an increasing trend within the literature concerning the relationship between transsexualism and sex/gender, to deconstruct those normative assumptions about our gendered existence. Concordantly, there has been a trend within much trans academic literature and within certain sections of the trans communit[ies] to espouse a more radical, deconstructionist project, which, under the auspices of Transgender, seeks a place outside of the sex/gender system, and as such, aims to deliteralize the relationship between transsexualism, sex and gender. As a necessary juxtaposition, a number of feminist and poststructuralist writers have sought to suggest a situation whereby ‘trans’ women actually make literal the sex/gender system, by seeking a home within its rigid binaries.

The aim of this section is to provide an overview of the literature relating to the rise of Transgender as a politically motivated movement which seeks to reclaim the trans experience from the confines of a narrow and rigid medico-psychiatric definition, and from the shackles of sex/gender. However, it is also necessary to address that literature which stands against the ‘turn to Transgender’, and which sees such a perception as a radical denial of a legitimate subject position (O’Hartigan, 1993, 1995, 1996). As we shall see in this section, there are an
increasingly visible number of trans subject positions that are positioned to varying degrees along, or outside of the sex/gender binary. The intention of this theme then is to provide an insight into the relationship between transsexualism and sex/gender, and which necessarily moves us beyond thinking in terms of a literalizing/deliteralizing dyad. Moreover, by understanding transsexualism’s relationship to sex/gender, we are in a position to problematize Transgender’s somewhat unproblematic call for a turn to a queer politics which seeks to break away from both the shackles of a rigid sex/gender system, as well as rejecting the medico-psychiatric control of trans bodies. Here then, as with the previous two themes, I suggest that by recognizing the heterogeneity of trans subject positions we are able to move beyond simplistic typologies of a trans identity and its relationship to sex/gender.

Surveying the literature, Jennifer Harding (1998) makes a number of useful observations with regards to the organizational and ideological nature of sex/gender systems. Sex/gender systems have been described as “fundamental variable[s] organizing social life throughout most recorded history and in every culture today” (Harding, S. 1983: 316). As such, their purpose “is to delimit and contain the threatening absence of boundaries between human bodies and among bodily acts that would otherwise explode the organizational and institutional structures of social ideologies” (Epstein and Straub, 1991: 2). It is in this way then that sex/gender systems have been described by Rubin as being so fundamental to the organization of social life that the challenge presented to them by various transgender phenomena is widely felt to be deeply threatening (1975: 157-210).

I would argue that sex/gender needs to be understood as constituting what Mauss (1925) called a “social fact”, whereby social assumptions are based on the congruency of genitalia and gender identity. Despite the best efforts to deconstruct this ideological system of representation, the embodiedness of gender and material existence of sex continues to be an ever present reality in all of our lives. The necessary project is then to find a way of understanding sex/gender ‘reality’, which takes into account both the socially constructed nature of this binary way of knowing whilst simultaneously recognizing the structural constraints placed upon different ways of ‘being’.

Social constructionist theory has proved a useful tool in analysing the ways in which sex/gender operates within contemporary western societies. Thus, it is through the premise of social construction that we can begin to understand the relationship between transsexualism and sex/gender.
Many gender theorists applying social constructionist epistemologies to the binary gender system, argue that the very division of the world into two distinct genders correlated with two distinct sexes is an artefact of social construction and can and ought to be modified. Accordingly, gender roles are seen as social, political and institutional constructs. The essential axiom is that our understanding of what it is to be a ‘man’ or a ‘woman’, to be ‘male’ or ‘female’, is not something innate and unchangeable, and thus fixed in nature, but is rather, something that is created by and through social and historical forces. Thus, as Suzanne Kessler has urged, “we must use whatever means we have to give up on gender” (1998: 135).

Theories on the Relationship between Transsexualism and Sex/Gender

According to Prosser thinking of the body as a discursive effect (see also Stryker, 1998) has meant that the ‘trans’ woman, when considered in social theory, is thought of “as either a literalization of discourse – in particular the discourse of gender and sexuality – or its deliteralization” (Prosser, 1998: 13). The aim of this section is then to assess those theories that make sense of the transsexual body in terms of this literalizing/deliteralizing binary. Moreover, following Prosser, I will seek to show that “such interpretative frameworks effectively impose a constraint upon the variety of narratives” (Prosser, 1998: 15) of transsexualism, and their ability to achieve voice.

Transsexualism and the Literalization of Sex/Gender

As a social phenomenon, transsexualism has often been criticized for being conservative or essentialist. So, for example, Irvine (1990) has accused transsexualism of not living up to its radical potential as a political movement, because trans people, from this perspective, are said to reinforce the sex/gender system rather than challenge the boundaries they seek to cross.

One theoretical perspective from which transsexualism has been critiqued for its literalization of the categories of ‘gender’, ‘sex’ and ‘sexuality’, is that of poststructuralism and especially feminist poststructuralism, which has at its heart the very deconstruction of such ‘fictive ontologies’ (Butler, 1990). Here then, the ‘trans’ woman is said to “reinscrib[e] as referential the primary categories of ontology and natural …” (Prosser, 1998: 13) that stands as the antithesis of poststructuralist deconstruction. The intention of poststructuralism is to make
apparent the ways in which subjects are constructed in and through language and social institutions. Here then, rather than seeking to suggest the ‘naturality’ and inevitability of identities and subject positions, poststructuralism seeks to examine the ways in which they have been constructed within social life.

Building upon the work of Foucault (1976, 1979; see also Theme 1), Butler (1990) argues that because sex/gender can be thought of as being constructed in and through discursive and non-discursive practices, they must be thought of as ‘fictive’. From this, Butler argues that we are able to move beyond thinking of the body as possessing a pre-given, essential sex. Instead, Butler contends that bodies are made intelligible through gender, and as such “cannot be said to have a signifiable existence prior to the mark of gender” (Butler, 1990: 8). Our bodies are not then ‘naturally’ gendered, but rather they come to be gendered through a continual process of performance. Butler’s understanding of the fictionality of gender categories and the performative utterances which “congeal over time to produce the effect of identity” (1990: 33), has been instrumental in understanding the ways in which ‘trans’ women can be said to literalize sex/gender by reifying its claims to ontology. For Butler, gender identities acquire stability through a range of available discourses which serve to delineate the body. Moreover, that these discourses are framed within a rigid heterosexual matrix means that for Butler, identities are always and necessarily normative.

Butler does concede to the potential subversiveness of such performative displays as drag and transsexualism which effect a ‘feminine’ identity: “the proliferation of sexual acts performed in non-heterosexual contexts thus disrupt and weaken normative gender framings” (1990: 31). But it is important that we present a real challenge to the ways in which she negates trans identity. Ultimately for Butler, trans people can only offer “an uncritical miming of the hegemonic” (1993: 131). Moreover, Butler’s (1997) understanding of agency and identity as being formed through the internalization of discourse, whereby an autonomous sense of self is constructed which lacks an essentialized base, fails to account for the fact that many ‘trans’ women experience a sense of self which is different from their bodies. In this way then, we need a model that understands the ways in which trans-subjectivity often rests upon an assumption of innate gender, and not upon its mere performative utterance.

Other writers from within poststructuralism have also seized upon transsexualism as providing evidence for the literalization of sex/gender. Thus, Marjorie Garber condemns the collapse of the signifier into referent when she states that trans people “essentialized their genitalia” (1992: 98). Here then, transsexualism is critiqued for positioning the sexed body
before language. Taking up the positions of Butler (1990) and Garber (1992) queer theorist Carol-Ann Tyler argues that “[t]ranssexualism literalizes the loss patriarchy tropes as woman.” (1989: 163). That these theorists, who conceive of transsexualism as the literalization of sex/gender binaries give scant theoretical attention to the experience of transsexualism is of little surprise. Within this paradigm then, “the narratives of transsexuality have yet to be carefully read” (Prosser, 1998: 13-14).

Criticisms of transsexualism making literal the sex/gender system can also be found in the words of psychoanalytic feminist Catherine Millot. Following in the tradition of Lacan, Millot argues that, “in the requirement of truth … transsexuals are the victims of error. They confuse the organ and the signifier.” (1990: 143).

Probably the most damning critique of transsexualism’s supposed literalization of, or conformity to, the sex/gender binary, comes from radical feminists, and most notably Janice Raymond (1979) and Shelia Jeffreys (1996). Raymond’s 1979 publication The Transsexual Empire: The Making of the She-Male, has become the most (in)famous attack on ‘trans’ women’s claims to ‘gendered realness’ that exists today. For Raymond, ‘trans’ women literalize the sex/gender binary as a result of holding conservative views about what it means to be a ‘man’ or a ‘woman’. For Raymond then, despite the fact that ‘trans’ women can be seen as ‘deviant’ in terms of the cultural norms about how someone becomes a man or a woman, when they get there they seem to hold very conservative views about what to do or how to behave.

Raymond’s criticism then is that rather than helping to show that femininity equates with oppression, and the need to break away from such a rigid stereotype, ‘trans’ woman actually conform to it. In a similar vein, Raymond accuses ‘trans’ women of reducing “gender resistance to wardrobes, surgery or posturing – anything but real sexual equality” (Raymond, 1996: 223). If Raymond’s claims are true, and ‘trans’ women do little more than reinforce the values of a white, heterosexist patriarchy, then as Whittle contends ‘trans’ women would be “struggling to become the oppressed, and to leave behind a position of privilege” (2001: 155).

In a vein similar to Raymond, Jeffreys suggests that transsexualism provides evidence for “the lengths to which it is possible to go to reproduce heterosexual desire” (1996: 82). For Jeffreys, gender is conceived of as a “vital force in constructing and maintaining heterosexuality as the scaffolding of male supremacy” (1996: 75). It is from such a critical standpoint that Jeffreys concludes that in order for heterosexuality and heterosexual desire to
operate, a bi-polar system of gender difference, which conceives of ‘femininity’ as equating to submission and of ‘masculinity’ as equating to domination, is essential. From this, Jeffreys postulates that what she regards as the ‘trans’ woman’s enactment of ‘archetypal femininity’ is in fact the product of a series of learnt behaviours, which sanction and reproduce the submission of women. The power of heterosexuality as a “political institution” (Jeffreys, 1996: 78) is then in its ability to dissipate those practices which are potentially dangerous, and bring them neatly back into a position of conformity.

By viewing as essential the relationship of heterosexual desire to gender, Jeffreys argues that “[t]ranssexualism ... maintains gender; ... by accepting gender and its rules as real and inevitable and demanding only the right to swap rather than evacuate gender” (Jeffreys, 1996: 85). However, this is somewhat of a simplistic argument which fails to account for the ways in which transsexualism has, and continues to demonstrate the futility of thinking in terms of the ‘naturalness’ of sex/gender. Further to this, Namaste argues:

“Once we acknowledge the energies transsexuals have invested in repealing legislation that enforces a compulsory sex/gender system, it is impossible to reduce transsexual identities to those that enact an ‘uncritical miming of the hegemonic’.

(2000: 14)

Moreover, by insisting that ‘trans’ women merely ‘swap’ genders, Jeffreys fails to account for the growing number of ‘trans’ women who, whilst not identifying as Transgender, continue, in subtle ways to dismantle sex/gender bi-polarity through their identification as ‘trans’ women as opposed to merely ‘women’.

As with Theme 2, we again see the construction of ‘trans’ women as the dupes, not this time of the medico-psychiatric profession, but of the sex/gender binary. However, this is a somewhat simplistic reading, if not a mis-interpretation of ‘trans’ women’s relationship to sex/gender. That is, by taking ‘trans’ women at face-value, theorists who subscribe to such a premise can be said to fail to look at the wider issue and as such see the ways in which the lived experience of trans actually opens up a conceptual space between, rather than reifying the categories of ‘male’ and ‘female’. Moreover, by subscribing to a literalizing view of ‘trans’ women, such theorists seek to position ‘trans’ women as feminism’s ‘Other’, by assuming that their relationship to sex/gender is radically different from other ‘female’ subject positions. Theorists who seek to understand transsexualism as the literalization of sex/gender
discourses fail to recognize the ways in which sex/gender has come to assume the role of a ‘total institution’ (Mauss, 1925). It appears troubling then, that a number of feminist scholars should discredit the fact that the same institutional forces that have for so long oppressed women, are also at play in the oppression of ‘trans’ women. What is needed then is a feminist theory that can accommodate all forms of gendered expressions and which opens up the ‘sisterhood’ to include ‘trans’ women.

Transsexualism and the Deliteralization of Sex/Gender

As we have seen, a number of theorists from within the poststructuralist tradition have conceived of ‘trans’ women as reifying sex/gender. Yet a number of scholars from within poststructuralist theory have also located transsexualism on the other side of the literalizing binary. Here then, trans is read as involved in a process of deliteralizing the gendered body – positioning the signifier of sex beyond the body.

In this vein, Epstein and Straub posit the question of “[w]hat is more postmodern than transsexualism?” (1991: 11), whilst for Kroker and Kroker, transsexualism demonstrates how sex should be: “sex [that] has fled its roots in the consanguinity of nature, refused its imprisonment in the phallocentric orbit of gender” (1993: 15). For Judith Halberstam (1994), the transsexual is the pinnacle of postmodern identity, whereby the process of transition illustrates the ‘fictionality’ of gender.

Support for a poststructuralist deconstruction of sex/gender can also be found in the writings of a number of Transgender authors who argue for a gender fluid world, which Plummer succinctly captures when he states that:

“What seems to be sought is a world of multiple gendered fluidities – a world at home in a postmodern cacophony of multiplicity, pastiche and pluralities that marks the death of the meta-narratives of gender which have dominated the modern world. The claim, as Whittle so precisely puts it ... is to ‘live outside of gender.’”

(Plummer, 1996b: xvi)

Transgender can be defined as a politically motivated movement, which seeks to reclaim the trans experience from the confines of a narrow and rigid medico-psychiatric definition, as
well as from the shackles of sex/gender. These two paradigms — medico-psychiatric control and sex/gender rigidity — acting in concert curtail those presentations of self which do not conform to the normative assumptions entrenched within the discourses of a heterosexual, sex/gender system. The literature relating to this area suggests the dawning of the age of Transgender — a politicized identity category which has at its heart the deconstruction of those binaries, which have thus far limited the trans experience to a standard medical type. By understanding (trans)gender as socially constructed, this movement is critical of ‘normative’ trans expressions of self, which it regards as constituting a failed effect. Transgender theory then literally fucks with our normative assumptions about sex/gendered and sexual ‘reality’. Contained within trans academic writings, this project of gender deconstruction is made explicit. Thus for example, Nataf (1996) suggest that Transgender highlights gender and sexual ambiguity and fluidity, while Bornstein (1994) describes the multiplicity of gendered possibilities, whereby those who identify as Transgendered are able to escape the cultural imperative to be a ‘man’ or a ‘woman’. Likewise, Cameron, et al (1996) see transsexualism as existing in a place outside of duality.

Queer theory has arguably taken the deliteralizing/deconstructive project of poststructuralism one step further, and argues for the subversive potential of transsexualism, through its ability to challenge the assumption that sex, gender and sexuality are fixed and rooted in biology. What queer theory does then is to deconstruct the sex/gender binary and to present a challenge to the idea that certain sexed or gendered behaviours are either unnatural or deviant, and in this way, queer theory is concerned with ‘gender fuck’ (see Whittle, 1996). One of the central tenets of queer theory is to demonstrate the ways in which sexual and gendered identities are textually produced. Moreover, by rejecting individualistic agency, reaffirming the productive nature of power, and questioning the basis of political action, queer theory seeks to envisage a different kind of sexual and gendered politics (Namaste, 2000), which embraces all forms of dissident sexuality, which each demand “visibility in the straight world” (Segal, 1999: 56).

It is perhaps easy to see why queer theorists have supported a view of transsexualism as a perfect example of the deliteralized body as well as highlighting the ways in which gender can be said to be socially achieved and performed. Because the trope of transsexualism is that it crosses the borders of sex and gender it clearly demonstrates the malleability of the sexed body. In this way then, the sexed body does not necessarily fix a person’s gendered sense of self (Garber, 1992). By crossing the boundaries of sex/gender, the ‘trans’ woman, from a queer perspective, is able to challenge the assumption of man/male/masculine and
woman/female/feminine. So rather than perpetuate the idea of congruency between the sexed body and the gendered self, the trans body, within queer theory is treated like a blank canvas which the person uses to construct their own unique sense of self, playing with their body as opposed to positioning themselves within the sex/gender binary (Cameron et al, 1996).

However, it is impossible for theorists who advance a deliteralized view of transsexualism to fully account for the nature of the trans experience. It cannot account for the importance of the body in understanding the self, nor can it account for the difference between sex and gender identity and, most importantly, it cannot account for the overwhelming desire for the majority of trans people; the ability to pass as really gendered in the world without trouble. Moreover, the actual number of ‘queer transsexuals’ is very small, with those that do proclaim such an identity often afforded a certain level of protection as a result of being academics, performance artists and the like. Thus, the claim of queer theory - that trans people should revel in their ‘Outsider’ status – as desirable as that might be, does not help those hundreds or even thousands of trans people who have been discriminated against, abused, attacked or even killed, precisely because of that ‘Outsider’ status (Califia, 1997). What gets dropped from queer theory’s understanding of transsexualism is the one thing that most concerns so many trans people – living in the world as a man or a woman rather than simply performing one. Whilst my research shows that a number of individuals are claiming pride in their trans status and wish to be recognized as such, a great many more wish only to be known women.

As Ken Plummer (1996b) usefully points out, queer theory harks back to those binaries that it seeks to transcend. Thus, it is important to recognize that there is no such thing as a complete break, which will liberate us from the shackles of sex/gender. So even if we accept that transsexualism challenges the (bio)logical basis of gender, it is important to recognize that any ‘new’ expression of gendered selfhood will ultimately continue to be defined in relation to the very sex/gender system that it is seeking to disrupt. What queer theory misses then, in viewing transsexualism as disruptive to the established norms of gender, is the institutional nature of sex/gender, which hinders the development of alternative expressions of self.

What I suggest instead, following the work of Prosser (1998) is that it is only through listening to what trans narratives are actually saying that we are able to more fully appreciate the need for a theory that can account for both gendered embodiment and sexed materiality. A theory that centralizes the importance of narrativization in the formation of a trans identity is, I suggest, a means by which we can begin to rethink the relationship between transsexualism and sex/gender.
Reading Trans Narratives: Clues to the Relationship with Sex/Gender

Prosser (1998) makes claims to the inadequacy of the literalizing/deliteralizing binary, as well as the attendant subversive/hegemonic dyad, when considering the relationship between transsexualism and sex/gender. However, that current theorizing on the subject seems so imbued with this way of knowing means that the ability to move beyond it seems impossible.

“Perhaps we might begin our conceptual transitions by reading transsexual narratives to rupture the identity between the binaries, opening up a transitional space between them” (Prosser, 1998: 16). Because trans narratives, understood by Prosser as ‘body narratives’ both engage with gendered embodiment whilst allowing for changes in somatic materiality the task of rupturing identity between the binaries of literalization/deliteralization is made possible. What we needed then is to re-evaluate and re-value our understanding of what is essential. To simply disregard essentialism is not helpful to any project trying to understand those identity positions, which are so invested in the body. It is because the trans narrative cannot be read apart from the subjective experience of being trans, that our reading of them necessitates “the risk of essentialism” (Sedgwick and Frank, 1995: 513). This is because trans narratives are experientially derived, whereby “the body, sex, feeling, belief, lie in an immanent self” (Prosser, 1998: 17), and as such, we cannot make sense of them without making use of essentialist concepts. The task then is to move away from the assumption that such categories require a priori deconstruction.

Furthermore, the juxtaposition of the literalizing/deliteralizing binary allows us to bear witness to another binary superimposed upon it, that of reinscriptive/transgressive. Contemporary theory has tended to attach value connotations to the literalization/deliteralization binary, whereby the former becomes regarded as hegemonic and hence ‘bad’ and the latter as subversive and hence ‘good’ It is because of such an unfortunate and indeed formulaic means of reading, that even those theories that “purport to value multiplicity, difference and the deconstruction of binaries” (Prosser, 1998: 14-15) have failed to attend to the specificity of trans narratives. As Prosser shows us, trans narratives

“return us to the complexities and difficulties that inevitably accompany real-life experiences of gender crossing and the personal costs of not simply being a man or a woman ... [where] transition often proves to be a barely liveable zone.”

It is only by moving away from imposing a reading of trans narratives as either literalizing/hegemonic/bad or deliteralizing/subversive/good, and instead allowing trans narratives to speak for themselves that we are more able to fully understand the relationship between transsexualism and sex/gender, without the imputation of theoretical prejudice. Moreover, it is through conceptualizing trans becoming outside of a queer paradigm that we are able to see more effectively the ways in which the lived 'reality' of trans and its subsequent gender crossing, plays with and destabilizes our insistence upon the 'naturalness' of sex/gender congruence, than does a queer politics which harks back to, and hence reaffirms the existence of those binaries that it seeks to deconstruct.

Transgender: The Rise and Reality of a Political Movement

Transgender activism emerged as a ‘new’ movement (Gamson, 1995; Califia, 1997) in the 1990s. Originally “a U.S based effort” (Whittle, 2001: 153) its effects spread to the U.K during the latter half of the decade. Whilst the original use of the term ‘transgender’ was to signify a cultural space between the transsexual and the transvestite (Boswell, 1991: 31; Cromwell, 1999: 23), it has subsequently come to act as an umbrella term for the rich diversity of trans-situated identities (Whittle, 1996; Stryker, 1998: 149; Cromwell, 1999: 23). In so doing, it encompasses a whole host of ways of ‘being’ ‘male’ or ‘female’ that serve to problematize our dichotomous notions of sex (Stone, 1991; Denny, 1991: 6; Boswell, 1991; Feinberg, 1993b; Bornstein, 1994; Nataf, 1996: 32; Califia, 1997).

A Change of Emphasis: New Aims for a New Age

Prior to the emergence of this radical identity movement, its predecessor – transsexual activism – took as its key motivation, the gaining of social acceptance for post-surgical transsexual individuals (Califia, 1997). As such, the goal of transsexual activism was to allow, through a process of (re)educating the medico-psychiatric profession, the trans person quick and easy access to the technologies of sex reassignment, and ultimately, to the recognition and acceptance of trans individuals as members of the subjectively experienced gender, “as if they had been assigned that sex at birth” (Califia, 1997: 245). Contrastingly, the politicisation of Transgender is directed principally toward the failure of medico-
psychiatry to accommodate the rich diversity of (trans)gender experience (Hale, 1995: 20; Califia, 1997: 224; Cromwell, 1999).

The Transgender epistemology presents a challenge to medicine's reduction of trans 'authenticity' to the desire to sex reassignment surgery. In doing this, Transgender calls for the reconceptualization of the 'wrong body' narrative, which normalizes and contains the 'threat' of trans-situated behaviours to sex/gender (Cromwell, 1999: 23). Transgender is about the refusal to accept the 'solution' of SRS as offered by medico-psychiatry. Instead, Sharpe (2002) argues that many Transgender people have come to consider their anatomy and psychology "to be harmoniously male or female even though and precisely because, it is located outside either sphere of medico-legal binary constructions of sex" (Sharpe, 2002: 35). Furthermore, it presents a challenge to the medico-psychiatric privileging of a unitary and standard trans narrative. In line with this, particular counter discourses have been generated to challenge medical assumptions of the trans person's hatred of their genitalia (Nataf, 1999: 25; Califia, 1997: 185-6; Cromwell, 1999: 10-12) and their sexual identification as principally heterosexual in orientation (Bolin, 1998; Lewins, 1995; Nataf, 1996; Califia, 1997). It is in this way then that Transgender refuses to identify in terms of a hetero/homo dyad.

One of the main counter discourses to be generated as a result of this 'turn to Transgender', and the consequent reordering of experience away from the conceptual limits of a medico-psychiatric definition, is, as Whittle (2001) discusses, a demand for status recognition, not as men or women, but precisely as 'trans' men and 'trans' women. It is then, through the recognition of a legitimate identity category of 'trans' that Whittle argues the community will be afforded true protection (2001: 4). Concordant with this change in the community's call for status recognition, is a change to the way in which 'passing' is perceived within the community. Thus, this new Transgender community is forgoing passing and hence invisibility, in order to actualise an 'authentic self' (Stone, 1991; Whittle, 2001: 5) rather than a medically constructed self. The issue then is one of pride, Transgender pride.

Moreover, the reconceptualization of 'passing' and the reordering of trans experience along Transgender lines are evident, according to Whittle (2001), in the changing nature of legal activism, whereby the Transgender community are again asking to be recognized as occupying a space outside of the normative male/female dyad.

The result of this 'turn to Transgender' is, according to Whittle, that
"the community has been ... reordered. ... Essentially, we no longer see
the definitions provided by the medico-profession being adopted by the
community as its boundary distinguishers" (2001: 159).

There has been then, according to Whittle, a move away from a medically naïve paradigm
"which excludes most people to a complex paradigm which is inclusive rather than exclusive" (Whittle, 2001: 159). However, as we shall see in the next chapter, this is perhaps a little
optimistic, with a hierarchy along Transgendered lines an ever-present reality. The perceived
need for exclusivity is especially evident among much of the trans communities, who fear that
the move towards inclusivity will present a challenge to their social acceptance. For them, the
need to be distinguished from other Transgendered people is a real one, premised on a
dichotomy of need versus choice. Much of the drive towards the maintenance of exclusivity
is a result of, or is reflected in the current battle for the achievement of legal recognition.
Here then, more than ever before, trans is juxtaposed with Transgender, with the former being
understood as a legitimate medical condition and the latter as a lifestyle choice. The
perception is then, that an inclusive Transgender approach will curtail important shifts in the
social and legal recognition of transsexualism, through continuing to conflate it with other
form of trans-identification, such as transvestism, cross-dressing, drag and Transgender.

Whittle (2001) also contends that the shift away from the medicalization of transsexualism
has meant that the community’s boundaries are no longer premised on surgical demand, or
controlled by physicians. However, again such a view is unfortunately problematic, in that it
has not been reciprocated with an attendant shift in the attitudes of medico-psychiatric
professionals. Moreover, surgery continues to be a crucial reality, with the promise of
eventual legal recognition fixing it as its definitional limit. Finally, the suggestion of a
decline in the authority of medico-psychiatry is something that was not borne out in my own
research, with most psychiatrists in particular continuing to reject self-diagnosis as in any way
a reliable predictor of a person’s sense of self. In this way, the medico-psychiatric profession
continues to pay only lip service to trans-subjectivity.
The ‘turn to Transgender’ has been argued to have created a situation whereby a growing number of individuals have sought inclusion under a new political identity category (Whittle, 2001; Califia, 1997). Rather than accept the ontological ‘reality’ of sex/gender, they have sought to question and destabilize that entire binary system. This new Transgender activism sought to politicise the trans experience, with many of its forerunners calling for trans-identified people to direct their attention towards the elimination of the categories of ‘male’ and ‘female’ – that is, to break free from the shackles of sex/gender, and to embrace fully, a conception of personhood, free from the constraints of limited and oppressive binary ways of knowing, which bear little relation to the ‘reality’ of gendered experience. Califia, (1997: 245) provides evidence for this ‘turn to Transgender’, stating that it coincided with the rise of gender-variant or ‘queer’ identities, such as third-gendered, two-spirited, both or neither gender(s) – who all “insist on their right to live without or outside of the gender categories that our society has attempted to make compulsory and universal.” Theorists from a number of disciplines have used this ‘turn to Transgender’ as an opportunity to dissect and deconstruct the whole system upon which our sex/gender ‘reality’ exists.

The Post-Transsexual: Politicizing and Re-Conceptualizing Transsexual Identity

Trans activist and scholar Sandy Stone in her seminal piece *The Empire Strikes Back: A Post-Transsexual Manifesto* (1991) proffers an insightful challenge to the way in which transsexualism has been constructed by medico-psychiatric discourse, and subsequently reaffirmed in legal jurisprudence, and the limitations this places upon sexed embodiment.

Concerns over the medicalization of transsexualism as it is formulated within radical trans politics, such as that proffered by Stone, relates to the need to highlight gender relative to questions akin to a racial politics. Radical trans politics also incorporates a critique of the violation of cultural values and beliefs about the relationship between sexed embodiment and gendered materiality that medico-psychiatric and legal discourses represent. In line with this theorizing, Stone calls into question the mechanisms by which the trans experience has been analysed. For Stone, the medico-psychiatric colonization of trans-subjectivity incorporates an:
initial fascination with the exotic extending to professional investigation;
denial of subjectivity and a lack of access to the dominant discourse;
followed by a series of rehabilitation”

(Stone, 1991: 137)

Stone’s thesis strives for a new type of trans politics, one that does not seek acceptance and thus disappearance within the normative categories of sex/gender, but instead challenges those assumptions and turns them on their head. By presenting the possibility of subverting the dominant discourses drawn upon and indeed maintained by medico-psychiatry, Stone contends that trans individuals should, rather than occupy a position of complicity, stand and “seize upon the textual violence inscribed in the transsexual body and turn it into a reconstructive force” (Stone, 1991: 295). Stone’s position is that those trans people who “live to pass (and pass to live)” (Roen, 2001: 255) be ‘recruited’ from the realm of the invisible, where ‘plausible histories’ are maintained, to insist upon the promulgation of “the genre of invisible transsexuals” (Stone, 2001: 296). It is the possibility of identifying as visibly trans, and consequently challenging the binary male/female, that Stone describes as ‘posttranssexuality’, an identity category in which the bounds of culturally intelligible gender are expounded.

The Shift from Radical Transsexuality to Transgender

Following on from Stone’s ‘posttranssexuality’, a growing number of scholars and activists (Feinberg, 1992; Bornstein, 1994, Halberstam, 1994; Stryker, 1994) began to speak of different kind of politics, which while continuing the theme of the deconstruction of sex/gender, also spoke of inclusivity for all individuals who in some way present a challenge to normative sex/gender – that is, individuals who ‘do’ gender ‘differently’. The term ‘Transgender’ was used to capture this new way of organizing and thinking about identity.

As explained by Leslie Feinberg (1992) in a pamphlet entitled ‘Transgender Liberation: A Movement Whose Time has Come’, Transgender activism and indeed identification should be recognized as distinct from previous transsexual organizing:

“In recent years a community has begun to emerge that is sometimes referred to as the gender or transgender community. Within our community is a diverse group of people who define ourselves in many
different ways. Transgendered people are demanding the right to choose our own self-definitions.”

Scholars and activists writing from within this new identity category have suggested a number of insights into what this ‘new’ movement should look like, all pivoting around the deconstruction of sex/gender. Judith Halberstam (1994) argues for the ability of Transgender to highlight the ‘fictionality’ of gender, through the postmodern mix-match of body parts. Halberstam’s project is centred on the need to deconstruct the idea of ‘crossing’, in terms of the trans person’s shift between or among gender categories. Instead, she proffers a theory which conceives of us all, trans or not, as in fact transsexual, and thus involved in the ‘fiction of gender’. The ‘gender fictions’ to which Halberstam refers are:

“[F]ictions of a body taking its own shape, a cut-up genre that mixes and matches body parts, sexual acts, and postmodern articulations of the impossibility of identity.”

(1994: 210)

Building upon Stone’s (1991) call for transsexual visibility, and Halberstam’s claims about the ‘strangeness of all gendered bodies” (1994: 226), Susan Stryker (1994) talks about what she calls ‘transgender rage’. It is through this idea of rage that Stryker reclaims the notion of monstrosity, through a subversive identification with Frankenstein’s monster. In this way Stryker proclaims that:

“As we rise up from the operating tables of our rebirth, we transsexuals are something more, and something other, than the creatures our makers intended us to be.”

(1994: 242)

The specific concern of Stryker’s ‘monstrosity’ is with the motivations of medical science and its relationship with trans agency. Stryker sees the reclaiming of ‘monstrosity’ as a means of affirming the possibility of investing in medical processes of transsexing without maintaining the gender binary. According to Stryker, despite the normalizing strategies contained within medico-psychiatry, there is no guarantee of the “compliance of subjects thus embodied with the agenda that resulted in a transsexual means of embodiment.” (1994: 242).
Finally, Kate Bornstein, in her 1994 publication ‘Gender Outlaw’, uses the concept of Transgender as a means of rejecting the traditional trans narrative, and specifically the trope of ‘wrong embodiment.’ Bornstein’s rejection of the orthodox trans narratives stems from her assertion that it is not sex that is changed, but gender. Thus, her motivation for ‘changing gender’ was not so much that she felt like a woman – “I have no idea what ‘a woman’ feels like” – but that she “was not a boy or a man” (1994: 24). According to Bornstein, the trope of ‘wrong embodiment’ which forms the cornerstone of traditional trans narrativization, is far from being a true reflection of the ‘reality’ of Transgender, but is instead “an unfortunate metaphor that conveniently conforms to cultural expectations” (1994: 66).

For Bornstein, it ought not be necessary for the trans person to undergo surgery to achieve bodily comfort; a claim underpinned by her belief that gender is mythical, a social construction enforced by culture, but with no (bio)logical or psychological reality. Rather than conceiving of trans people as being born in the wrong body, Bornstein contends that in fact they bridge the female/male divide or combine them in varying ways. Thus, it is not possible, from this perspective, for trans people to become men or women. Moreover, and as a consequence of the rigid medicalization of transsexualism, Bornstein claims the life histories and desires of trans people have been distorted, and as such the sex/gender system has been maintained.

Not totally rejecting gender reassignment, Bornstein believes that it continues to be necessary for some in order that they reach a comfort zone within themselves, however, she does present an alternative option:

“Now there’s a new generation of transsexuals who are assessing their journey not as either/or, but as an interrogation, as a whole. In by-passing their either/or construct ... these new transsexuals are slipping out from under the control of culture. And a whole new sub-culture is being born.

Many people divide transsexuals into pre-operative and post-operative, referring to genital conversion surgery. I want to include the option of a ‘non-operative’ transsexual – someone who doesn’t opt for genital surgery.”

(Bornstein, 1994: 120-121)

However, as with any new social movement or identity position, the shift from trans to Transgender has not been uniformly accepted, but has instead been a great source of debate
and controversy, with some trans people adamantly rejecting its epistemology and desire for apparent inclusivity.

I'm Not Queer! The Problem of Transgender

Theories on the subversion, and deconstruction of gender, such as that advanced by Bornstein (1994) are controversial both within and outside of the trans communities, with many people both objecting to the use of Transgender as an umbrella term on the one hand, and to the idea that it is gender and not sex that is transcended in the individual's quest for comfort and home on the other. One of the most vociferous rejections of Transgender comes from the transsexual activist and scholar Margaret Deidre O'Hartigan (1993, 1995, 1996). O'Hartigan's rejection of Transgender can be evidenced in the following quotation, which is worth citing at length:

“Naming is power. ... The beginning or end of freedom lies in the power to name ourselves – or others.

There are names for people such as I – transsexual, gallae, changeling, male-to-female, sex change. These names describe us: what we’ve done, what we do ... what we’ve done is change sex; we shape shift; we transform ourselves from one form of humanity to another.

This power of ours to transcend the human form we were given is too much for some people to bear contemplating; they would deny us our power, they would deny us our names. ... These people would pin their own labels. These people would have us be eunuchs, or freaks, or simply men – or transgender.

Every application of the term transgender to me is an attempt to mask what I’ve done and as such co-opts my life. Like the hijra of India and the gallae of Rome I took cold steel to myself and proved that anatomy is not destiny. Like the Siberian Chukchee Shaman, I have died and been taken apart, reassembled, changed sex, and come back with new powers. Like the inkte of the Mdewakanton Sioux I grew up amongst, I have had my visions.

I am not transgender.”

(O'Hartigan, 1993: 20)
In contrast to Bornstein (1994) O’Hartigan denies that she has changed her gender, since gender is socially constructed. Instead, for her, it is sex that has been changed. It is from this position that she talks about “the desperate desire to escape life in an alienating body which epitomizes the transsexual experience” (O’Hartigan, 1996: 15). O’Hartigan’s words then would appear to form a majority position from which most of those ‘trans’ women involved in my research spoke – that is of sex reassignment as being a medical necessity not a cosmetic artefact, and the rejection of an inclusive approach to community politics.

Whilst the increasing visibility of trans people and the move towards the proclamation of the identity category ‘trans’ as opposed to ‘man’ or ‘woman’, is undeniably something which was born out in my own research, equally however, this is not a reality for all. As Nataf explains, “[O]f course people’s experiences vary, and many find their sense of gender identity approximates closely to one of the two accepted genders in the binary system” (1996: 16).

Here then is the limit of Transgender. Moreover, the idea that a Transgender expression of self is more ‘authentic’ than that, which approximates more closely the medico-psychiatric scripting of transsexualism and thus the sex/gender binary, becomes problematic when we rethink the history of trans-situated identities. The medico-psychiatric scripting of transsexualism was indeed an imposed paraphilia for some, who as a result, lost the uniqueness of their personal history. However, if we remember that trans-situated identities are multiple and diverse and that the story so standardized by medico-psychiatry was originally a trans-situated story of ‘being’, then we can only conclude that all forms of trans experience are authentic. What has changed is that more and more trans people are being allowed the freedom to speak a story which differs from the medically co-opted and standardized script. In this way then, the rise of Transgender expression represents, not necessarily the turn to a truly ‘authentic’ experience for all, but simply that the variety and richness of trans-experiences are finding both a language and a platform from which to more safely speak.

Conclusions

As we have seen in the previous themes, since the inception of trans within medical discourse, the medico-psychiatric profession have held an enormous amount of power over the lives and subjectivities of those whom they purport to ‘treat’. However, much is beginning to change.
The rise in, and politicisation of many trans people has created a situation where the once silenced are pulling off their gags and are beginning to speak up without fear of reprisal from a profession that has attempted (effectively up until now) to mediate their existence. However, trans activism, and specifically Transgender activism, and the changes that it brings are not necessarily considered desirable by all members of the various trans communities. What we see then is the need almost, to take a middle ground, and one that recognizes that the total disavowal of medico-psychiatry brings with it a plethora of problems.

The problem with Transgender, deconstruction of gender categories and its rejection of medicalization and surgical necessity, is that it serves to exclude a very ‘real’ and legitimate subject position. What we need to recognize then is that trans identification is not a homogeneous entity, but instead consists of a number of subject positions, with each occupying a distinct relationship to the sex/gender binary. It would be a mistake to think of that trans narrative promulgated within medico-psychiatric discourse as being only constructed in and through that discourse. Instead, it exists as a legitimate trans subject position, which ‘fortunately’ for some and ‘unfortunately’ for others, became co-opted by medico-psychiatry and consequently epitomized as the only or ‘true’ trans narrative. What we need then is a theoretical position that recognizes and accepts the various positions from which trans subjects speak, and have always spoken. It is from such a perspective that we can understand that those speaking in a language similar to that of medico-psychiatry – wrong embodiment, genital hatred, early onset, surgical necessity – are speaking a legitimate position, which ‘trans’ women themselves were active in constructing, not one simply capitulated from medico-psychiatry. Such a position also allows us to recognize and accept the legitimacy and authenticity of those who speak from an identity position which position themselves outside of the normative sex/gender binary.

Moreover, and as we shall see as this theme unfolds, the use of the term Transgender as a means by which to identify all those individuals who identify outside of the position of normative sex/gender, raises serious concerns for many trans people, with regards to issues of legitimacy and authenticity. We are witnessing what promises to be an exciting time in trans politics, with the British Government promising to come in line with the rest of Europe and thus grant the trans person legal recognition in their subjectively experienced gender. Since the landmark ruling in the case of Corbett v Corbett (1970), which sought to determine the sex, for the purpose of marriage, of April Ashley, trans people have been denied the right to have their subjectively experienced gender recognized; that is, trans people have not, despite a number of attempts (Rees v UK, 1986; Cossey v UK, 1991) been able to have their birth
certificates altered to reflect their subjectively experienced gender, post reassignment. Recently, however, there has been a promise of this denial of trans-subjectivity being overturned. The drafting of the Gender Recognition Bill and its discussion within the Parliamentary forum (2000) is making real steps towards granting trans people full legal recognition. Whilst undeniable a fantastic move, it has spurred a number of concerns from within the trans communities, not least with regards to who exactly should be entitled to this new status recognition.

With this promise of eventual full legal recognition, many within the trans communities note concern that this privilege should be granted only to those individuals who, as a result of a legitimate medical condition, seek the reassignment of their sex along somatic lines. As Whittle contends, "histotically, the author's of 'transsexual' autobiographies have often sought to distance themselves from the rest of the trans/gendered/sexual community" (2001: 160), and this has never been more true than at the dawn of this legal moment of change. Here then Transgender is conceived of as a lifestyle choice, a political identity, whilst transsexualism is argued to be as conceptually far away from 'choice' as is possible. The shift toward Transgender identification, from the point of view of many of those 'trans' women I spoke to, would serve to further entrench, in the minds of the medico-psychiatric and the legal profession, and indeed the lay community, the conflation of transsexualism with other trans subjectivities – transvestism, Transgender, cross-dressing, etc. The result being the setting up of a dichotomy of transsexual need versus Transgender choice.
It is the aim of this chapter to assess the extent to which Transgender is replacing or superseding trans identification as the primary means by which to understand those identities that 'transgress' normative assumptions about sex/gender. Moreover, the research presented here seeks to understand the ways in which those 'trans' women involved in the research position themselves in relation to the sex/gender dyad.

The stories of gendered selfhood presented in this chapter provide a glimpse into the variety and richness of trans-situated identities. Whilst those stories told differed in many respects, calling into question the notion of one 'true' or 'authentic' trans identity, what they did all express was a very real sense of both the embodied nature of gender and the material conditions of sex, despite their gendered 'difference'. What was relayed then was a unique insight into what it must feel like to be positioned outside of the encompassing institution of gender, whether that is on a permanent or a temporary basis.

Finally, a great many of the personal stories told to me pointed to the need to question a total 'turn to Transgender', and instead, reflected a position more akin to that of trans activist and writer Margaret Deidre O'Hartigan (1993, 1994, 1996), who argues for a rejection of Transgender's calls for gender fluidity and deliteralization. Rather, O'Hartigan explains the need to keep the term 'transsexual' as a means of describing the experience of living in and eventually escaping the confines of the 'wrong' body. Thus, for O'Hartigan, to embrace Transgender would be to loose the uniqueness of transsexualism as an identity category. What my research indicated then, was that whilst in many instances, those people involved spoke increasingly of a sense of pride in their trans status, that status was more often than not,
understood to be trans and not Transgender. Thus, while Transgender seeks to embrace all trans-subject positions, what it cannot account for is the fact that not all subject positions want to be embraced.

**Trans-Subjectivity and Sex/Gender**

Through analysing those stories told to me during the period of the research, two broad narrative plots can be said to have emerged in relation to identification with sex/gender. The first relates to identification as a ‘woman’, whereby transsexualism was seen as ‘nature’s’ mistake, in need of correction in order to make the body and gendered self congruent. The second narrative plot conceives of ‘trans’ woman as a legitimate identity category in its own right. Here, many argued that they saw themselves, not as women, but ‘trans’ women, but nonetheless positioned themselves, and wished to be accepted within the ‘sisterhood’. Imbued with this is an understanding of their trans status as a unique process, of which to be proud. What both narratives — identification as ‘woman’ and identification as a ‘trans’ woman — shared, was a deep understanding of the pressures of a rigidly dichotomised sex/gender binary. Whilst the second narrative plot — identification as a ‘trans’ woman — opens up a conceptual space between the male/female binary, it would be a misnomer to consider such an identity intrinsically ‘queer’. Such identifications are, as we shall see, invested in the material conditions of sex. What we are witnessing instead is a growth in trans pride and the rejection of internalised transphobia.

Identification as a ‘Woman’

Identifying and wanting to be accepted as a woman was evidenced in a number of the stories told to me during the course of the research. One way in which this identification is expressed is through the relational understanding of gender, whereby being a woman is defined as knowing that one is not a man; as Janine explained:

“...when someone says to me like, how do you know that you are a woman? My reply is well how do you know you’re a woman? [...] all I knew was I wasn’t a bloke, erm ... you know you go on Jerry Springer and you’ve got people saying ‘I’m a transsexual, I used to be a man’ and
the last thing I’m going to say is that because I’ve never been a man. …
So, I’m not transsexual. I’m 100% woman and proud of it.”

Similarly, Anna explained:

“The need to stand in front of the mirror and see ‘Woman’, to see the ‘reality’ of ones self perception is the underlying driving force that makes ‘Transition’ possible. Now, I can see where this is leading! You may say here, so you also think that penis = man? Well it would be quite easy for anyone to jump to that conclusion but it would be quite wrong to do so. The emphasis here is ‘I am a woman’ not ‘I am a man’.

Identification as a woman as opposed to a transsexual or even a ‘trans’ woman can be evidenced through those stories told to me by a number of those involved, which drew upon essentialized assumptions. Here then, as we saw in Chapter 6, such stories pivot around an understanding of ‘being’ as opposed to ‘becoming’. Thus one is born a woman - albeit with a number of physical ‘differences’- but journeys through an arduous process to ‘become’ more socially female. That the body is incongruent to the sense of gendered self is of little matter in the initial determination of that person’s sense of self, but as they grow and become socialized into a heavily gendered world, that incongruity needs to be corrected in order that one is made ‘whole’:

“I don’t like reassignment because, and it’s certainly not gender reassignment cos you’re not reassigning my gender, I have always been female, I’m correcting my … physical outward body to be in line with what I’ve always said it is. Reconstruction I like, I like that and that’s sort of being used more and more and that’s really all it is because they don’t chop anything off as people think they do …”

(Janine)

Similarly, Sue argued:

“I would prefer complete acceptance as a woman … for me it is to live and be accepted as the woman I am. For me it’s bringing my body into conformity with the woman I am.”
The need to reject the label 'trans' in favour of that of 'woman' was something which Anna
strongly articulated:

"Some 'Trans' people often use the term to describe themselves as a
means of identifying with and creating a sense of belonging to a group
because they feel they are not part of, or have been shunned by, society in
general. I would say I'm not Trans, I am one of 30 million or so women
in the UK."

What these three narrative extracts share is the need to conceive of transsexualism as a
temporary state, used to designate that point at which a somatic change of sex is sought.
Trans, for these women is not an identity category. For them, the appropriate method of
identification is that of a 'woman'.

A final way that identification as 'woman' is transformed into a narrative plot is through the
rejection of the word 'transsexual', which for Charlotte signifies little more than a medico-
psychiatric pathology, used to oppress a group of women who's bodies do not translate the
subjectively experienced gender upon its surface:

"The original conception to pathologize what naturally occurs was a moral
one accorded by the intersection of medicine and law. It is necessary to
reject the word 'Transsexual' as it is a medical construction designed to
pervert the legitimacy of a minority group of UK citizens. It is a word that
holds no dominion over the nature of who I am. A woman. It is a cruel
and inappropriate construction that has been widely rejected by the
community and progressive clinicians working in the field. ... I am a
woman, not a 'trans' woman, transsexual, or any other form of corrupt
theory designed to pervert the legitimacy of my life. I am a woman."

It is the identification as a woman, and the whole hearted rejection of the term 'transsexual'
that runs through each of these stories that stands as the anthesis of both O'Hartigan's
'transsexual pride' and queer theory's depiction of the subversive nature of transsexual
subject positions. Instead, for those claiming this sense of self, gender is firmly located
within the binary system of sex/gender, and as such is not so much 'bad/reinscriptive', but is a
narrative heavily invested in the materiality of the sexed body. As such it reflects one subject
position contained within the variety of trans identifications.
Identification as a ‘Trans’ Woman

The second way in which those involved in the research expressed a sense of gendered selfhood was through identifying as ‘trans’ women. A major part of this form of identification is a sense of pride in who you are and your journey there. These self-defined ‘trans’ women recognize the uniqueness of their journey, and take pride in their ‘difference’. Contained within this narrative is a sense of the need to be visible as a means of enabling social and personal acceptance, which resonates with Stone’s (1991) Posttranssexual Manifesto. What these ‘trans’ women are expressing then are a form of ‘radical’ transsexual identification. In terms of the relationship with sex/gender, it could be argued that these ‘trans’ women open up a conceptual space between ‘male’ and ‘female’.

Firstly, those speaking from such a subject position saw no problem in being referred to as trans or transsexual, viewing it as a descriptive term, which served to highlight their unique position within the gender spectrum. The following narrative extracts make this clear:

"Erm, yeah, trans-gifted … err … I don’t know, it’s a descriptive word for me, I know a lot of people don’t like it but they say that and yet they all find the groups by the name, you know by the trans name, how else do you find things, you know? That’s what it is, when you see your doctor, psychiatrist, GIC, you go there and tell them your transsexual because that is the word that’s used. I don’t see why people are so annoyed, to me it’s a descriptive word, that’s it, and it helps people to know what you’re talking about."

(Julie)

That the journey ‘home’ is something to take pride in and accept rather than try to conceal was poignantly discussed by Zóë:

"I am transsexual; I will not deny my past. I had a happy past, I’m quite open about it, I will tell somebody quite quickly that I’m transsexual … because I think it’s important to educate people that we’re not all, well very few actually […]. People have a very false view of what a transsexual person is and I think it’s quite important to tell people ‘look, I’m normal; it’s quite a normal condition.’ Erm and it’s part of educating people. The whole idea was, that I know I will never be completely
female, I only know what it is to be me, I’m definitely not male, so in a way I’m trans-intersexed, I’m in a kind of half-way place and I’m happy in myself and I’m not ashamed. But there are people, especially the young, who go under deep cover, deep stealth and they’re always terrified of people finding out, or their outer-circle have just been told and there are some nasty rumours spreading round, it’s horrible. I spent 35 years of my life terrified that people knew about me, but I’m not going to hide this way. … Yeah, cos I’m a person and I’m very proud of my journey. I wish my journey had started earlier … My life’s positive and I view being trans as a positive thing, a small part of my life is a result of how I was born, but that’s like a whole variety. It hasn’t been a negative journey.”

Furthermore, the idea that invisibility is the best way to live is rejected by Julie, who disagrees with the idea that ‘passing’ should be treated as the be-all-and-end-all for ‘trans’ women, but instead they should strive to be comfortable with themselves:

“I don’t mind it, people get upset about it but I don’t mind. … Everybody I know knows me as trans so err I don’t really mind. And also people get upset about it and I think maybe it’s a case of how well you pass and things like that, I mean I don’t look at myself as if I really pass, anybody who has a good close look at me or talks to me is going to know so they might as well know, so I’ve always been pretty happy and open about it. I’ve done T.V programmes that have been shown locally and I’ve been in the paper, it’s just you know, a lot of people have read it so, you know I’m quite well known when I go into the shops and things, I mean I don’t get any bother now, no one shouts at me and says ‘oi tranny’, what’s the point? [laughs] you know it’s so well known it’s like shouting there’s a bus, it’s nothing you know, I don’t get any trouble. So I don’t mind.”

(Julie)

Likewise Emma explains:

“I don’t mind trans, I don’t particularly like transsexual, I used to be transsexual, I don’t know what I am now, I know I’m not female … I’m somewhere between the 2 … it’s funny, so many people, so many trans people afterwards say look I’m a woman, they are post-operative trans
people ... who should have been and have done everything they possibly can to be as close ...so I don’t mind trans, I’m quite open about it. If I’d been the only one then I would have said right this is me, go totally stealth, erm but I didn’t want to live like that.”

What becomes apparent here is that for those individuals who self-identify as ‘trans’ women, the denial of the past is something of a futile act. This movement towards openness and disclosure has the potential then, in the eyes of these ‘trans’ women for total self-acceptance.

Identifying as a ‘trans’ woman is also a way in which one can open up the conceptual boundaries, and find a transitional space between the male/female binary. Those involved in the research who expressed such a view saw themselves neither as a ‘normal’ woman, but more importantly, they never were, nor could they pretend to live as ‘normal’ men:

“...but I never actually considered myself to be a normal woman and I was never a normal man I am and always will be a transsexual woman and I don’t actually have an issue with that ...”

(Jane)

“I’ve come to be, acceptance of myself as a ‘trans’ woman and that’s how I will define myself, because I don’t consider myself to be a woman, in some respects but, conversely I’m very far from being a man and I know that isn’t the case so you know. So it’s a strange thing that, and I just feel that actually [...] I reached a point in my self where I, I came to the conclusion or the understanding that if I were to constantly, for the rest of my life compare myself to non ‘trans’ women I would always find myself wanting in some ways, some essence, or something, you know, whatever it was, whether it would be trivial or whether it would be fundamental I would always find myself wanting, I would always feel that cracked pot, that sort of [...] that erm [...] what’s the word? Flawed, I would always be flawed. As a ‘trans’ woman I’m not at all flawed. And I just thought well then I could stand tall and proud ...”

(Jessica)

Jessica also goes on to problematize the notion of ‘womanhood’:
"but actually is a ‘trans’ woman a woman? You know because some ‘trans’ women would say no, maybe a feminist ‘trans’ woman might say we are not the same as other women. We are ‘trans’ women but we are not the same as non ‘trans’ women and [...] you know, if we insist we are it is not necessarily for the good of any of us, trans or non ‘trans’ women, or men or anything else.”

Moreover, Jessica firmly believes that there is much for a feminist politics to gain by accepting ‘trans’ women into the sisterhood:

“I identify as a ‘trans’ woman now, and I definitely feel, and I think about it a lot, and I definitely feel that from my attitude, from my point of view, ‘trans’ women should be included in the sisterhood, that’s what I, I feel there should be room in the sisterhood for ‘trans’ women, ‘trans’ women are, are not the threat that some women perceive them to be.”

Importantly, as these narrative extracts demonstrate, the personal identification as ‘trans’ woman does not so much resonate with queer theory’s project of gender deconstruction, as it does with O’Hartigan’s ‘transsexual pride’, and as such is demonstrative of the extent to which this form of trans identification is just as heavily invested in gendered embodiment and sexed materiality as are those narratives which seek identification as a woman. Moreover, the commitment to visibility as a form of personal comfort and to some extent social re-education is a reflection of the growing sense of pride people have in expressing one’s trans identity. Moreover, it acts as a testament to the opening up of a conceptual space from which those located outside of that trans identity position co-opted and standardized by medico-psychiatric discourse, can finally speak, and importantly, be heard.

The Pressures of a Bi-Polar Gender Dictate

The problem of viewing transsexualism as the deliteralization of sex/gender, and the converse critique of transsexualism as making literal the categories of ‘female’ and ‘male’, is that both perspectives ignore the ways in which gender acts as a very real social institution, curtailing alternative expressions of gendered selfhood. In this way then, any understanding of the relationship between transsexualism and sex/gender needs to be mindful of the materiality of sex and the embodied nature of gender. That structural constraints forcibly act upon
expressions of gendered selfhood can be evidenced by the words spoken by so many of those people who contributed their stories to this research.

For instance, Jessica talked about those social pressures that made her all too aware of her Outsider status, forcing her into years of silence:

“I think that pressures were from society, I was very aware that, that, how much of an outsider status it was ... and so for somebody that insecure erm, I think it’s very difficult to voluntarily step outside the scope of what’s considered to be normal or acceptable in society, it’s a big deal, and even though looking back on it I realise it wasn’t a choice it was something that I was compelled to do, nonetheless I fought it for an awfully long time and I wanted to conform and erm ... at the time I thought it was just something I had to live with. ... erm, so I think there were an awful lot of reasons to be very afraid to come out, and I have huge admiration for anybody...”

Becky adds to this when she said that:

“I think it would be hard for society to create a situation where you could live with your boy bits but be female.”

Here then is a recognition that living in a ‘gendered no-man’s land’ proves to be a barely liveable zone. Moreover, these narrative extracts make clear the extent to which gender exists as an embodied artefact, as well as pointing to the very real material force of sex.

Pressures to conform to sex/gender come also from medico-psychiatry, which is invested heavily in maintaining the status quo, as Charlotte explains:

“The idea to ‘gender re-assign’ is the designation of gender stereotype which propagates the bi-polar gender model. It is the role of psychiatry to protect and preserve the idea, and such a thesis today has never come under so much scrutiny. We witness the slow erosion and rejection of psychiatry in an age of social liberalism and human rights activism.”

But pressures come too from wider society, as the following narrative extracts make clear:
"I want to be fully functional in society. At the moment society still sees us as weirdos, freaks erm, and that's their final, I mean some people, I don't know whether this will improve with a change in law or not but if we've got a document saying we're female then that's just another proof to the bigots, that it is normal, not some weirdo."

(Zoë)

Similarly:

"I mean I've not got anything to be ashamed of but I just know that people will treat you differently if they know you're trans, and I don't see why I should particularly hide that, but I don't see why I should be treated differently, you know I'm not ashamed that I'm a trans person but I just want to be treated the same as everyone else."

(Claire)

Clearly then we can see the ways in which a fear of being stigmatized as a 'freak', a 'pervert' or 'queer', acts in such a way as to repress for many years any expression of one's 'true' self, forcing people into years of denial, only daring to 'come out' when they can no longer take the masquerade of their male lives. Moreover, a recognition of the ways in which the fear of stigmatizing judgements often propel 'trans' women in to adhering to the social rules of gender, creates a degree of reflectivity on the part of these 'trans' women, making them question the 'naturalness' of such rules of behaviour. That many continue to make sense of themselves in relation to the rules of gender, rather than 'queering' the binaries, speaks no more of complicity on the behalf of the 'trans' woman than it does for the vast majority of people as a whole, who despite widespread recognition of gendered oppression continue to structure their sense of self, or have their sense of self constructed along gendered lines.

The 'Reality' of Transgender

Those stories told to me during the course of this research revealed some interesting insights into the 'reality' of Transgender, and in many ways problematize the assumption made in much of the queer and Transgender literature, which calls for a shift in identification away from trans expressions of self, and toward a more radical, gender destabilized and
deconstructed sense of Transgendered self. Moreover, the suggestion of queer Transgender politics, which argues that trans politics should move away from a position of exclusivity, and should embrace a more inclusive politics, which incorporates all forms of gendered and sexual selfhood into one politically strong community group, was seriously questioned by those 'trans' women speaking in my research. The fear of an inclusive politics, as suggested by the use of the umbrella term 'Transgender' would seem to be exacerbated given the current climate of pending legal reform - as drafted in the Gender Recognition Bill and discussed in the Parliamentary Forum on Transsexuality (2002) – that is the move towards giving trans people full legal recognition in their subjectively experienced gender. Here then, the need for strong definitional boundaries was seen by many involved as a necessity in order to protect one's self in such a precarious situation. Thus, many expressed the fear that if legal recognition was not to be premised around either surgical body change or a permanent commitment to one's gender, then transvestites and cross-dressers and Transgenderists would also be able to petition for civil recognition in the female gender, something which many involved in this research feared would have dangerous consequences, hindering social acceptance for the new law. Again, we see the demarcation between transsexualism as need and Transgenderism as choice.

Expressions Against Transgender Inclusivity

As suggested, many of those involved in this research spoke of the need to keep separate the disparate identities that Transgender seeks to include. So, for example, Claire speaks of her perceived need to keep separate trans and Transgendered identities, demarcating the two along the lines of need versus choice.

"I'll often see transgenderists as pursuing something as a lifestyle choice where most people who are primary transsexuals, there isn't really a great deal of choice there. ... If you're making a lifestyle choice then yeah, I suppose if you're gonna live your life as a woman you should have certain recognition but I don't believe that it's the same thing as transsexualism, and I wouldn't like to see it treated the same as transsexualism cos often the issues the transgenderists put forward are as portraying it as their lifestyle and their allowed to portray it as a lifestyle, but the comments that come back to hurt trans people because people get the two confused and I get quite upset really that I've lost friends and people are kinda trying to
say well it was your choice, and I say well, it’s not, it’s not a choice. ... Where that line should be drawn between transgendered people and transsexual people, I’m not really sure, cos that debates not really taken place yet, but I think there should be some demarcation between them because I don’t believe that gender is the same for transgendered people as gender is for transsexual people.”

Similarly, Becky speaks of the need to differentiate between transsexualism and transvestism, something that she believes Transgender destroys:

“... there are a lot of trans girls who argue that we are transgendered, and they say people say you’re transsexual and doesn’t it bother you the word sexual and I said I don’t mind cos at the end of the day that differentiates me from transvestites, so if someone wants to say I’m transsexual that’s all right, trans female that works because at the end of the day it explain where you’ve come from, so yeah, well the word transgender …”

Marie also discusses the problems that she sees with the use of Transgender as an umbrella term:

“... because transgendered is like an umbrella to cover all gender issues and so transvestites are put in the same bracket, under the same umbrella as transsexuals and it’s just caused massive problems.”

Addressing the problems of demarcating transsexualism and Transgender, Jessica explains the problem of who gets to decide upon issues of who should and should not be included. Here then, Jessica aptly questions the representativeness of more radical community viewpoints:

“...the other thing that I think is a concern, is something that Rikki Anne Wilchins said, who is it who are members of minority groups who are the self appointed police of the borders and the boundaries of those minority groups? Generally the people who self appoint become the police of those boundaries, so the most extreme members of the minority group and so you find that they will be the ones who decide who joins, who is allowed in, who is not allowed in, but that most of the people in that minority group may not feel the same as the extreme people in the minority group,
they just keep quiet and let more extreme people take that responsibility, of, of policing the boundaries …”

What these narrative extracts show then is the ever present felt need to demarcate transsexualism from broader Transgendered identifications. The need to keep transsexualism and Transgender separate pivots around the need/choice dyad, and as such, these views resonate with the increased sense of transsexualism being a legitimate medical condition, explicitly understood as we saw in Theme 2, as an intersexed condition of the brain.

Legal Recognition and the Problem of Inclusivity

A number of concerns over Transgender inclusivity relate in many ways to the current project of legal change, which, as we noted in Chapter 8, promises to allow trans people full civil recognition in their subjectively experienced gender. Concerns raised by many involved in the research related to the issue of who would be granted this right. In line with this, many expressed a concern that the decision should be granted along surgical lines, and where that is not possible — due to ill-health or in the case of ‘trans’ men, for whom surgery is an incredibly complex procedure, with poor success rates — a declaration of permanent commitment to social gender change be made. This was seen as a necessity to safeguard against other Transgendered persons having access to legal recognition, which was felt to potentially damage the trans person’s claims to legitimate identity recognition on the grounds that a mistake had been made during the process of sex determination at birth. Again, then is a perceived need for demarcation along the lines of need versus choice.

The opposition to Transgendered people seeking legal recognition was clearly evidenced in the words of Sarah:

“That’s why I’m a bit against erm with this coming law change that people in that situation will be able to have their birth certificates amended as well. To me they’re frauds, if they’re trying to say they’re female and they’re birth certificates say they’re female and they’re not fully female and it’s wrong you know. So even though that letter, you saw the Press for Change thing? Well I’ve done that and they say don’t state your
surgical situation and I disagreed with that so I told them my surgical situation.”

That legal recognition should be granted once surgical change has been established, or where surgery is not a viable option, a permanent social change of gender has occurred, was strongly expressed by many involved in the research:

“... but on the website and they’re saying well you know, basically anybody that recognises as female or says they do should be given the right to change their birth certificate and I said no I don’t agree with that, because at the end of the day you’ve got so many scales of everything you know, you’ve got transvestites, at the end of the day when a guy puts a dress on he feels female so should he have a female birth certificate? And they’re saying if he want one yeah and I said no because I think of it from the point of view, I will stand up in front of society and argue that my friend is as female as is possible and you know she wants the rights to marry as a female then you know I would argue that she should have that right, but I wouldn’t argue that she should have that right if she’s got meat and 2 veg in her knickers, I know it’s a bit crude but that is the way that I feel ...”

(Becky)

Similarly:

“... this is also a very debatable subject at the moment particularly when we were talking with the UK government with the Goodwin and I v UK, erm because if we’re gonna change our birth certificates there has to be some sort of gate keeping [...] and this is where my views [...] differ from the mainstream, erm, the mainstream viewpoint is basically it doesn’t matter whether you have hormones, whether you’ve changed your body or whatever, because if you know you’re a woman, then yeah, change you’re birth certificate.”

(Janine)

And finally:
“...it’s difficult to say because it opens up a whole other can of worms with regard to issues of identity, sort of in my position at the moment being pre-operative err and issues with birth certificates, if they turn round and say you can only change your birth certificates if you’re post-operative then I could live with that and I could accept that, but what I’m quite anti is the fact that it’s done for important reasons that have had GRS or through no fault of their own and medical complications and can’t actually have GRS and I don’t feel just because transsexuals are getting on to getting birth certificates that a transvestite should be able to get one or any other documents just purely for kudos so they can wave it in front of people and say look what I’ve got this makes me a woman now, I’ve got a female birth certificate, passport or driving licence.”

(Jane)

Looking at and understanding people’s concerns over and feelings towards eventual legal recognition, we can clearly see that the shift towards inclusivity is something that is not welcomed by all. Such views allow us to further problematize the supposed ‘turn to Transgender’.

**Demedicalizing Transsexualism: A Desirable Step?**

Whilst a great many of the ‘trans’ women I spoke to talked at length about their experiences and feelings towards the GIC system (see Theme 1), it would be naive to assume therefore, that they were all in full support of the demedicalization of transsexualism as argued for by a number of trans activists and scholars. As such, we need to call into question the universality of a homogenous trans politics.

Indeed, some of the ‘trans’ women speaking in this research did express a heartfelt need to reject medical controls over their lives and bodies, as the following extracts make clear:

“I’m not sure about the medicalization of transsexuality and indeed this sort of, you know, be-all-and-end-all, the executioner’s axe that they hold over people which causes no end of suffering and, erm, frustration and personal pain on behalf of trans people that they feel that things are being
withheld and that there is no possible, no guarantee that they will ever be allowed by a health care professional.”

(Jessica)

Similarly:

“... people wish to take control of their treatment. That control is denied a patient in the case of transsexualism.”

(Sue)

Contained within such sentiments is the need to reclaim their bodies from the hands of medico-psychiatry, and take control of their own destinies:

“But it’s my point that I should be in control as long as I’m not trying to harm myself.”

(Zoë)

And:

“My body is my body, and what I do with my body is my business, no one should tell you what to do with your body. If a psychiatrist goes around saying you shouldn’t be doing this, you shouldn’t be doing that, you need a bit of guidance, but I don’t think they should interfere.”

(Ruth)

Sadly however, a comment made by Claire was indicative of the futility with which any challenge to medical hegemony is so often met:

“But as for, I can understand the reasons why people want to reclaim that, but however, let’s be realistic, that’s never going to happen; you know there’s always going to be that barrier to get through unless you can afford to go privately, which most people can’t.”

(Claire)

Many of the ‘trans’ women involved in my research expressed some support for the continued application of medical controls, seeing them as a necessary step in order to safeguard access
to an already limited resource. The ‘trans’ women here then, are supportive of the continuation of a ‘treatment’ regime that is structured via the medical paradigm. For Claire, whilst understanding why some people may wish to reject medicalized controls, she takes a rather pragmatic approach to the issue:

“I can understand their reasons why they would want to reject that control, the psychiatric control certainly, to me it’s always going to be a medical condition, there’s always going to be room there for the medical profession but I don’t believe that you can just demand really these treatments because they are irrevocable treatments and really that has been proven that not everyone who goes forward for treatment or presents for treatment will actually move forward for that whole process, therefore there are a certain number of vulnerable people that you’ve got to protect and I can see that argument as a trans person so you need certain barriers to be there along there process but it’s the extent of those barriers.”

Referring to the diagnostic usage of hormones, Janine comments that:

“Yes you’re female, you can have pills, no, you’ve got a male brain, no, you’re not. So perhaps there should be some gatekeeping there rather than just handing out smarties.”

Here both Claire and Janine recognize what can be seen as the paradox of medico-psychiatric imperialism. Whilst it may well be the case that medico-psychiatric profession construct barriers which often serve to hinder an individuals’ ability to transition, those barriers can also serve the dual function of a safety-net, ensuring that only those people who are truly in need of such ‘treatments’ are able to access them. It is in this way that the actions of the medico-psychiatric professionals can be seen as protecting vulnerable people from harm. The issue remains however, of who gets to decide who is deserving of such ‘treatments’ and who is not?

While many of the ‘trans’ women involved in my research did not perceive of the need to demedicalize transsexualism, they did however, see the challenge to psychiatric imperialism as fundamental. The challenge to psychiatric imperialism from my respondents ranged from the mild to the extreme, as the following extracts make clear:
For Emma, the only role that psychiatry should assume is as a form of support for people to come to terms with both their transsexualism and the deal with the stigma that they face in their daily lives. For Emma, then, it is not transsexualism *per se* that should be ‘treated’ by the medico-psychiatric profession, but those problems and difficulties that emerge from being trans in a hostile world.

“I’m not saying there isn’t a need for psychiatric care or counselling, there is, because you need help trying to get through it and that’s where counselling comes in. The trouble with being transsexual is that it causes a lot of psychiatric problems, it’s not a psychiatric problem itself, but trying to cope with it, trying to live with it brings on all sorts of other problems. So there is still a need for them but it would be nicer if they had a more modern approach and it would be a bit nicer if they were a bit more willing to learn, not just do what they think is right…”

That medico-psychiatry continues to pathologize transsexualism was also expressed by Janine:

“… Psychiatrists oh erm … what psychiatrists are trying to work out is if you’ve got a mental condition that’s erm … causing you to feel like you’re a woman or a male, so they’re trying to find a way out rather … than a way into accepting it.”

For Claire, the need to reject psychiatric control is due to her insistence that transsexualism is a medical condition, which should be treated as such:

“I agree it’s a medical problem, I don’t doubt that for a moment, it’s a medical problem, but I think it should be treated as a medical problem not as a psychiatric problem, which is the way the system is geared up at the moment, and so that’s where my kinda, erm, thoughts would come from is that it shouldn’t be treated purely as a psychiatric problem, which is the way it is more or less approached at the moment, I think it should be more or less a medical problem, you know because after, I mean, I don’t feel I’ve got a mental illness, as far, as far as the psychiatrists and the doctors and everything are concerned I’m being treated for a mental illness at the moment, that, that really annoys me, you know that really does annoy me
because I feel that I've got a medical condition, it has a biological basis ... but no, I don't think it should be treated purely as a psychiatric illness which is the way it is at the moment:

Similarly, Cerridwen argues:

"Erm ... it's perfectly understandable [the rejection of psychiatry] ... I don't regard the condition as a mental illness ... I don't see that, they have their uses for a person who's been badly affected by being transsexual, but actually to control the system of ... jumping fences that you need to get, I think it's totally wrong. Unfortunately, I don't see what I can actually do about it until somebody decides to change the law."

(Cerridwen)

While many of the 'trans' women I spoke to did not perceive a need to challenge or overturn the medicalization of transsexualism, the same cannot be said with regards to psychiatric imperialism. That many in my research were in favour of medicalization, whilst expressing concern over the future of psychiatric involvement can be understood as a result of the ways in which they understand trans becoming. That is, for the majority of the 'trans' women I spoke to, transsexualism is understood as constituting an intersexed condition of the brain, and is therefore a medical 'condition' rather than a psychopathology and thus deserving of psychiatric assessment. The perceived need to reject the psychopathologization of transsexualism, whilst continuing its medicalization can perhaps be explained by the desire to have the stigmatizing label of mental illness removed from understandings of transsexualism. Moreover, by continuing with the medicalization of transsexualism, trans identities are given legitimacy and as such can be regarded as a legitimate medical condition, as well as something over which they had no control.

Conclusions

When we attempt to theorize the relationship between transsexualism and sex/gender we need to remember that whilst a queer theory, which advocates the fluidity of gender, is desirable, and could potentially create an end to the horrors of gender oppression, it often bears little relation to much of the trans experience. Even those 'trans' women involved in the research,
who expressed a subject position more akin to 'radical transsexualism', are still confronted with socially stigmatizing judgements with regards their transsexualism, which can act in such a way so as to constrain an individual’s ability to express a ‘differently’ gendered self, through the fear of derogatory and stigmatizing attitudes.

Transgender, as a politically motivated identity category, which seeks the deconstruction of sex/gender and an inclusive approach to identity politics is far from being universally accepted by many involved in this research. The need then is to question the ‘turn to Transgender’, as suggested within the literature. Whilst undoubtedly we are witnessing the turn towards trans pride and the rejection of internalised transphobia as evidenced in the words spoken by many of my respondents, it is problematic to assume that ‘trans’ women are therefore embracing a radical Transgender identification, with its attendant demands on inclusivity across the spectrum of ‘gender difference’.

Moreover, the assumption made by many scholars, that Transgender identification is a more ‘authentic’ expression of self than its trans counterpart as a result of its liberation from, and willingness to stand outside of medico-psychiatric discourse, is, to my mind seriously flawed, especially when we (re)consider the history of trans situated identities. The existence of trans subject positions prior to its discursive naming by medico-psychiatry, and precisely because many such identities appear akin to what we now understand as ‘true’ transsexualism attests to the fact that the story of transsexualism, subsequently standardized by medico-psychiatry, is in fact an ‘authentic’ subject position and not a medicalized paraphilia. Rather than understand the growth in the voices of those who identify along more Transgendered lines as bearing witness to a more ‘authentic voice, we need to understand that the story that those people told, once silenced, now has the opportunity to speak and to be heard, something which was not conceivable in earlier epochs. We need then to move away from the tendency to hierarchialize trans experiences and instead find a place and voice for all trans situated identities regardless of where they are positioned along/or outside of the sex/gender dyad.
As with the other discussion chapters, the intention here is to bring together the findings of this theme, and to suggest the implications that my research has for an understanding of trans politics. Moreover, it connects the findings of my research into this area with the findings of the previous two themes. By situating trans politics within the wider discussions of definitions and trans becoming, I hope to be able to suggest new ways of thinking about trans politics, which recognizes the multiplicity of trans subject positions as well as the active role played by 'trans' women in the construction of a trans identity.

Throughout much of the literature relating to the relationship between transsexualism and sex/gender we find opposing attempts to suggest either a literalizing or a deliteralizing relationship at work. Here then, 'trans' women are said to either blindly conform to social constructions of sex/gender and 'female' as if they were an ontological given (see for example, Raymond, 1979; Tyler, 1989; Millot, 1990; Irvine, 1990) on the one hand, or to highlight the 'fictionality' of gender on the other (Halberstam, 1994; see also, Epstein and Straub, 1991; Bornstein, 1994). However, neither of these views fully takes into account to diversity of trans-situated identities. Moreover, they either fall into the trap of ignoring the extent to which gender assumes the role of a 'total institution', or, as in the case of feminist writers such as Raymond (1979), fail to recognize that the same structural constraints that oppress non-'trans' women are also at work in the oppression of ‘trans’ women. Furthermore, such an understanding ignores the importance of the somatic body in constructions of self. What so many writers fail to do then, when theorizing the relationship between
transsexualism and sex/gender is to adequately listen to what those people doing the telling are actually saying.

In order to fully understand those subject positions that narrativize a sense of gendered self in relation to the personal identification as ‘woman’, we need to move beyond regarding such subject positions as somehow providing evidence for them making literal the sex/gender binary. Instead, we need to understand the important ways in which such trans narratives engage with gendered embodiment, whilst simultaneously allowing for changes in somatic morphology. Moreover, to read this group of trans narratives as reinscriptive, and hence ‘bad’ is to negate the existence of a valid and ‘real’ subject position, which, like that of so many non-‘trans’ women, is firmly positioned within the sex/gender dyad. Here then, the question of how a ‘trans’ woman knows that she is a woman is one that can be equally be applied to all women. The answer is that our gendered self, whilst involved in a complex relationship with, needs to be understood apart from the specific somatic morphologies.

That a number of people involved in the research position themselves more firmly within the sex/gender binary than those who identify as ‘trans’ women is demonstrative of the existence of, not one coherent subject position located within ‘transsexualism’, but of many trans subject positions. Here, transsexualism and those positioned within that temporal locality, either by themselves or by others, are as heterogeneous, that is, as different from one another, as they are from those people who identify as cross-dressers, transvestites, drag kings, drag queens and Transgender.

In order to understand the relationship between the narrativized plot of ‘trans’ women and the sex/gender system, we once again need to move beyond the confines of a literalization/deliteralization dyad. Such identifications are not more ‘authentic’ because they move away from that trans narrative – whereby identification is as a woman – which came to be co-opted by medico-psychiatry. Nor are they more ‘authentic’ because they open up a conceptual space between the binaries of male/female. Rather, it is just one way in which trans-identification is personified. What we can say is that such identities, once excluded due to the dominance of medico-psychiatric discourses on transsexualism and the constraints placed upon gendered identification are now being given the opportunity and an environment in which to speak, and most importantly, be heard.

A second area within the literature concerning the politics of trans and its relationship to sex/gender tends to stress the growth in political activism and the project of gender
deconstruction, culminating in an identity shift away from so-called 'normative' trans subjectivity – that is, the identification of oneself as man or woman – towards Transgender, a more radical subject position which speaks from outside the established parameters of sex/gender, thus embracing a queer subjectivity. However, this position is not without criticism (see O’Hartigan, 1993, 1995, 1996), not least for its denial of transsexualism as a ‘real’ sex crossed subject position. Criticisms also centre on Transgender’s call for an identity category, or socio-political movement premised upon an inclusive politics, as opposed to the exclusivity of transsexual organizing.

Many involved in the research saw incorporating a Transgender identity as ultimately masking the uniqueness of their identity and their journey there. Moreover, Transgender was often articulated as being a potentially dangerous move. By claiming a Transgendered sense of self, many of my respondents felt that they would lose their claims to gendered ‘authenticity’, and moreover, the coupling with people who identified as cross-dressers, transvestites and transgenderists – which many involved saw as a lifestyle choice – was viewed as a move that would further entrench social, legal and medical hostility.

What so many of the narrative extracts contained within the research make clear then is that there is an ever present need to distinguish between trans and Transgender identities. The result of this is the perceived need to maintain a somewhat exclusive trans identity. Imbued within this is the idea of ‘authenticity’. Whether the individual identifies as a ‘woman’ or as a ‘trans’ woman, many believed that transsexualism is borne out of a legitimate medical condition, which should not, and cannot be conflated with their perception of Transgender as a lifestyle choice.

Following discussions with those involved in the research, it would appear that far from there being an increased trend towards Transgender identification, as suggested in much of the contemporary literature, there is an attempt to maintain a distinct trans politics. Many of my respondents spoke of a sense of pride in being trans, whereby ‘passing’ was becoming less privileged. The research then, in many ways echoes Stryker’s claims of reclaiming ‘transsexualism’ from the medico-psychiatric profession. Moreover, it is important to recognize that as we saw in Theme 2, many articulated a sense of self, whilst framed within a medicalized border – transsexualism as an intersex condition of the brain – that sense of self is of their own making and importantly contrasts starkly with those sanctioned medico-psychiatric discourses of transsexualism.
That no whole-hearted rejection of the medicalization of transsexualism by those 'trans' women interviewed became apparent throughout my research is perhaps of little surprise given that, as we saw in Theme 1, the majority of 'trans' women I spoke to articulated a sense of their transsexualism as being the result of an intersexed condition of the brain, and hence a legitimate medical condition. Instead, their anger and frustration would seem to be directed towards the medico-psychiatric professionals involved in their healthcare, an involvement which continues to propagate an imaginary connection between transsexualism and psychopathology. What became apparent throughout this research was the demand for a new kind of healthcare, which medical doctors and not psychiatrists have control over. Thus, where a consensus between Transgender activism and the views of many of those 'trans' women involved in my research exists, is in relation to the need to challenge psychiatric imperialism.

However, that little consistency with regards the demedicalization of transsexualism exists, points to the need to problematize a universal trans politics, which has the potential effect of homogenizing trans experiences and subjectivities. The limits of a Transgender politics is then its inability to speak for all trans subject positions. Moreover, by casting those 'trans' women who identify within a 'medicalized border', Transgender fails both to understand the ways in which that subject position (as we saw in Themes 1 and 2) confronts medico-psychiatric discourses, as well as failing to conceive of 'trans' women as active in the construction of a subject position subsequently colonized by medico-psychiatry. In doing so, Transgender serves to pacify those 'trans' women who do not identify within a queer politics, thus positioning them as the 'dupes' of a narrative script which they in fact had a hand in constructing. From this then, the Transgender call for the rejection of medicalization serves only to homogenize trans-subjectivities, and fails to recognize the ways in which this is a problematic move for some. Moreover, and perhaps crucially, Transgender fails to pay attention to the disastrous consequences that such a move could potentially have. That is, by demedicalizing transsexualism, you take away its medical legitimacy. The effect of this is that already scarce funding could be further constrained as 'sex change' comes to be perceived as more of a cosmetic procedure than a medical condition.

The narrative extracts taken from my research with 'trans' women throws light upon our understanding of the issues of ownership and authority, and gives us a glimpse into how and why it is that psychiatric imperialism is beginning to be challenged, as well as why, for some, the medicalization of transsexualism continues to be thought of as desirable within certain trans subject positions. What we are left with then is a complex set of power relations, which
encourage us to move beyond thinking in terms of a uniform trans politics. Instead, I suggest that we are witnessing a period of intense negotiation; where by trans people are making sense of their selves, to varying degrees, in relation to both medico-psychiatric and trans-political discourses. What I am arguing here is that a cohesive and uniform trans discourse is necessarily contradicted by the multiplicity of trans subjectivities. Thus one discourse or one subject position cannot speak for a multitude of voices. Rather, what we need is a politics that is able to combine those differing subject positions in such a way as to strengthen their unity whilst respecting their difference.

It has not been my intention here to negate the political importance of Transgender, but rather to recognize that trans situated identities are heterogeneous, with neither transsexualism nor Transgenderism being more ‘authentic’ or real than the other. The trouble with Transgender as an inclusive identity category is that it runs the risk of failing to recognize the stark differences between trans subject positions, and whilst it speaks of embracing difference it nonetheless runs the risk of collapsing these varied subject positions into one homogenous entity, which stands apart from the ‘non-queer’ world, and as such negates the embodied nature of gender and the material conditions of sex.

What is needed then is a theory that recognizes the long history, and diverse nature of trans situated identities, and importantly, their existence prior to medico-psychiatric naming. Moreover, by understanding those situated identities that narrativize an identity within the male/female binary as having been co-opted by medico-psychiatric discourse, we are able to move away from the conception that they are somehow involved in a duped or duplicitous relationship with it, and as such are less ‘authentic’ than those trans-subject positions which speak from outside of the proscribed medico-psychiatric and sex/gender borders. It is through recognizing the ways in which the latter subject positions have been silenced by medico-psychiatric discourses that feared the ‘threat’ it posited to the sex/gender status quo, that we are able to understand the richness and diversity of trans-situated identities, rather than fall into the trap of hierarchializing trans identity, as is often the case within much Transgender and queer theorizing. Moreover, by accepting that trans identities vary in relation to the sex/gender binary, we can begin to understand the richness and diversity of trans experience and hence move away from thinking of trans as a coherent subject position with one ‘true’ tale to tell. All trans voices need to be celebrated for their richness and diversity. The inability to speak of that diversity for so long surely means that we should not condemn any trans expression of self.
By drawing together the key findings from each theme, we can see that a number of key tropes seem to be at work. Firstly, we have seen the ways in which ‘trans’ women can be said to have been active in the construction of a trans identity, which emerged from around the late nineteenth century. This clearly confronts those theories, largely informed by the work of Foucault, and from within labelling theory, which stress that transsexualism emerged in and through medico-psychiatric thought about it (see Hausman, 1995 and Billings and Urban, 1996). By conceiving of ‘trans’ women as active agents in the construction of a trans identity we are also able to problematize those feminist assumptions which position ‘trans’ women within a duped/duplicitous relationship to medico-psychiatry (Raymond, 1979; Shapiro, 1991; Hausman, 1995). My own research findings within both Theme 1 and 2 clearly build upon the necessity of this critique, and enable us to see the ways in which the stories that ‘trans’ women narrate about transsexualism, in terms of its definition, aetiology and diagnostic criteria, clearly confronts hegemonic medico-psychiatric discourses of their ‘being’ and becoming.

The second trope to emerge from my research relates to the need to think in terms not of one ‘true’ or ‘authentic’ trans identity, but in terms of multiple trans-subjectivities. Such a premise allows us to critique the medico-psychiatric scripting of transsexualism (Theme 1 and 2), but also enables us to problematize much Transgender theorizing. Thus, the recognition of multiple trans-subjectivities necessarily confronts Transgender’s call for a universal and inclusive politics which seeks to deconstruct and thus stand apart from both medico-psychiatric scriptings of a trans self, as well as the limitations of a rigidly dichotomized sex/gender binary. With regards the former, such an inclusive approach fails to attend to the specificities of all trans subject positions, as well as the fact that ‘trans’ women and not medico-psychiatry were the original authors of the subject position which Transgender seeks to overturn. Finally, and with regards to the latter, Transgender fails to consider the ways in which those ‘trans’ women, whilst positioning themselves within a medical border, do indeed open up a conceptual space between ‘female’ and ‘male’. It is my suggestion that a gender politics that recognizes lived experience over radical deconstruction provides a more useful and insightful means by which to critique and move beyond those ontological assumptions as to the ‘naturalness’ of sex/gender congruency.
Conclusion

It is undoubtedly an exciting time for trans theory and politics, with academics from almost every theoretical persuasion – social constructionists, gender theorists, labelling theorists, feminists, poststructuralists, queer theorists, and many more – entering into debates as to the significance of transsexualism and its implications for the ways in which we think about the gendered world. From this comes fresh insights and new political agendas; and as new problems arise, together with new solutions to them, this once small domain of gender studies will continue to grow and make advances towards the social, legal and medical empowerment of trans people across the western world. However, as with anything, those current debates as to the origins and status of transsexualism as a socio-medical phenomenon have been hotly contested, and have sparked fierce debate from within the sociological imaginary. Here we see contentions over the origins of transsexualism (King, 1993, 1996, Hausman, 1995; Prosser, 1998), its relationship to medico-psychiatry (King, 1987, 1993, 1996; Hausman, 1995; Califia. 1997; Namaste, 2000) as well as what the existence of transsexualism means for the sex/gender system (Raymond, 1979; Shapiro, 1991; Bornstein, 1994; Jeffreys, 1996).

What I hope I have been able to show throughout this thesis is the ways in which we can move some of these debates on, and as such offer a fresh perspective on the relationship between medico-psychiatry and trans-subjectivity. By looking at the divergent ways in which medico-psychiatric discourses and clinicians, and 'trans' women tell stories of trans becoming I hope to have been able to have offered a critical insight into the relationship between medico-psychiatry and trans-subjectivity. Moreover, it is by placing the words and voices of 'trans' women at the centre of any empirical investigation, that I suggest we are able to look to the future and rethink our contemporary understandings of trans becoming as well as its implications for trans politics.

The political implications of trans theory are immense, but within much of the literature, especially that within radical lesbian and psychoanalytic feminism (Raymond, 1979; Millot, 1990; Jeffreys, 1996) and medicalization theory (Hausman, 1995; Billing and Urban, 1996), it would seem almost that any potential for political action and change by 'trans' women is deemed impossible. For, it is from such a position, which has so often conceived of 'trans' women within a duped/duplicitous dyad, that such theorists naively assume that 'trans'
women present no challenge to the controlling discourses and practices that surround their lives and identities.

However, evidence from my research confronts and problematizes such a simplistic and somewhat damning typology of trans becoming. Thus, it became apparent that the ways in which trans becoming is understood within medico-psychiatric discourses and clinical practice, and by ‘trans’ women significantly diverge from one another. Thus, we saw the ways in which ‘trans’ women’s scriptings of their becoming can be said to present a very real challenge to those discourses that abound within medico-psychiatry. Whilst drawing upon the medical paradigm to understand the self, the ways in which the ‘trans’ women I spoke to did so, confronts in significant ways trans becoming as it is scripted within medico-psychiatric discourses and clinical practice. Moreover, whilst from a queer or Transgender perspective, it might be tempting to suggest that in scripting their becoming in terms of a (bio)logical predisposition, those ‘trans’ women I interviewed ascribed to and hence reified medico-psychiatric discourses, my research revealed the ways in which ‘trans’ women negotiate their becoming in relation to, whilst simultaneously standing outside of that which is scripted of and for them by the medico-psychiatric profession. It is from my understanding of the multiplicity of trans-subjectivities, the construction of such subject positions prior to their medico-psychiatric, or discursive naming, and the divergences between stories of trans becoming as told within medico-psychiatry and by ‘trans’ women, that I hope to have been able to engage with and build upon interactionist theory. Thus, I have attempted to offer an account of trans becoming, as it is perceived by ‘trans’ women, not simply as the result of resistance to, or reification of hegemonic discourses, but instead, as a process of continual negotiation between subject and discourse, which at different historical moments has ebbed and flowed, at times giving more authority to lived experience, whilst at other moments, attaching legitimacy to the voices of powerful Others, who have sought to define and control that which they perceived to be ‘different’ and perhaps ‘dangerous. This process of negotiation in the formation of understandings about something is equally at play within those controlling discourses, which have, to varying degrees drawn upon and been influenced by the stories told by those whom they ‘treat’. Such a conceptualization, I hope, moves us beyond a somewhat simplistic typology of either conformity to or resistance to the stories of power holders by those about whom they speak

One of the significant problems with so much of the medico-psychiatric literature on transsexualism has been its assumption of one ‘true’ or ‘authentic’ trans narrative. It is such a contention that has necessarily served to silence the voices of trans people, as well as negating
the multiplicity of those very voices and subject positions. This grand silencing of trans-subjectivities has had enormous implications for the ways in which trans groups have been able to politicize their concerns, for it is hard to speak from a position that is believed not to exist. However, it has been my intention throughout this thesis to suggest that there exist not one, but multiple trans subject positions. Moreover, and in line with this, it has been my suggestion that medico-psychiatry came to co-opt and standardize one such subject position, which through a process of reification came to stand for the experiences of all. The result was that those personal narratives of self which stood apart from that co-opted subject position, lost ground and thus their ability to speak, and importantly, be heard. However, as we have seen in recent years, and on the back of the enormous strides made by gay and lesbian activists, those trans voices, once silenced are beginning to speak and be heard.

It is by thinking in terms of the multiplicity of trans-subjectivities that we are able to question the homogenizing tendencies of medico-psychiatry, as well as begin to present a challenge to reductionist assumptions regarding the relationship between medico-psychiatry and trans-subjectivity. This, together with a recognition of the ways in which ‘trans’ women can be seen to have been active in the construction of that trans narrative, later colonized by medico-psychiatry that we are able to offer a critical perspective on the relationship between medico-psychiatry and trans-subjectivity. Thus, it becomes possible to critique a discursive position which suggests that transsexualism only became meaningful once it had been named, and once the technologies of ‘sex change’ became possible, and instead suggest that trans is in part a self-constructed subject position. Moreover, rather than there being but one trans narrative, there is in fact a whole array of trans possibilities.

However, it needs to be recognized that the scripting of a ‘true’ trans narrative, or at least a more ‘authentic’ expression of self, and the consequent homogenizing of the trans experience is not something peculiar only to medico-psychiatry, but can also be found amongst some Transgender theorizing. It is because of the homogenizing of trans-subjectivities by Transgender theory that their challenge to the control of trans bodies via medico-psychiatric and sex/gender discourses, becomes problematic. The contemporary literature relating to trans politics calls for a movement away from more ‘normative’ forms of trans identification, which it argues are premised upon the maintenance of the sex/gender dyad, as well as the medico-psychiatric discourses of transsexualism, and towards a more queer, destabilized sense of self contained under the rubric of Transgender. Within this new politics, we find calls for the radical disrupture of identity categories in order to find a place outside of normative sex/gender categories. Here then, the body is regarded as a blank canvas upon
which the self can be written, played with and re-written as a means of destabilizing those ontologies which have long since been regarded as socially constructed. However, it is the trappings of such a theory which has ultimately lead to its downfall. There is a tendency within queer theory, despite its intentions, to homogenize trans subject positions, calling as it does for all self-identified trans people to break free from the shackles of sex/gender and medico-psychiatric imperialism. In so doing, Transgender theorizing not only negates lived experience, but also the multiplicity of trans-subjectivities. The danger then in espousing a radical subjectivity that does not pay attention to the heterogeneity of lived experience, is that those who advance such a position ultimately become the police of the very subjectivities they are arguing should be free.

One of the principle challenges to Transgender theorizing that came out in my research stands in relation to its call for an inclusive politics, which seeks to bring together all forms of gendered difference under one queer umbrella. Yet, it was the contention of so many of the ‘trans’ women I spoke to, that transsexualism and Transgender ought to be thought of a qualitatively different, with the former being regarded as a legitimate medical condition, and as such makes claims to ‘gendered realness’. Meanwhile, the latter was cast as a lifestyle choice, premised not on need but on desire. The two positions, from the perspectives of the ‘trans’ women involved in this research, are then antithetical to one another, each with their own distinct political aims, objectives and desired outcomes.

Whatever form future trans theorizing and politics takes, its success will lie in its ability to speak to as many subjectivities as possible, and as such, bring together dissident groups, whilst at all times being mindful of, and indeed embracing their difference. Moreover, for any theory to succeed, lived experience needs to be made central, for to do otherwise serves only to exclude and segregate.

It is by placing the voices of those ‘trans’ women that I spoke to at the centre of my research and writings that I have been able, not only to demonstrate a sensitivity to the field in which I was situated, but to demonstrate the importance of recognizing lived experience as the only means by which we can ever truly understand, and thus begin to theorize about those whom we purport to study. To neglect lived experience is to do so at our peril, for it is only by submerging ourselves in the field, seeing how something is lived, negotiated and understood from the perspective of those whom we engage with in our research, that we are ever able to truly understand. This was especially pertinent to my research, given my outsider status. And even though I would never presume to suggest that I can ever fully appreciate what it must be
like to be a ‘trans’ woman, I would have had no comprehension at all if it were not for those courageous women who so freely shared their experiences with me.

By insisting that all social research should endeavour to be emancipatory, whilst simultaneously recognizing some of the limitations of such an approach – our ultimate position as the authors of the research, as well as the fact that many people may not wish to be empowered – I hope I have been able to suggest ways in which, as researchers and academics we are able to make real steps towards equalizing the relationship between ourselves and our respondents. It is by stepping outside of the box of academic neutrality and privilege that seems to have been constructed for us that I suggest we are able to produce research which is meaningful and empowering. Moreover, by centralizing lived experience within our research we are able to recognize the pivotal role played by our respondents, without whom after all our research would not be possible.

Moreover, I hope that through the deployment of a range of methods, I have been able to reflect multiple voices throughout my research. Here then, the thesis reveals and documents those stories of, and about transsexualism, as told by a range of different groups, from general practitioners, to ‘gender specialists’ (psychiatrists, psychologists, psychoanalysts, surgeons and gender counsellors) and ‘trans’ women. It is by presenting a wide range of voices, rather than simply reflecting one group, that I have been able to produce some clear and weighty research material that goes towards constructing a rounded account of the relationship between medico-psychiatry and trans-subjectivity, from the perspectives of all involved. Finally, I hope that I have been able to demonstrate a clear engagement with the history of, and background to the construction of a trans identity as well as its relationship to medico-psychiatry.

Whilst I have undoubtedly engaged with a range of voices, it is my belief that the thesis could have benefited from having engaged with for example, ‘trans’ men, as well as individuals who identify as Transgender. This would I believe, have enabled me to paint a more rounded picture of the relationship between medico-psychiatry and all trans subject positions. However, it is important to stress that I do not see this as an exhaustive piece of research, but instead as something which I hope to be able to build upon throughout my academic career. It is in this way then, that the weaknesses of this thesis can be seen as an important starting point for future research.
Looking to the future, one possible way in which this research could be extended would be by exploring the ways in which law and legal discourses have served as an important site of cultural production. This line of inquiry is especially pertinent, given the current climate of pending legal change which should allow trans people to have their subjectively experienced gender recognized in a court of law, and which would in turn grant them long awaited civil recognition. When legal jurisprudence encounters the trans body, the body becomes an important site for the “production and non-production” (Butler, 1993: 22) of sexed, gendered and sexual identities. Thus, it is by assessing the extent to which English case law, when confronted with transsexualism, draws to varying degrees upon discourses of essentialism and a homo/hetero dyad that we are able to understand the ways in which sex, gender and sexuality are worked through in the stories of law.

The first way in which legal jurisprudence acts as a site for cultural production stands in relation to its quest to determine sex. This was an issue that first came to the fore as a result of the 1970s landmark case of *Corbett v Corbett*, which resulted in the formulation of a test to decide upon the sex of an individual for the purpose of marriage. The case concerned the marriage of April Ashley (a ‘trans’ women) to Arthur Corbett. Upon the breakdown of the marriage, Arthur Corbett petitioned for nullity on the following grounds: that the respondent (April Ashley) remained male and hence the marriage was void, and that the marriage was never consummated due to the incapacity of the respondent. The presiding judge, Lord Ormrod, devised a test in order to determine the sex of April Ashley, the result of which considered her sex, determined through chromosomal, gonadal and genital features, to be male at the moment of birth. Thus, the legal test for the determination of an individual’s sex was to be born, and henceforth became inaugurated within both the English judicial imaginary, and much of the common law world (see *Bellinger v Bellinger*, 2000; *S-T [formerly J] v J*, 1998). Moreover, the triumvirate test, whilst originally devised to determine sex for the purpose of marriage, subsequently came to be applied to such areas as criminal law (*R v Tan*, 1988) and beyond. Legal judgements drawing upon the essentialist approach look at one key feature and assign all individuals accordingly into either the ‘male’ or the ‘female’ sex. Such an essentialist approach to the determination of legal sex, which rejects psychological or behavioural sex, remains the current test applied within UK courts.

In recent years, an alternative test for the determination of sex, known as the ‘psychological and anatomical harmony test’ has been applied in United States case law (see, *Re Anonymous*, 1968) and Australian courts of law (see, *R v Harris and McGuiness*, 1989). Such a reformist strategy, which has attempted to move towards the legitimatization of trans people’s claims to
'gendered realness'. This approach, whilst also drawing upon essentialist features characterized as either 'male' or 'female' does allow for "concepts such as masculinity or maleness [and femininity and maleness] to appear within the legal matrix" (Whittle, 2002: 12). Moreover, the approach has the potential to allow for personal choice as opposed to merely ascription. It is just such an approach, as a reformist strategy, which underpins the British Government's eventual pledge to grant trans people legal recognition in their subjectively experienced gender. However, such an approach is limited in its demand for the surgical congruence of body and self, thus reinscribing sex/gender congruency as a socio-legal necessity. Where the demand for surgical congruence becomes most problematic is in the case of 'trans' men, who often, as a result of phalloplastic procedures being so incredibly arduous, expensive and often only of partial success, choose or are unable to somatically 'change sex'. It is as a result of this that such a legal strategy may well serve to exclude many 'trans' men from legal recognition.

Trans bodies of law can also be seen as important sites for the cultural production of a hetero/homo dyad as maintained within the judicial imaginary. As Sharpe discusses, "judicial anxiety over the homosexual body proves to be a consistent and central feature of [trans] jurisprudence" (2002: 5). It is through a fear that the trans body closely approximates that of the homosexual and that sexual practices are indistinguishable, especially when the judiciary is asked to consider the question of marriage, that an anxiety over the homosexual body can be seen to emerge. This homophobia of law manifests itself, according to Sharpe (2002), in terms of both the conflation of trans and homosexual bodies and desires, and in the contradictory medico-psychiatric insistence on viewing both sets of bodies and desires and incommensurate. Homosexuality, when imagined through the trans body of law, functions then as a sign of 'inauthenticity' of a trans identity.

Thus, it is by considering the ways in which legal jurisprudence acts as a site for the cultural production of sexed, gendered and sexual identities, as well as the ways in which its foundations are constructed in an almost symbiotic relationship to contemporary medico-psychiatric discourses on transsexualism that the study of the effects of such an imaginary on the lives of 'trans' men and women becomes crucial. Moreover, by looking at the ways in which alternative methods of testing for an individual's sex have been imagined within courts of law, along with their benefits and limitations, that we can perhaps begin to look at both the hostility with regards to granting civil recognition to trans people on the part of the British Government, as well as alternative strategies for a legal recognition of trans bodies and identities, together with what such a change would mean for trans politics in the future.
General Practitioner Questionnaire 1

The information provided in this questionnaire will be treated as strictly confidential.

Name: 
Age: 
Gender: 
Surgery Address: 
Where Qualified: 
Years in Practice: 

1) How many transsexual patients have you seen during your time as a GP?
   a. None: 
   b. One: 
   c. Two: 
   d. Three: 
   e. More than three: 

2) Are you familiar with the treatment process for transsexualism?
   a. Yes, extensive knowledge of the treatment process: 
   b. Yes, some familiarity with the treatment process: 
   c. Very little familiarity: 
   d. No knowledge of the process at all 

3) Do you have ready access to the names of psychiatrists/psychologists specializing in transsexualism?
   a. Yes: 
   b. No: 
   c. Don’t know: 

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4) Whilst at medical school, were you taught about transsexualism?

a. No, not at all: 

b. 1 Lecture: 

c. 2 Lectures: 

d. 3 Lectures: 

e. Appeared across several modules: 

5) Do you feel that you were given sufficient training on transsexualism?

a. Yes: 

b. No: 

6) Since qualifying, have you studied the topic of transsexualism any further?

c. Yes, a lot: 

d. Yes, a little: 

a. No: 

7) If YES, was this due to:

a. Having a transsexual patient: 

b. For medical reference purposes: 

b. Other: (please specify) 

______________________________
______________________________
______________________________

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8) Would you be willing to participate in either a further postal questionnaire or a 30-minute interview at a time of your choice?

   a. Questionnaire: □

   b. Interview: □

   c. Both: □

   d. Neither: □

If there is anything else that you wish to add, please do so in the space provided below:

Thank you for your time and co-operation.
APPENDIX 1b -

General Practitioner Questionnaire 2

The information provided in this questionnaire will be treated as strictly confidential.

Name:
Surgery Address:

1a) In your initial questionnaire you stated that you had seen X number of transsexual patients. What proportion of those were transsexual women and what proportion were transsexual men?

a. Transsexual women:

b. Transsexual men:

b. Are you aware if subsequent patients came to you because of your previous experience with transsexual patients?

a. Yes:

b. No:

c. Don’t know:

2) When they came to you had they already self-diagnosed?

a. Yes:

b. No:

c. Don’t know:
3) **Was this as transsexual or something else?**
   a. Transsexual: □
   b. Transvestite: □
   c. Homosexual: □
   d. Other (please specify) ________________________________

4) **Were you happy to accept their self-diagnosis, or did you offer an alternative diagnosis?**
   a. Happy to accept: □
   b. Not happy to accept: □
   c. Offered an alternative diagnosis: □

   If you answered YES to C, please state the alternative diagnosis given
   _____________________________________________________________

5) **If you answered YES to 5C, did the offer of an alternative diagnosis create hostility on the part of the patient?**
   a. Yes: □
   b. No: □
   c. Don’t Know: □

6) **What do you understand transsexualism to be?**
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
Listed below are a series of statements. Please indicate the degree to which you think each is important or unimportant in order to diagnose transsexualism in a TRANS WOMAN by ticking the appropriate box for each response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Important</th>
<th>Important</th>
<th>Neither Agree nor Disagree</th>
<th>Not Important</th>
<th>Not at all Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>They are able to pass convincingly in their subjectively experienced gender</td>
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<tr>
<td>They have come dressed in a manner appropriate to their subjectively experienced gender</td>
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<td></td>
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<tr>
<td>They display the behaviour and mannerisms of their subjectively experienced gender</td>
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<tr>
<td>They should have adopted the gender role of their subjectively experienced gender</td>
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<tr>
<td>They should already be living in the gender role of their subjectively experienced gender</td>
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<tr>
<td>They should express the feeling of being trapped in the wrong body.</td>
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<tr>
<td>They should have a strong and persistent desire to live as the other gender.</td>
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<tr>
<td>They should have a strong and persistent desire to change sex.</td>
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<td>They should desire hormone therapy.</td>
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<td>They should desire full hormonal and surgical realignment.</td>
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<td>They should have felt this way since earliest childhood.</td>
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<td>They should be heterosexual in orientation.</td>
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<tr>
<td>They should not be sexually aroused from dressing/being their subjectively experienced gender?</td>
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8) Diagnosis and TRANS MEN:

Listed below are a series of statements.
Please indicate the degree to which you think each is important or unimportant in order to diagnose transsexualism in a TRANS MAN by ticking the appropriate box for each response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Important 1</th>
<th>Important 2</th>
<th>Neither Agree nor Disagree 3</th>
<th>Not Important 4</th>
<th>Not at all Important 5</th>
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</tbody>
</table>
9a) Are you aware that transsexualism is classified as a mental illness by the American Psychiatric Association?

   a. Yes:  
   b. No:  
   c. Don't know:  

9b) What are your views on that?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10) On what grounds would you refuse to refer a person presenting as transsexual?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11) Do you believe there to be a typical personality type associated with transsexualism, and can you describe it?

   Yes:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

   No:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
12) Do you believe that a certain pattern of socialization can lead to transsexualism?

Yes:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

No:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

If there is anything else that you wish to add, please do so in the space provided below:


Thank you for your time and co-operation.
General Practitioner Interview Schedule

Section A: Your Role as a General Practitioner:

1. How many trans patients have you seen?

2. Have these patients come to you because they are trans, or have they come for other health reasons?

3. Do you prefer to use the term ‘patient’ or ‘client’? Can you explain why?

4. How do you see your role in the treatment process for trans people?

5. How important do you think it is that GPs have prior knowledge about transsexualism before seeing such a patient?

Section B: Your Understanding of Transsexualism:

1. In the questionnaire that you completed, you stated that you believe transsexualism to be ____________, can you explain that in more detail for me?

2. In your opinion, does transsexualism constitute an acquired, an inherited, or a congenital condition?

3. Do you believe biological sex and psychological gender to be always and necessarily congruent?

4. What factors do you think give rise to transsexualism and can you explain them?

5. Under what circumstances do you think that an individual would falsely identify as transsexual?

Section C: The Treatment Process:

1. In your opinion, what is the best treatment method for transsexualism?

2. Do you think that it is important that trans people undergo some form of clinical treatment?

3. In your opinion, is it important that trans people undergo full hormonal and surgical alignment?

4. Do you believe that trans people have the right to demand hormonal and surgical intervention?
Section D: Diagnostic Differences:

1. Do you think that transsexualism and transvestism are related?
2. If no, in your opinion, what differentiates the two?
3. Do you think that transsexualism and homosexuality are related?
4. If no, in your opinion, what differentiates the two?
5. Do you think that transsexualism is related to intersex conditions?
6. In your opinion, what differentiates the two?
7. Do you think that transsexualism provides evidence for the existence of a third sex?

Section E: Differences in Gender:

1. Do you think that there is a qualitative difference between trans women and trans men?
2. Do you think that trans men and trans women are equally as likely to seek medical intervention or not?
Gender Specialist Questionnaire

The information provided in this questionnaire will be treated as strictly confidential

Name:
Age:
Sex:
Hospital Address:
Years in Practice:

1) What would you describe as your role within the treatment process for gender dysphoria?
   a. Psychiatrist: □
   b. Psychologist: □
   c. Counsellor: □
   d. Surgeon: □
   e. Endocrinologist: □
   f. Other ____________________________

2) Do you specialise in the treatment of trans women, trans men, or both?
   a. Trans Women: □
   b. Trans Men: □
   c. Both: □

3) Why have you chosen to specialise in the treatment of one or the other or both?
   __________________________________________________

4) Are you aware if patients come to you especially as a result of a reputation that you have built up?
   a. Yes: □
   b. No: □
   c. Unsure: □
5) **What terminological language do you prefer to use?**

   a. Transsexualism  
   b. Gender Identity Disorder  
   c. Gender Dysphoria  
   d. Other _________________________________

6) **Why do you make use of that particular classification?**

   __________________________________________
   __________________________________________
   __________________________________________

7) **Do you prefer to use the term ‘patient,’ ‘client,’ or ‘service user’? Please give your reasons:**

   a. Patient  
   b. Client  
   c. Service User

8) **Can you briefly outline what you believe transsexualism to be?**

   __________________________________________
   __________________________________________
   __________________________________________

9) **Do you believe that transsexualism is an acquired, an inherited or a congenital condition?**

   a. Acquired:  
   b. Inherited:  
   c. Congenital:  
   d. A combination of the above. (please specify)

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
Listed below are a series of statements. Please indicate the degree to which you think each is important or unimportant in order to diagnose transsexualism in a TRANS WOMAN by ticking the appropriate box for each response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Important 1</th>
<th>Important 2</th>
<th>Neither Agree nor Disagree 3</th>
<th>Not Important 4</th>
<th>Not at all Important 5</th>
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<tr>
<td>They are able to pass convincingly in their subjectively experienced gender</td>
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<td>They have come dressed in a manner appropriate to their subjectively experienced gender</td>
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<td>They display the behaviour and mannerisms of their subjectively experienced gender</td>
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<tr>
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<td>They should desire hormone therapy.</td>
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<tr>
<td>They should have felt this way since earliest childhood.</td>
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<td>They should be heterosexual in orientation.</td>
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<tr>
<td>They should not be sexually aroused from dressing/being their subjectively experienced gender?</td>
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11) Diagnosis and TRANS MEN:

Listed below are a series of statements. Please indicate the degree to which you think each is important or unimportant in order to diagnose transsexualism in a TRANS MAN by ticking the appropriate box for each response.

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</table>
12) Would you be willing to participate in a further interview of approximately 1 hour in length?
   
   a. Yes: □
   b. No: □

If there is anything else that you wish to add, please do so in the space provided below:

Thank you for your time and co-operation.
Gender Specialist Interview Schedule

1. What do you think motivates people to attend a gender identity clinic?
2. What do you think motivates people to seek sex reassignment surgery?
3. What do you understand transsexualism to be?
4. And what do you see as the main causes of transsexualism and can you explain them?
5. Would you say then that transsexualism is a mental illness?
6. And how would you explain trans people's desire to match their genitals and/or bodies to their subjectively experienced gender?
7. Would you say that the desire for hormonal and surgical reassignment is indicative of a 'true' transsexual identity?
8. What factors do you think are important for a diagnosis of transsexualism?
9. And would you say that childhood onset is important in terms of diagnosis?
10. And what can you tell me about the sexual orientation of trans people?
11. Thinking about when a client comes to see you to discuss surgery, how important is it that they wear the clothes of their subjectively experienced gender?
12. In terms of actually making a diagnosis, how important is it for you that a patient acts or behaves in a manner appropriate to their subjectively experienced gender?
13. And is the ability to pass or at least physically look like a member of their subjectively experienced gender important for diagnosis?
14. So, under what circumstances do you think that people may falsely identify as transsexual?
15. What measures do you put in place to make sure that a patient is genuine in their wish for hormonal and or surgical reassignment?
16. And are you aware if any of your patients have lied, or made modifications to their life histories in order to receive a positive diagnosis?
17. And on what grounds would you refuse to diagnose someone as transsexual/ perform SRS?
18. Do you make use of the ICD10 or the DSM, and why\(^1\)?

19. Does the clinic’s treatment protocol differ for trans men and trans women?

20. Why do you believe that it is important that a patient undergoes a real life test before starting hormones?

21. And if somebody had say lived in role for a year before coming to see you would that make a difference?

22. And do you have a policy on name changes?

23. So you don’t require you patients to adopt a gender marked as opposed to a unisex name?

24. Do you think surgery is an effective treatment for transsexualism?

25. And so would you say that the desire for hormonal and surgical intervention is indicative of a true transsexual identity?

26. And do you think that patients can live both happily and successfully without full hormonal and surgical reassignment?

27. And what do you see as the most important outcome of hormonal and surgical reassignment?

28. And in terms of the surgery itself, what do you regard as more important, functional or aesthetically pleasing genitalia?

29. Would you say that your patients change their sex or change their gender?

30. And do you think that surgery should be given on demand?

31. Can you explain the surgical techniques that you perform? (Surgeons only)

32. Would you say that your techniques are geared toward creating functional or aesthetically pleasing genitalia? (Surgeons only)

33. And would you say that your surgical techniques effectively meet the needs of your patients?

34. What do you see as the most important outcomes of sex reassignment surgery?

35. Finally, much of the recent trans-academic literature suggests that a growing number of trans-identified people are actively seeking to reject the medicalization of their bodies, why do you think that is and how do you feel about it?

\(^1\) The ICD10 and the DSM-IV are the two main diagnostic systems for transsexualism currently in operation. Developed by the World Health Organization, the ICD10 is the European classificatory system, while the DSM-IV is principally a United States system of classification. In practice however, the DSM-IV is used far more extensively, especially within Britain than is the ICD10.
Trans Interview Schedule

1. Can you tell me about when you first realised that you were trans/a woman?

2. Can you tell me about your transition?

3. Can I ask what you believe transsexualism to be?

4. Do you think that it is important for trans-identified people to eventually have hormonal and surgical gender reassignment?

5. Can you tell me about your experiences with psychiatrists working in this field?

6. Can you tell me about your first point of contact with the medical profession your GP?

7. What do you think the psychiatrists working in this field think transsexualism is, and does that differ from your own view?

8. Can you tell me about your experiences with surgeons?

9. Can you tell me about your experiences with endocrinologists?

10. What are your experiences of the diagnostic process?

11. Have you had any experience with the law as a result of being trans?

12. Would you say that you were politically active within the trans community?
Mini Biographies of the ‘Trans’ Women Involved in the Research

Jessica:
Jessica identifies as a lesbian ‘trans’ woman. She first realized that she had ‘trans issues’ when she was around 10 years of age. At this point she knew that something was wrong, but couldn’t put her finger on exactly what that was, but couldn’t help thinking that if only doctors did some kind of test, or looked underneath, they would find out the truth of her identity. Having been pushed into years of therapy by her mum as a teenager, Jessica lived in denial up until her 30s. Jessica used to obsessively read everything that she could about transsexualism and it was then that she found out that there were others who felt like her, and finally she could put a name to her feelings. Jessica finally sought help from an NHS gender identity clinic in the mid 1980s. Jessica explained that she was propelled into treatment because she couldn’t keep living a lie, and that she had to be true to herself; she also explained that even if she lived on a dessert island, surgery would still be crucial for her, because it is that that made her whole.

Janine:
Janine began to realize that something was ‘wrong’ when she was about 8 years of age, but describes not knowing quite what that was until someone in her local community ‘came out’. From that point on she began reading everything she could about transsexualism. Janine began to transition in the mid 1990s with the assistance of an NHS gender identity clinic. For Janine her identity is that of a woman, and was so even prior to transition, it was her body that was ‘wrong’ not her gender, which she describes as having always been female. Since coming out Janine has appeared on several television programmes, where she has talked openly about her experiences, Janine also plays an active role within the trans community.

Isabel:
Whilst Isabel realized that ‘changing sex’ was a possibility when she was around 12 years of age, she has only recently, now in her mid-50s, begun transition. Isabel, like so many ‘trans’ women, suppressed her feelings for a long time, got married and had children, but
came to the point where she couldn’t pretend any longer. Following an acrimonious divorce, Isabel began to make steps towards living in the role of her subjectively experienced gender, and now identifies as a ‘trans’ woman.

Claire:

From her earliest memories Claire knew that something was ‘wrong’, and although at that point she didn’t articulate those feelings as evidence of being a girl, she knew that she wanted to be like the other girl she played with. Claire began to read everything she could about transsexualism from the age of 10, and it was then that she began to find a name for the way that she was feeling. Claire began to transition only a few years ago, and at the point at which we first spoke, Claire was awaiting surgery. Claire identifies as a woman, and feels that surgery is important in order to make her complete.

Anna:

Anna realized something was ‘wrong’ when she was still very young, and when she was a little older she began to read all that she could about transsexualism. Finding a name for how she was feeling helped in some way to alleviate some of the anguish that she had gone through. For Anna, transsexualism is a physical birth defect, and because of that she identifies as a woman, and is against the label ‘transsexual’. For Anna, surgery was important so that she could ‘stand in front of the mirror and see woman’. Anna began her transition in 2000, where she first sought the help of an NHS GIC, but has subsequently chosen to seek private ‘treatment’.

Sue:

Sue realized that she was a woman in 2002 after a lifetime of exploring alternatives, but came to realize that she had to transition, in fear that to not do so would lead to her ‘doing something terrible.’ Sue chose to take a combination of NHS and private treatment, and identifies fully as a woman.

Zoë:

At around the age of 5, Zoë thought that a ‘big mistake’ had been made and that she should have been born as a girl. During her mid teens Zoë began to cross-dress, but living in a very strict family forced her cross-dressing and feelings of being a girl into silence. Zoë only
recently found out about the possibilities of ‘changing sex’ although she had up to this point already been living in the role of her subjectively experienced gender. For Zoë finding out about SRS was such a relief and she finally realized that she was not ‘a freak’, nor was she alone. Zoë began to transition in the late 1990s, and identifies as a ‘trans’ woman, and remains proud of her journey there.

**Ruth:**

Paula felt that something was ‘wrong’ at a very early age, but couldn’t quite put her finger on it. Approximately 15 years ago Ruth underwent a series of aversive and cognitive therapy sessions, but with little effect. After spending 6 harrowing years at an NHS GIC, where she kept being refused treatment, Ruth finally sought the help of a private psychiatrist a few years ago. Whilst Ruth has experienced quite a lot of problems with local children and employers, Ruth explained that she was happy with her life, which she shares with her partner and dog. Ruth identifies as a ‘trans’ woman.

**Becky:**

Becky stated that she had always known that she was ‘trans’, and found out about the possibility of SRS in her late teens. Having transitioned some years ago now, Becky plays an active role in both the trans and the lesbian communities. Becky is an open and vivacious self-identified ‘trans’ woman, who talks candidly about her life and experience to anyone who will listen! She is great fun to be around, and because of this is an appointed mother-figure in her local support network.

**Marie:**

Marie is Becky’s best friend. They met about six years ago during a support group meeting which both now play an active role in. Marie first realized that something was ‘wrong’ in her teens, although she quickly learned to suppress these feelings, burying herself in masculine pursuits, such as joining the army and covering her body in tattoos. Marie has only recently had surgery, which she had done abroad. Although there were a few complications, Marie now has a very happy life with her new partner. Like Becky, Marie identifies as a ‘trans’ woman.
Sharon:

Sharon first realized that something was ‘wrong’ when she was about 7 years of age. However, as she explained, she was born a girl and always had been one, and it was just that she was born with a ‘genetic malfunction’ which made her body develop along ‘male’ lines. Knowing that she would face enormous social condemnation if she ‘came out’, Sharon secretly cross-dressed and eventually married. Sharon finally transitioned only a few years ago and continues to live with her partner. At the point at which we met, Sharon was in the throws of a lengthy legal battle with her employers over charges of sex discrimination, a case which I am glad to say she won.

Jane:

Whilst Jane always felt that something was ‘wrong’, she doesn’t believe that she fits the ‘classic mould’ of a ‘trans’ woman. Having gone through lots of therapy as a child, she finally sought help from an NHS GIC in the mid 1980s, which she continued with until the mid 1990s, but because she felt that she wasn’t getting anywhere, she eventually transferred to the private sector however, she subsequently went back to the NHS GIC. Jane is pre-op and hopes that she won’t have to wait too long, but continues to be demoralized by the whole system.

Sarah:

Sarah began cross-dressing before puberty, and realized that she ‘wanted to be a girl’ in her mid teens. Because of the hostile reactions of her parents to her cross-dressing, Sarah kept pushing her feelings of wanting to be a woman to the back of her mind, and went on to marry and have children. Sarah eventually transitioned after meeting her partner and a TV/TS social event, who encouraged and supported her transition into her subjectively experienced gender. With a successful job and stable life, Sarah identifies as a ‘trans’ woman.

Daphne:

Daphne believed that something was ‘wrong’ for a very young age, but struggled for years to put a name to the way that she was feeling. Daphne has not long since had surgery, but is still coming to terms with the stigmatization that being trans often sadly brings with it. Although Daphne identifies as a woman, she has no problems with the term ‘trans’, and only wants to be accepted as herself.
Cerridwen:

Cerridwen realized that she was female when she was still very young, but did not know that the term ‘transsexual’ existed. At Grammar school she realized that she was not like the other children, but it was not until the 1990s that she realized that she was trans. After years of denial as a result of a hostile father, Cerridwen finally sought help only a few years ago, although she had been living almost 90 per-cent of her time in her subjectively experienced gender before that point. Cerridwen explained that she did not feel like a ‘trans’ person, but like any other woman.

Emma:

Emma realized that something was ‘wrong’ when she was aged 9, and explains how she felt a complete sense of alienness from her body. Misdiagnosed in the 1960s and sent for a barrage of ‘treatments’, Emma finally requested help again in the 1990s, after having been married to her partner, whom she still lives with, and describes as her ‘soul mate’. Emma plays a very active role in a number of trans organizations and has appeared in a number of magazine articles and television documentaries.

Julie:

Julie explained to me how she felt that something was ‘wrong’ from her earliest memories, although it was not until she was 12 that she first heard the term ‘transsexual’. Julie first started to transition over 20 years ago, but kept being refused treatment, or was constantly pushed back. After meeting her partner, Julies ceased hormone treatment after deciding that they would like to start a family. Since the birth of their gorgeous daughters, Julie has begun the process of transition again, and is now awaiting surgery. Julie openly identifies as a ‘trans’ woman, which she sees as the ‘only way to make people realize that we are normal’.

Charlotte:

For Charlotte, transsexualism is a medical term and does not reflect how she identifies. Charlotte rejects the term ‘transsexual’ and identifies as a woman, no different from any other woman. I know little about Charlotte’s early experiences, as she was extremely reluctant to talk about such issues. Moreover, because her interview was conducted using letter writing, the things that Charlotte relayed to me were the things that she felt needed to be discussed.
Chris:

Chris has not long since started transition, which she is doing via the private healthcare sector. Being incredibly socially isolated, at the point at which I met Chris, she was unsure whether she was going to continue, feeling that at least in the male role, she felt safe to leave her house. I have met Chris since the interview and these are still issues that trouble her.
Bibliography


- Gender Education and Advocacy (GAIN). [www.gender.org](http://www.gender.org)


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